NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

TRUST BOARD OF DIRECTORS – PUBLIC BOARD
Tuesday, 5 December 2023
Main Boardroom, Diana, Princess of Wales Hospital
Time – 10.15 am – 1.30 pm
For the purpose of transacting the business set out below

No	Agenda Item	Lead	Format	Purpose	Time
Standing Items					
1	Welcome and Apologies	Chair	Verbal	Noting	10:15 hrs
2	Declarations of Interest/Conflicts of interest with any agenda items	Chair	Verbal	Noting	
3	Minutes of the meeting held on Tuesday, 3 October 2023	Chair	Attached NLG(23)199	Approval	
4	Action Log - Public	Chair	Attached NLG(23)200	Noting	
5	Matters Arising	Chair	Verbal	Noting	
6	Trust Board Reporting Framework	Interim Governance Advisor	Attached NLG(23)201	Information	
7	Patient Story	Senior Nurse – Patient Experience	Verbal	Assurance	10:25 hrs
8	Report from the Group Chief Executive	Group CEO	Attached NLG(23)202	Assurance	10.45 hrs
9 Board Committees Highlight Reports					
9.1	Escalation from the Quality & Safety Committee	Chair of Committee	Attached NLG(23)203	Assurance	11.05 hrs
9.2	Escalation from the Finance & Performance Committee	Chair of Committee	Attached NLG(23)204	Assurance	11.20 hrs
9.3	Escalation from the Workforce Committee	Chair of Committee	Attached NLG(23)205	Assurance	11.35 hrs
9.4	Escalation from the Audit, Risk & Governance Committee	Chair of Committee	Attached NLG(23)206	Assurance	11:50 hrs
9.5	Escalation from the Group Development Committee-In-Common	Chair of Committee	Attached NLG(23)207	Assurance	12:05 hrs
9.6	Health Tree Foundation Trustees' Committee	Deputy Chair of Committee	Attached NLG(23)208	Assurance	12:15 hrs
BREAK – 12:25 hrs – 12:35 hrs					

10 Quality & Safety					
10.1	Maternity & Neonatal Oversight Report	Deputy Chief Nurse	Attached NLG(23)209	Assurance	12:35 hrs
11 Workforce					
11.1	Freedom to Speak up Guardian (FTSU) Report – Quarter Two	FTSU Guardian	Attached NLG(23)210	Assurance	12:45 hrs
12 Finance & Performance					
12.1	Winter Plan	Group Chief Delivery Officer	Attached NLG(23)211	Assurance	12:55 hrs
13 Governance and Assurance					
13.1	Board Assurance Framework	Interim Governance Advisor	Attached NLG(23)212	Assurance	13:05 hrs
14 Items for Approval					
14.1	**Emergency Preparedness**				
	Emergency Preparedness, Resilience & Response (EPRR) Annual Report	Group Chief Delivery Officer	Attached NLG(23)213	Approval	13:10 hrs
	Northern Lincolnshire and Goole NHS Foundation Trust Compliance with the NHS England Core Standards for EPRR 2023/24	Group Chief Delivery Officer	Attached NLG(23)214	Approval	
Any Other Business					
15	Other Business	Chair	Verbal	Noting	13:25 hrs
16	**Date and time of the next meeting:** Thursday, 8 February 2024 Time: 9.00 am Boardroom, Hull Royal Infirmary	Chair	Verbal	Information	
17 Supporting Documents					
17.1	**Quality & Safety**				
	Quality & Safety Committee Minutes – August & September 2023	Chair of Committee	Attached NLG(23)215	Noting	
	Nursing & Midwifery Assurance Report	Deputy Chief Nurse	Attached NLG(23)216	Assurance	
	Faculty of Medical Leadership & Management – Affiliated Organisation Report	Group Chief Medical Officer	Attached NLG(23)217	Assurance	
	Infection Prevention Control Annual Report	Deputy Chief Nurse	Attached NLG(23)218	Assurance	
	Safeguarding & Vulnerabilities Annual Report	Deputy Chief Nurse	Attached NLG(23)219	Assurance	

	Annual Medicines Optimisation Report 2022-2023 Annual Report	Chief Pharmacist	Attached NLG(23)241	Noting	
	Annual Patient Reported Outcome Measures (PROMs) Report	Head of Quality Assurance	Attached NLG(23)242	Noting	
	Serious Incident (SI) Annual Report 2022-2023	Associate Director of Quality Governance	Attached NLG(23)243	Noting	
17.2	**Workforce**				
	Workforce Committee Minutes – September 2023	Chair of Committee	Attached NLG(23)220	Noting	
	Guardian of Safe Working Hours Report – Quarter Two	Group Chief Medical Officer	Attached NLG(23)221	Noting	
17.3	**Finance & Performance**				
	Finance & Performance Committee Minutes – September & October 2023	Chair of Committee	Attached NLG(23)222	Noting	
17.4	**Audit, Risk & Governance**				
	Audit, Risk & Governance Committee Minutes – July 2023	Chair of Committee	Attached NLG(23)223	Noting	
17.5	**Health Tree Foundation Trustees'**				
	Health Tree Foundation Trustees' Committee Minutes – September 2023	Chair of Committee	Attached NLG(23)224	Noting	
	Health Tree Foundation's Annual Report 2022-2023	Chair of Committee	Attached NLG(23)236	Noting	
17.6	**Other**				
	Trust Board & Board Committee Meetings Timetable	Interim Governance Advisor	Attached NLG(23)225	Noting	
	Communications Report	Associate Director of Communications	Attached NLG(23)226	Noting	
	Integrated Performance Report	Interim Chief Information Officer	Attached NLG(23)227	Noting	
	Documents Signed Under Seal	Group Chief Executive	Attached NLG(23)228	Noting	

PROTOCOL FOR CONDUCT OF BOARD BUSINESS

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

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

NLG(23)199

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

TRUST BOARD OF DIRECTORS (MEETING IN PUBLIC)

Minutes of the Public Meeting held on Tuesday, 3 October 2023 at 9.00 am
In the Main Boardroom, Diana, Princess of Wales Hospital

For the purpose of transacting the business set out below:

Present:

Sean Lyons	Group Chair
Jonathan Lofthouse	Group Chief Executive
Linda Jackson	Vice Chair
Ellie Monkhouse	Chief Nurse
Shaun Stacey	Chief Operating Officer
Dr Kate Wood	Chief Medical Officer
Fiona Osborne	Non-Executive Director
Sue Liburd	Non-Executive Director
Gillian Ponder	Non-Executive Director
Simon Parkes	Non-Executive Director

In Attendance:

Adrian Beddow	Associate Director of Communications
Jackie Fenwick	Senior Nurse Vulnerabilities (for item 7)
Stuart Hall	Associate Non-Executive Director
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates & Facilities
Jo Loughborough	Patient Experience Lead (for item 7)
Suzanne Maclennan	Corporate Governance Officer
Ivan McConnell	Director of Strategic Development
Shauna McMahon	Chief Information Officer
Simon Nearney	Interim Director of People
Ian Reekie	Lead Governor
Sarah Meggitt	Personal Assistant to the Group Chair, Vice Chair & Director of Corporate Governance (note taker)

Standing Items

1 Welcome and Apologies

Sean Lyons welcomed everyone to the meeting and declared it open at 9.00 am.

Sean Lyons welcomed Jonathan Lofthouse, Group Chief Executive and Carla Ramsay, Chief of Staff to their first board meeting.

Apologies were noted from Kate Truscott and Lee Bond.

2 Declarations of Interest / Conflicts of Interest with any Agenda Items

Sean Lyons requested any declarations and conflicts of interest in respect of agenda items. Jonathan Lofthouse noted an outside role of Board Assessor for the Care Quality Commission (CQC).

3 Minutes of the meeting held on Tuesday, 1 August 2023 – NLG(23)168

The minutes of the meeting held on the 1 August 2023 were accepted as a true and accurate record and would be duly signed by the Chair once the following amendments were made.

- Dr Kate Wood referred to page two, item 1.3. It was noted this should read compassionate care and not passionate care.
- Dr Kate Wood referred to page five, item 3.1 regarding the comment made in respect of the Electronic Prescribing Medicine Administration (EPMA) system link with the WebV system. It was noted this would not be in place from October 2023. It was agreed the minutes would be amended to reflect this.

4 Action Log – Public – NLG(23)169

Sean Lyons referred to the action log and requested updates. The following updates were noted.

- Item 3.1, 1 August 2023 meeting - Quality & Safety - Key Issues – Integrated Performance Report (IPR). Shauna McMahon advised the target dates would be shown within the next report as this information would be available from the 6 October 2023. It was agreed this action would be closed.
- Item 3.3, 1 August 2023 meeting - Quality & Safety Committee Highlight Report - Board Development Session – Patient Safety Incident Reporting Framework (PSIRF). It was agreed this action would be further considered once the Group was in place. It was agreed this action would be closed.
- Item 5.1, 1 August 2023 meeting - Key Issues - Finance - Month 03 - Additional Summary to be included within report. It was noted this item would be covered as part of the Group Chief Executive (CEO) Report. It was agreed this action would be closed.

5 Matters Arising

There were no matters arising raised.

6 Board Reporting Framework – NLG(23)170

Helen Harris referred to the report and asked Board members to consider that reports should be submitted as detailed in the framework. Sean Lyons advised any changes would need to be approved through Jonathan Lofthouse.

7 Patient Story

Jo Loughborough and Jackie Fenwick introduced the patient story regarding transition of young patients moving from paediatrics to adult services, this related to Lisa's story.

Jo Loughborough explained this had previously been a missed opportunity as the service had not been in place. Unfortunately, this had an impact on disengagement which could affect patients' whole lives by reoccurring admissions.

Jonathan Lofthouse queried how many patients this would mean going forward. Jackie Fenwick explained this was approximately 60 per year, however, this would mean an increased number over a five-year period of approximately 300 patients. A query was raised as to why patients with epilepsy were the first ones to be part of this service. It was explained diabetic patients were to be the first, however, the engagement had not been as successful. As better engagement within the diabetic services was in place this was introduced first. Jonathan Lofthouse offered Executive support for the introduction of this service.

Shaun Stacey thanked Jackie Fenwick for sharing the story. Shaun Stacey advised Navigo had recently taken on Complementary and Alternative Medicine (CAM) Services for this patch, a query was raised as to whether the Trust would be linking into those services. Jackie Fenwick was an attendee at transition meetings for North Lincolnshire (NL) and North East Lincolnshire (NEL), however, was unsure whether Navigo linked in to this meeting so agreed to resolve this. It was highlighted that good working relationships were in place with Navigo. Fiona Osborne queried what success measures were in place in terms of involving other teams. Jackie Fenwick explained part of the process would be to meet with some 18 – 20-year-olds to obtain feedback on what individuals would have wanted from experiences. Ellie Monkhouse explained this had unfortunately been an unsupported element of healthcare, it was envisaged more issues would be highlighted in coming years.

Sean Lyons explained that his experience within further education had highlighted those children had nowhere to go and this did place a burden on them. Jackie Fenwick explained a National Strategy looking at Transition was to be put in place.

Sean Lyons thanked Jackie Fenwick for highlighting the issues to the Board.

8 Report from the Group Chief Executive – NLG(23)171

Jonathan Lofthouse referred to the Group CEO Report and highlighted key points. Numerous visits had been undertaken by Jonathan Lofthouse at all Trusts to numerous areas, it was noted communication would continue with monthly live video calls. This would include support from Executive colleagues where

questions would be responded to. Any questions not answered during the session would be published in weekly bulletins. The Board were advised Sue Symington, Integrated Care Board (ICB) Chair Designate had recently visited the Trust and Sarah Marsh, Chief Operating Officer at NHS England had advised of a future visit.

Jonathan Lofthouse referred to the Patient Safety and Quality update and asked Executive colleagues to provide updates. Ellie Monkhouse reported the Trust had received two assurance visits, some of which supported the exit programme from special measures. Feedback from both visits had been very positive.

It was noted the Joint Advisory Group (JAG) Accreditation had been sustained for Endoscopy at both sites. Shaun Stacey confirmed the national return for elective recovery had been submitted following appropriate approvals. There had been a slight under performance in terms of elective care mainly due to industrial action. Plans were in place to mitigate this and it was hoped this would be recovered by the end of the year. Sustained pressure within the region had recently impacted on ambulance handover. Work was being undertaken to support improvements within this area as there had been a slight increase in patients waiting more than 12 hours in the Emergency Department (ED). There had been a 13% increase in attendance at ED overall. Jonathan Lofthouse confirmed the Same Day Emergency Care (SDEC) Centre at Diana, Princess of Wales Hospital (DPOWH) was still on schedule and would be opened prior to the Christmas period. The Scunthorpe General Hospital (SGH) SDEC was due to be opened June 2024.

Jonathan Lofthouse referred to the Humber Acute Services Review (HASR) and confirmed the consultation process had commenced on the 25 September 2023, this would run until the 5 January 2024. Ivan McConnell explained there would be attendance at the Overview and Scrutiny Committees across the patch to share information, this would be extended to other relevant authorities. Improvements had been highlighted from a public perspective and the Councils had welcomed the approach being used.

Jonathan Lofthouse reported that although the financial position was better than plan there were particular risks around the Cost Improvement Plan (CIP) target as detailed within the report. It was noted the Chief Financial Officer with support from the Executive Team would work on providing more assurance going into quarter three and four to the Finance and Performance Committee (F&PC) and Trust Board.

In respect of workforce Simon Nearney reported on the Covid and flu vaccination programme. It was explained an incentive with remuneration reward was to be introduced at NLAG. Staff would receive an additional day leave if both vaccines had been received by the individual, however, this would only be rewarded if the 75% compliance was achieved across the Trust.

Simon Nearney referred to improvements being made for the costing of agency staff. The Trust was due to invite three companies to provide information and costings on agency usage, following this process the Trust hoped to reduce agency and bank spend.

Jonathan Lofthouse advised Executives would be encouraging staff to openly speak up regarding any concerns. Open sessions had been held and staff were encouraged to use the Freedom to Speak Up Guardians (FTSUG) to express any concerns.

Shauna McMahon explained it had been acceptance by partner colleagues that the funds received for the Electronic Patient Record (EPR) system had been insufficient. Following discussions regarding this it had been agreed the Business Case would be further updated and shared with the Trust Board for approval.

Simon Parkes referred to the additional leave day being awarded to staff and queried whether this could be implemented without appropriate approvals. Simon Nearney confirmed many Trusts offered the additional day, however, it was agreed to review this further. Linda Jackson queried how staff receiving vaccinations outside of employment would be captured. Simon Nearney advised a process would be in place for capturing that information from staff. It was noted staff would be able to provide written information from providers that offered the vaccination. Linda Jackson advised not all providers were providing written confirmation. Simon Nearney explained the Standard Operating Procedure (SOP) confirmed staff would require a written confirmation as proof, this process had worked well at HUTH in the past. Sean Lyons felt this was an issue that needed to be resolved to enable staff to provide the information.

Action: Simon Nearney

Gill Ponder queried whether staff should be rewarded for ensuring individual protection against those viruses, as in some circumstances awarding the additional day would impact on agency and bank cover. Jonathan Lofthouse advised discussions had taken place during Executive meetings and it had been explained that protecting staff had meant additional days sickness would possibly not be taken, it was proposed this would outweigh the costs of the additional days leave. Dr Kate Wood advised vaccinations had been discussed in national forums and issues had been raised how this stood from an ethical stance. The national stance had been that although Trusts had compliance that was required to be met this was not a mandatory requirement.

Sue Liburd queried whether there had been any negativity at HUTH for staff that had not wanted the vaccine, Simon Nearney advised this had not been the case. Those staff that could not have the vaccine due to medical reasons would still be awarded if 75% compliance was achieved.

9 Board Committees Highlight Reports

9.1 Escalation from the Quality & Safety Committee – NLG(23)172

Fiona Osborne referred to key points in the report and advised the Quality & Safety Committee (Q&SC) had gained assurance in some areas. The committee had received a referral from the Audit, Risk & Governance Committee (AR&GC) following a rating of limited assurance from Audit Yorkshire in relation to the World Health Organisation (WHO) Surgical checklist. The surgical team had attended

the committee to provide assurance and confirmed actions were being taken to address issues raised.

Concerns raised at the committee related to items of equipment, one being the Hemofiltration equipment replacement at DPOWH and the Magnetic Resonance Imaging (MRI) capacity at SGH. This was due to the scanner being out of use causing capacity to reduce by 50%.

The committee continued to be concerned about the level of vacancies in midwifery and pharmacy. Both teams continued to manage the issues and were assured staffing within areas was safe.

Fiona Osborne explained the committee had recommended the Annual Patient Experience Report for sign off.

Linda Jackson referred to the WHO checklist and queried what the issues were. Fiona Osborne explained one issue related to what happened on the day. One example referred to the daily team huddle, if no concerns were raised this was not noted in the feedback but should be included. Dr Kate Wood explained the audit compliance in maternity was currently 93% whereas theatre combined compliance was 98% both were deemed as limited assurance as this was not 100%. Further concerns raised related to findings not being discussed at relevant Governance Meetings, this had now been resolved. There were no safety concerns due to the compliance being met and any previous concerns raised had been resolved.

Linda Jackson referred to the birth ratio detailed within the report and queried how this would be managed in terms of skills mix. Ellie Monkhouse explained staffing ratios within maternity were managed by occupancy levels, robust daily staffing assessments were being undertaken. Previous process would be in place for new staff expected within the unit. Pastoral support and buddying arrangements would be in place to enhance support. It was recognised some individuals may require additional support after that period.

Shaun Stacey confirmed an increased number of MRI mobile units had been put in place to reduce the waiting times for a scan. The Capital Investment Board (CIB) had discussed the issues raised and would look at resolving the existing issues with the scanner. Unfortunately, the current capital allocation would not allow the scanner to be replaced. Jonathan Lofthouse advised national funds were being reviewed to try and support this.

Sean Lyons referred to the PSIRF arrangements as detailed within the report querying whether there was confidence the migration of data from the previous system would be supported. Dr Kate Wood explained work had been undertaken with the ICB to ensure this would be successful. Support had been offered at the implementation groups. Fiona Osborne explained any patients currently undergoing a Serious Incident (SI) investigation would remain on the current system. Thanks were noted to Richard Dickinson for leading the process.

Sean Lyons queried whether there were any further concerns in respect of the paediatric audiology issues. Dr Kate Wood was not aware of the position with the business case, however, the new Head of Service had commenced in post.

External support would continue and external support had been sourced to provide training to the teams. It was hoped the service would be brought back in-house next year. Ways of integrating the service would be reviewed by the Head of Service. Sean Lyons queried whether anything had been raised through Communications, Ade Beddow advised other than the article in the Health Service Journal (HSJ) nothing further had been raised.

9.2 Escalation from the Finance & Performance Committee – NLG(23)173

Gill Ponder referred to the Finance and Performance Committee (F&PC) report advising there had been concern raised around the level of risk to the delivery of the financial plan. It had been recommended the Board should have a discussion regarding this to review the position and agree actions. Agency spend was at its highest with queries raised as to what could be put in place to reduce this. A suggestion had been made for the Executive team to review the position with a Board discussion to take place. Jonathan Lofthouse explained the Executives would consider various issues one being the procurement of improved technology later in the year. This would provide up to date trending information for review. The second element was around the costs of higher consultant fees and whether payment on a bespoke basis would be preferred as staff would be paid internally on a higher rate than use agency which incurred more costs. Discussions regarding this had already commenced.

The committee had been informed plans were behind on progress for net zero, this had been due to particular issues as detailed within the report. Jug Johal reported a desk top review of reinforced autoclaved aerated concrete (RAAC) had been undertaken in 2019 confirming a nil return for the Trust. As the media around this had increased a physical survey had been undertaken identifying RAAC in Cardiology at SGH. Surveys had been undertaken to understand the condition and no major concerns had been raised. Those areas had been vacated and costs for repair were awaited from the structural engineers. Although the funds for the RAAC national programme had been allocated the Trust had been asked to provide costs in case any Trusts were unable to spend allocation.

Gill Ponder advised the F&PC had acknowledged the overall improvement in ambulance handovers and a deep dive had been requested as detailed within the report. Concerns had been raised regarding the lack of traction for the reduction of out-patient follow ups. The committee remained concerned regarding the industrial action and the impact of this on the organisation. Concerns were raised regarding patients waiting more than 104 days on cancer pathways and the committee had requested plans to be received on how those patients would be reduced.

In terms of ambulance handover Shaun Stacey reported the Emergency Care Improvement Support Team (ECIST) would be attending the Trust in November to undertake a review. In respect of patient follow ups, standard letters had been compiled which would be sent to patients to support the management of this. Dr Kate Wood explained clinical teams had agreed to support this, however, due to a lack of understanding concerns had been raised regarding this. Monitoring would continue to ensure improvements were made. Shaun Stacey referred to patients waiting 104 days and advised there had been 29 patients at the time of the review.

Work had now been completed and this had reduced to 20, actions were in place to ensure this reduced further.

9.3 Escalation from the Workforce Committee - NLG(23)174

Sue Liburd referred to the highlight report and noted the Trust had not maximised its apprenticeship levy due to the underspend. The committee had noted activity was taking place in terms of better utilisation and improved assurance would be monitored through the committee. The Workforce Disability Equality Standards (WDES) and Workforce Race Equality Standards (WRES) had been received and concerns raised were noted within the highlight report. The reports had been shared with the Board for approval later in the meeting. Simon Nearney highlighted one point related to bullying and harassment in respect of all staff. It had also highlighted minority staff were not being appointed to higher banded roles. Some staff sessions had been held over the summer period and issues to be addressed had been highlighted. It was noted an Equality representative was now part of most recruitment panels. The Equality Diversity and Inclusion (EDI) training continued with work being undertaken with managers around understanding cultural differences. It was noted the Staff Survey was due to go out that day and it was hoped the Trust would achieve 60% completion from staff.

Gill Ponder referred to bullying and harassment and queried whether a campaign for zero tolerance had been considered. Simon Nearney advised this unfortunately continued to be an issue, however, work continued to support this. A further query was raised as to whether the Staff networks could consider Board member sponsors. It was noted this was raised at the recent Nursing Conference and was being considered. Sean Lyons and Jonathan Lofthouse agreed this was something that should be considered going forward. Simon Nearney felt staff had started working together across both Trusts and were sharing experiences.

Jonathan Lofthouse felt the development of networks should not be limited due to funding requirements and would be happy to support requests. It was noted the Staff Survey results would be received in February 2024 by the Trust and shared more widely after this date. Simon Nearney felt there was more engagement required with staff leaders to make improvements with staff through the various events being held. Sean Lyons highlighted improvements could start to be made now as issues had already been highlighted. Simon Nearney recognised the point raised and confirmed improvements had already started to be made and hoped this would be reflected in the survey. Ellie Monkhouse explained some of the issues were around cultural awareness; it was important to hold events as that contributed to conversations being held between individuals and meeting with specific groups would support this improvement.

Fiona Osborne queried whether other Trusts that had received a below national average score for WRES and WDES in order to seek ideas and whether there were any commonalities to make improvements at NLAG. Simon Nearney agreed this could be considered.

In respect of overseas staff, Ivan McConnell highlighted that although the organisation supported staff, more thought was required in terms of working with partners to integrate families into local communities.

Sue Liburd explained there was more need for educating white colleagues to highlight issues that were experienced by those in the minority groups, leadership staff would be key in implementing those improvements. There was a feeling the figures would not be as disappointing the following year due to the improvements envisaged. It was noted NLAG had signed up to be a Disability Confident Employer.

The Doctors in Difficulty Annual Assurance Report had received limited assurance. It had been recognised six weekly reporting mechanisms were in place, however, Dr Kate Wood had been concerned regarding the oversight and traction within the Group. Although oversight was in place, there was no clear description of what this was. Discussion had taken place earlier this year with the General Medical Council (GMC) to ensure the process became more robust. The final sign off was awaited from the Human Resources (HR) team. The difference would mean Dr Kate Wood would remain accountable, however, it would ensure leaders were able to make decisions, support teams and individual members of staff.

The committee recommended the endorsement of the two reports due to be approved.

9.4 Escalation from the Group Development Committee-In-Common – NLG(23)175

Linda Jackson explained there had been some debate regarding the Humber & North Yorkshire (H&NY) Integrated Care System / Collaborative of Acute Providers (ICS/CAP) in what would be the best way to contribute and meet the demands as a Group. Consideration of a possible restructure had been highlighted within the ICB. It was agreed any changes would be reported back to the committee. Going forward it was noted the CAP would be overseeing Diagnostics.

In respect of HASR it was reported a high level workplan was in place to support communication and engagement for the consultation. A number of risks had been flagged and would be worked through prior to the implementation at the end of March 2024, this would be subject to ICB approval in January 2024. The committee had noted maternity and neonatal services had been removed from the consultation process. Ivan McConnell reported each area would hold six structured workshops over a twelve-week period. Any areas of concern would be reported through the appropriate committees and Board. It was important to recognise the Overview and Scrutiny Committees (O&SC) and Joint Health O&SC Act rules had changed. However, secondary legislation to support this change had not been enacted. From an O&SC perspective they still had the right of referral to the Secretary of State and Reconfiguration Panel for a judicial review. From a legal point there could only be a referral on progress and not a decision. The Group would take the lead from a Business Case perspective and the consultation lead would be undertaken by the ICB. Sean Lyons thanked everyone for participating in this process and the additional work around this was noted.

The committee had been updated on progress with the Community Diagnostic Centres (CDCs). Ivan McConnell reported neither would go live from the 1 April 2024 due to delays with planning and statutory consultation; and this would not be

in the locations allocated. However, activity would go live in other locations which had been accepted due to delays, with the original accommodation being used once delays had been addressed.

Linda Jackson advised of a pause in roll out of the Humber Clinical Collaboration Programme (HCCP), one issue related to the Group Operating Structure being developed and secondly CAP needed to further consider what work would need to be undertaken. The Board were updated on consultant engagement in respect of sessions held. Dr Kate Wood explained the feedback received was that there had been a shift in perceptions, there was more collaborative working and it was felt this was due to the way Jonathan Lofthouse had presented the way forward. The need for further sessions would be discussed by the Executive team.

Linda Jackson reported on the Meeting Schedule in place to commence from next year and thanked Sarah Meggitt for scheduling this. The Group Leadership Structure was detailed within the report, progress continued to be made with the Committees-In-Common (CIC) and further workshops would be held with Non-Executive Directors (NEDs) and Executives over coming weeks. A Board session would be held in December to approve those arrangements. It was noted the Group Executive Structure consultation period had commenced.

Simon Parkes referred to the go live dates detailed within the report for the CDCs and queried what would happen if this did not go ahead on the specified dates. Ivan McConnell explained conversations would be held with the Centre as there had been significant delays with planning locally. At the moment those involved were comfortable with a July date as the service could be undertaken in other areas. Simon Parkes queried whether there was any financial risk to the delays. Ivan McConnell advised this could be the case and had been recognised.

Sue Liburd referred to the removal of neonatal services from the consultation and queried whether there had been any challenge around this. Ivan McConnell advised nothing had been raised so far, although there had been some internal challenge from paediatric consultant colleagues. A workshop had been held with those colleagues which included representation from NHS England which had been positive and an approach had been agreed.

9.5 Escalation from the Health Tree Foundation Trustees' Committee - NLG(23)176

Gill Ponder referred to the report and raised two points. The first was in respect of the drop in donations, efforts were being made to address this as it was recognised this was something affecting all charities. Secondly, the committee had agreed to postpone a decision regarding sky light windows within the Acute Assessment Unit (AAU) and SDEC. The committee had previously agreed to the purchase of the panels but were now being asked to fund the fitting of them which was a considerable amount. A final decision was postponed until the contractor could be approached to secure a reasonable reduction in the specified costing. Simon Tighe had spoken with the contractors to discuss reducing those costs, however, this had been declined. Sean Lyons queried the amount of the full installation across all units, it was confirmed by Gill Ponder this was almost £40,000. Jug Johal agreed to discuss this outside of the meeting with the contractors and report

back to the committee. Simon Parkes referred to the point regarding the fall of donations and explained the national picture was not the case and queried whether this may have impacted due to the industrial action. Ellie Monkhouse thought it would be useful for the charity to explore this in more detail as some areas appeared to not have been impacted in this way. It was felt there needed to be more awareness from a public perspective of other areas that may need charitable donations.

Action: Jug Johal / Gill Ponder

10 Quality & Safety

10.1 Maternity & Neonatal Oversight Report – NLG(23)177

Ellie Monkhouse referred to the report and highlighted appendix three which detailed the final part of the exit process from special measures. The Team asked the Board to have oversight of the sustainability plan. Although there were some amber ratings not all of them had to be completed to exit the programme, although the regional team would oversee those outstanding areas.

Jonathan Lofthouse thought this was an accurate reflective report which supported those actions in place. Sean Lyons referred to appendix two and queried why those actions had remained ongoing for a long period of time as they appeared relatively minor to resolve. Fiona Osborne highlighted progress was regularly reviewed and discussed at the Q&SC.

In respect of recent cases in the media, Linda Jackson queried whether any further detailed assurance would be provided within the report on issues that had been raised. Ellie Monkhouse agreed and explained a national database was now in place which would be included within this report or the IPR to provide assurance. This would include national data sets with the intention of reducing the narrative and include the national and peer benchmarks. This would be shared with the Maternity & Transformation Board to ensure trigger points were addressed before sharing with the Board. Fiona Osborne highlighted the Q&SC received an SI report and any particular points of concerns detailed were discussed at the committee. Dr Kate Wood advised the processes in place relating to those deaths were robust to hear any concerns raised and a number of other different processes were in place for raising concerns.

Sean Lyons referenced a conference that had been held recently that highlighted Boards recognising ‘smoke signals’, it was felt this would be a useful session for the Trust and agreed to follow up on this.

Action: Sean Lyons

11 Governance & Assurance

11.1 Board Assurance Framework (BAF) - NLG(23)178

Helen Harris referred to the report and noted the review for quarter two was under process and would be reviewed at committees before shared with the Board in December 2023.

The Boards attention was to those risks scored at 15 and above, notably four were scored at 20. A proposal for a broader discussion at Board level was suggested due to the length of time those risks had been at such a high level. Jonathan Lofthouse explained the Executives would be part of a risk oversight meeting on a monthly basis whereby those risks would be reviewed. The timeline for introducing this would be from December this year. At this forum Jonathan Lofthouse would hold Executives to account on key risks and BAF updates. Sean Lyons agreed this would provide more assurance to the Board.

Simon Parkes raised concerns regarding the estates risks, in particular fire. It was felt as a Board, assurance was not being provided as to this being where it should be. This exposed the organisation to risk if those issues were not resolved. Jonathan Lofthouse agreed with the point made, the Executives would be reviewing investment decisions amongst other issues as part of the new process. Jug Johal referred to the fire issues raised and advised a decision was made to significantly invest in the fire alarm systems at SGH and DPOWH. Scunthorpe was due to complete on the 31 March 2024, this risk would then be reviewed and reduced significantly. Sean Lyons queried whether the current mitigated risk reflected the point highlighted. Jug Johal explained the risk related to all risks within that area not only fire. Jonathan Lofthouse confirmed the infrastructure risk was included within this.

Fiona Osborne queried whether this should be reviewed in a separate way as it did not highlight the concerns of the overall structure of buildings within the report. This had been recognised at the F&PC. Gill Ponder confirmed the estates risks were discussed at the F&PC and plans were in place for completion. Concerns had been expressed at the committee regarding the number of fire doors that needed repair or replacement.

12 Items for Approval

12.1 Workforce Disability Equality Standard (WDES) – NLG(23)179

Simon Nearney referred to report and sought Board approval.

The Board approved the Workforce Disability Equality Standard Report.

12.2 Workforce Equality Standard Annual Report (WRES) – NLG(23)180

Simon Nearney referred to report and sought Board approval.

The Board approved the Workforce Equality Standard Annual Report.

12.3 Protocol for Matters Reserved for Private Meetings – NLG(23)181

Helen Harris referred to report and sought Board approval.

The Board approved the Protocol for Matters Reserved for Private Meetings.

12.4 NHS Impact – Baseline & Assessment – NLG(23)182

Ellie Monkhouse referred to report and advised this was being undertaken across the country at provider and ICS level. The Board had been asked to complete the survey and following this a collaborative review had been undertaken. The Board were asked to have oversight and approve the submission by the 31 October 2023. Jonathan Lofthouse advised the Group would be undertaking a leading position in ICB conversations around innovation and improvement. Stephen Eames had asked Dr Jacqueline Andrews, Medical Director at Harrogate & District NHS Foundation Trust to become the Clinical Lead for Innovation at a system level, Jonathan Lofthouse would take on the lead Chief Executive role to support this.

The Board approved the NHS Impact – Baseline & Assessment for submission.

12.5 Fit & Proper Persons Policy – NLG(23)183

Helen Harris referred to the report and noted changes. A Working Group for both Trusts had been introduced to implement the new policy. The policy would be shared for Trust Board approval once this had been completed. The new framework had been attached to the paper to highlight changes. A letter had been sent to all Trust Board members from Sean Lyons detailing the changes to be made.

The Trust Board approved the report.

12.6 Council of Governors & Trust Board Engagement Policy – NLG(23)184

Helen Harris referred to the report and noted changes, the report had been shared for ratification following Council of Governors (COG) approval.

The Board approved the ratification of the COG & Trust Board Engagement Policy.

13 Other Business

There were no items of any other business raised at the meeting.

14 Date and time of next meeting:

Date: Tuesday, 5 December 2023
Time: 9.00 am
Venue: Main Boardroom, DPOWH

15 Supporting Documents

The following items were shared at the October 2023 meeting:

- Q&SC Minutes – July & August 2023
- Annual Complaints Report
- Nursing & Midwifery Assurance Report
- Workforce Committee Minutes – July 2023
- F&PC Minutes – June, July & August 2023
- HTFTC – July 2023
- Integrated Performance Report (IPR)
- Trust Board & Board Committee Meetings Timetable
- Communications Report
- Documents Signed Under Seal

Cumulative Record of Board Director's Attendance (2023/24)

Name	Possible	Actual	Name	Possible	Actual
Sean Lyons	4	4	Shauna McMahon	4	4
Jonathan Lofthouse	1	1	Ellie Monkhouse	4	4
Dr Peter Reading	1	0	Simon Nearney	4	3
Lee Bond	4	3	Fiona Osborne	4	4
Stuart Hall	4	2	Simon Parkes	4	3
Helen Harris	4	4	Gillian Ponder	4	4
Linda Jackson	4	3	Shaun Stacey	4	4
Jug Johal	4	4	Kate Truscott	4	3
Sue Liburd	4	4	Dr Kate Wood	4	4
Ivan McConnell	4	4			

NLG(23)200

Northern Lincolnshire and Goole NHS Foundation Trust

ACTION LOG & TRACKER
TRUST BOARD - PUBLIC

2023/2024

Kindness · Courage · Respect

ACTION LOG & TRACKER

Northern Lincolnshire and Goole NHS Foundation Trust

Trust Board Public Meeting

2023/24

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored?
8	03/10/2023	Report from Group Chief Executive - Workforce related items		Staff providing written confirmation of Covid vaccinations. It was agreed this would be reviewed further with detail provided at the December 2023 meeting.	Simon Nearney	Dec-23				
9.5	03/10/2023	Health Tree Foundation Trustees' Committee Highlight Report - Installation costs of sky light windows		A query was raised by the Committee on funding the installation of sky lights, it was agreed further discussion would take place with the contractors to resolve the issue.	Jug Johal	Dec-23				
9.5	03/10/2023	Health Tree Foundation Trustees' Committee Highlight Report - Charity contributions		Committee to explore how donations have decreased in terms of certain areas. It was agreed this would be fed back to the committee.	Gill Ponder	Dec-23	This was raised at the HTF meeting on 9-11-23 and an action was created for this to be explored in more detail.			
10.1	03/10/2023	Maternity & Neonatal Oversight Report - Conference regarding recognising 'smoke signals' from staff regarding concerns raised		Sean Lyons referred to recent Conference held regarding recognising 'smoke signals' and agreed to review this session be held for NEDs in the future.	Sean Lyons	Dec-23	NED sessions agreed and organised through ICB due to commence in February 2024.			

Key:

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

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?
3.4	04.10.2022	Bank Incentives (raised in Maternity / Ockenden Update item)		It was agreed the Executive Team would review staff pay incentives when working bank shifts.	Dr Peter Reading	04.04.2023	Discussion had taken place with the Executive Team. A paper was now to be discussed at the Trust Management Board on options to be put forward for staff incentives. The paper would be shared with the board following discussion at that meeting. Further update to be provided as part of the CEO update at the April 2023 meeting.		Update shared at the April 2023 meeting as part of the CEO Briefing.	
2.2	07.02.2023	6 December 2022 Public Minutes - Items being referred to the TMB for recommendation		It was agreed a meeting would be held outside of the meeting on how to incorporate Best Practice Timed Pathways into the Integrated Performance Report as it was agreed this should not be the function of the TMB.	Dr Peter Reading / Shauna McMahon	04.04.2023	Further update to be provided at April 2023 meeting.			
5.1	07.02.2023	Key Issues - Finance - Month 09		Scrutiny of productivity being developed.	Dr Peter Reading, lee Bond, Shaun Stacey & Dr Kate Wood	04.04.2023	It was agreed a meeting would be held outside of the meeting to review this further.			
3.2	06.06.2023	Maternity Oversight Report		Information referring to the Patient Advice & Liaison Service data to be reviewed.	Nicky Foster	Aug-23	Update to be provided at the August 2023 meeting.		August 2023 minutes	
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Record on the risk register		Dr Kate Wood to review whether this issue was on the Risk Register.	Dr Kate Wood	Aug-23	Update to be provided at the August 2023 meeting.		August 2023 minutes	
3.4	06.06.2023	Quality & Safety Committee Highlight Report - Issues around bank and agency spend		Simon Nearney to arrange a Workforce Deep Dive for the Trust Board.	Simon Nearney	Aug-23	A Deep Dive was arranged for the 1 August 2023 following the board meeting.			
7.2	06.06.2023	Board Assurance Framework (BAF)		A request was made to consider an earlier review of the BAF and for this to be considered as part of the Group Governance Workstream.	Helen Harris	Aug-23	The Group Corporate Governance Workstream considered the review of the BAF for NLAG and HUTH and agreed that this would be undertaken at a later stage.			
3.1	01.08.2023	Quality & Safety - Key Issues - IPR		IPR to include target dates within the report, the Executive Team would provide the information	Executive Team	Oct-23	Shauna McMahon confirmed the IPR would provide target dates from October 2023			
3.3	01.08.2023	Quality & Safety Committee Highlight Report - Board Development Session - PSIRF		Helen Harris to incorpoate the Patient Safety Incident Reporting Framework briefing session into the Board Development programme	Helen Harris	Oct-23	It was agreed this action would be further considered once the Group Model was in place.			
5.1	01.08.2023	Key Issues - Finance - Month 03 - Additional Summary to be included within report		A request was made to include a summary of costs for particular vacancies, detailing premium costs	Lee Bond	Oct-23	It was noted this item would be covered as part of the Group Chief Executive (CEO) Report.			

Key:

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

Page 3 of 3

NLG(23)201

Name of the Meeting	**Trust Board**	
Date of the Meeting	5 December 2023	
Director Lead	Wendy Booth, Interim Governance Advisor	
Contact Officer/Author	Wendy Booth, Interim Governance Advisor	
Title of the Report	**Trust Board – Business Reporting Framework 2023-24**	
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is asked to note the Trust Board – Business Reporting Framework 2023-24.	
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 national 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

Trust Board - Business Reporting Framework

REPORTING YEAR					2023 / 24					
Agenda Item	**Committee Oversight**	**Lead**	**Frequency**	**Action**	**April**	**June**	**August**	**October**	**December**	**February**
Business Items										
Declarations of Interest	N/A	Chair	Bi-monthly							
Chair's Opening Remarks	N/A	Chair	Bi-monthly							
Chair's Briefing	N/A	Chair	Bi-monthly	Noting						
Chief Executive's Briefing (to include Trust Priorities)	N/A	Chair	Bi-monthly	Noting						
Minutes of the Previous Meeting	N/A	Chair	Bi-monthly							
Trust Board Action Log	N/A	Chair	Bi-monthly							
Patient Story	N/A	Chief Nurse	Bi-monthly	Noting						
Integrated Performance Report	All Committees	Chief Information Officer	Bi-monthly	Noting						
Trust Board - Business Reporting Framework	N/A	Director of Corporate Goverance	Bi-monthly	Noting						
Register of Directors Interest and Fit & Proper Persons	N/A	Chair	Annual	Approval						
Trust Strategy	N/A	Chief Executive	3 Yearly	Noting						
Strategic Objective 1 - To Give Great Care										
F&PC Highight Report & Board Challenge (incorporated as one report)	F&PC	NED Chair of F&PC	Bi-Monthly	Assurance						
Q&SC Highlight Report & Board Challenge	Q&SC	NED Chair of Q&SC	Bi-Monthly	Assurance						
Annual Establishment Review of Safe Staffing	Q&SC	Chief Nurse	Bi-annual	Approval						
Annual Quality Account	Q&SC	Chief Medical Officer	Annual	Approval						
Annual Review of Mental Health Strategy	Q&SC	Chief Operating Officer	3 yearly	Assurance						
Delivery of Mixed Sex Accommodation - Annual Declaration of Compliance to Trust Board	Q&SC	Chief Nurse	Annual	Approval						
Strategic Objective 2 - To Be a Good Employer & Strategic Objective 5 - To Provide Good Leadership										
WC Highlight Report & Board Challenge	WC	NED Chair of WC	Bi-monthly	Assurance						
Freedom to Speak Up Guardian Report	WC	Freedom to Speak Up Guardian	Biannual	Assurance						
Freedom to Speak Up Self Assessment	WC	Director of People	Annual	Noting						
Gender Pay Gap Report	WC	Director of People	Annual	Approval						
Modern Slavery Statement	WC	Director of People	Annual	Approval						
Staff Survey	WC	Director of People	Annual	Noting						
Workforce Equality Disability Standards (WDES)	WC	Director of People	Annual	Approval						
Workforce Equality Standards Annual Report (WRES)	WC	Director of People	Annual	Approval						
Medical Appraisal & Revalidation Annual Report (AOA)	WC	Chief Medical Officer	Annual	Assurance						
Equality & Diversity Strategy	WC	Director of People	3 yearly	Approval						
People Strategy	WC	Director of People	3 yearly	Approval						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Strategic Objective 3 - To Live Within Our Means										
F&PC Highight Report & Board Challenge (incorporated as one report)	F&PC	NED Chair F&PC	Bi-monthly	Assurance						
Operational & Financial Plan	F&PC	Chief Operating Officer	Annual	Approval						
Business Planning / CIP Timetable	F&PC	Chief Financial Officer	Annual	Noting						
Major Capital / Overarching Capital	F&PC	Chief Financial Officer	Annual	Noting						
Winter Plan	F&PC	Chief Operating Officer	Annual	Assurance						
Annual Accounts - Delegation of Authority	AR&GC	Chief Financial Officer	Annual	Approval						
Digital Strategy	SDC	Chief Information Officer	3 yearly	Approval						
Estates Strategy	SDC	Director of Estates & Facilities	5 yearly	Approval						
Strategic Objective 4 - To Work More Collaboratively										
HTFC Highlight Report & Board Challenge	HTFC	Chair of HTFC	Bi-monthly	Assurance						
Clinical Strategy	F&PC	Director of Strategic Development	3 yearly	Assurance						
Governance										
AR&GC Highlight Report & Board Challenge	AR&GC	NED Chair of the AR&GC	Quarterly	Assurance						
Annual Accounts / Going Concern / Audit Letter / Annual Report & Annual Governance Statement	AR&GC	Various	Annual	Approval						
Audit Committee Annual Report	AR&GC	NED Chair of AR&GC	Annual	Approval						
Board Assurance Framework (BAF) and High Level Risk Register	All Committees	Director of Corporate Goverance	Quarterly	Assurance						
Emergency Preparedness, Resilience & Response Annual Report	AR&GC	Chief Operating Officer	Annual	Noting						
Fire Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Health & Safety Policy Statement	AR&GC	Director of Estates & Facilities	Annual	Approval						
LSMS Annual Report and Workplan and Security Annual Report	AR&GC	Director of Estates & Facilities	Annual	Approval						
Protocol for Matters Reserved for Private Meetings	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Appetite Statement	N/A	Director of Corporate Goverance	Annual	Approval						
Risk Management Strategy	AR&GC	Chief Medical Officer	3 Yearly (next 2024)	Approval						
Trust Constitution & Standing Orders	Trust Board & COG	Director of Corporate Goverance	3 yearly	Approval						
Trust Board - NHS Provider Self-Certification	N/A	Chair	Annual	Assurance						
Trust Board, Board Committees & approval of changes to Terms of Reference	All Committees	Committee Chairs	Annual	Approval						

Agenda Item	Committee Oversight	Lead	Frequency	Action	April	June	August	October	December	February
Trust Board & Board Committee Meetings Timetable	All Committees	Director of Corporate Goverance	Annual	Approval						
Trust Board and Board Committees Performance & Effectiveness	N/A	Chair	Annual	Noting						
Trust Board Development Programme	N/A	Chair	Annual	Noting						
Trust Scheme of Delegation and Powers Reserved for the Trust Board / Standing Financial Instructions	AR&GC	Chief Financial Officer	3 yearly	Approval						
Items for Information										
Communications Report	N/A	Associate Director of Communications	Bi-monthly	Noting						
Committee Minutes - Public & Private	All Committees	NED Chairs	Bi-monthly	Noting						
Deviations from NICE guidance	Q&SC	NED Chair	Ad-hoc	Noting						
15 Steps Annual Report	Q&SC	Chief Nurse	Annual	Noting						
Nursing Assurance Report (includes same sex accomodation)	Q&SC	Chief Nurse	Bi-monthly	Assurance						
Guardian of Safe Working Hours	WC	Chief Medical Officer	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Patient Experience Report incorporating Annual inpatient survey result & action	Q&SC	Chief Nurse	Quarterly	Assurance	Q3	Q4	Q1		Q2	
Documents Signed Under Seal	N/A	Director of Corporate Goverance	Quarterly	Noting	Q4			Q2		
Executive & NED Statutory & Other Lead Roles	N/A	Vice Chair / Director of Corporate Governance	Annual	Noting						
Annual Complaints Report	Q&SC	Chief Nurse	Annual	Assurance						
Infection Control Annual Report	Q&SC	Chief Nurse	Annual	Assurance						
Safeguarding & Vulnerabilities Annual Report	Q&SC	Chief Nurse	Annual	Assurance						

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Jonathan Lofthouse, Group Chief Executive	
Contact Officer/Author	Jonathan Lofthouse, Group Chief Executive	
Title of the Report	**Report from the Group Chief Executive**	
Purpose of the Report and Executive Summary (to include recommendations)	This report is to provide an update to the Trust Board from the Group Chief Executive. The report includes: • A detailed update on the Group executive team • Summaries of key issues across the Trust, including patient safety and quality of care; elective and urgent and emergency care performance; finance; workforce • Includes a briefing on the Thirlwall Enquiry • Celebrates our staff awards and national recognition	
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	✓ 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)	Not applicable	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable	

Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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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

Group Chief Executive Officer

Briefing to the Trust Board
Tuesday 5 December 2023

1. Introduction

1.1 Since the last Trust Board meeting, significant progress has been made on the appointment processes to the new Group Chief and Director structure.

1.2 I am very pleased to announce the following Group Chief and Director appointments, all of whom have been through a robust stakeholder and panel interview process.

- Shaun Stacey, Group Chief Delivery Officer
- Dr Kate Wood, Group Chief Medical Officer
- Ivan McConnell, Group Director of Strategy and Partnerships
- Simon Nearney, Group Chief People Officer

1.3 Lee Bond has been undertaking a Group-level Chief of Finance role for both organisations, and has now been confirmed in post as Group Chief Financial Officer. My sincere congratulations go to all our successful appointees. All appointees took up their new larger portfolios of responsibility at the beginning of November. My grateful thanks are extended to the stakeholder representatives of north and south bank staff who formed the stakeholder panel, as well as to a number of subject matter experts from across the NHS, who joined specific interview panels.

1.4 My sincere thanks also go to Suzanne Rostron, Helen Harris, Ellen Ryabov, Ellie Monkhouse and Makani Purva for their hard work and dedicated service. They are moving on to new opportunities internal and external to the Group over the coming weeks.

1.5 I am also very pleased that since the last Trust Board, we have been joined by Adam Creeggan, interim Director of Performance, Rob Chidlow, interim Director of Quality Governance, and Michael Kaiser, interim Winter Director. I am also very pleased that Wendy Booth is continuing to support us as interim Group Assurance Officer. These colleagues will provide us with significant additional bandwidth and expertise as we navigate coming together as a Group. This is at the same time as needing to make progress at pace with quality and safety improvements, improved reporting and navigating the most significant winter pressures we have experienced.

1.6 This month and next month will also see the completion of the first recruitment campaign in to the Group Executive posts. The posts for which recruitment is being completed are Group Transformation Director, Group Chief Nurse Officer, Group Director of Assurance and Group Director of Quality Governance. We continue to explore options around the Group Chief Clinical Design Officer post, which has given me the opportunity to work with my Group Cabinet to review how this most senior leadership role and capacity can be secured.

1.7 The staff consultation on the new Operational Care Group structure commenced on 21 November 2023 and runs for 30 days. This is to move our Group organisation to a new structure for our current Clinical Divisions (south) and Health Groups (north) in to a fully integrated care group structure covering our full range of acute and community services. I am very pleased that a lot of detailed, constructive feedback has been received so far,

as well as engagement with the trade unions and staff impacted by this restructuring process.

1.8 Part of the Operational Care Group structure is to group services under the portfolio of the two new site teams, which consist of a Site Managing Director, Site Medical Director and Site Operations Director. These posts have been out to national advert and the stakeholder and interview processes take place this month.

2. Patient Safety, Quality Governance and Patient Experience

2.1 The Trust continues to focus on patient safety, quality and patient experience. There have been some positive improvements in rates of harms our patients are experiencing in our care, particularly falls over the last 3 months. However, our teams are seeing a small increase in hospital-associated infections and pressure damage.

2.2 We know that cases of norovirus in the community are on the increase, so I ask all of our staff, clinical and support staff, to be extra vigilant with handwashing and hygiene measures, as we know these make a real difference to reducing risk of infection spread, and keep our patients and each other safer.

2.3 The Quality Committee considered a report from the Family Services Division in respect of NHS Resolution's Maternity Incentive Scheme (CNST) and to receive an update on the 10 safety actions in respect of Maternity Incentive Scheme Year Five. The report highlighted risks in 4 of the standards and included the mitigating actions being taken. This will be covered in more detail by the Quality Committee Chair but I would like to draw the Board's attention to the current position with this important patient safety scheme and our ability to test out the evidence and assurances we have.

2.4 I am also pleased to note the continued progress in our CQC action plans. The Quality Committee received its regular detailed report, in which the number of actions rated with limited assurance has decreased to 22 and the number of actions with full or significant assurance now total 46. This is not to say that we can take our focus away from delivering the quality improvement plans and actions that we have committed to, nor from implementing and making further progress on other national must-do schemes for patient safety, including Learning from Deaths and the new Patient Safety Incident Response Framework, on which the Quality Committee were also updated.

3. Elective Care and Urgent and Emergency Care

3.1 Since the last Trust Board meeting, I have been asked to take the elective recovery 'tsar' role for the ICS. We are looking for ways to maximise capacity and elective recovery across our system, to work for our patients and make best use of our collective resources.

3.2 By 22 November 2023, all Trusts were required to respond to a national 're-set' exercise, which reviewed all current and projected acute trust positions on urgent and emergency care standards, financial plans, elective care and cancer delivery, and winter plans. On behalf of the Chairman and myself, I would like to thank Non-Executive Director colleagues who responded to the short-notice request to provide check and challenge to the submission put together by Group Cabinet colleagues with their teams, which was submitted successfully to the ICB on Monday 20 November 2023.

3.3 Within this return, our Trust confirmed its commitment to achieve the four-hour standard and ambulance handover requirements by March 2024, to meet its elective recovery standards, manage within its financial plan (taking account of the request to reduce the level of Elective Recovery Funding in the plan) and confirm that the bed base and surge capacity remain as planned. This exercise has given the Trust to re-base its trajectory for the achievement of 65-week breaches, given the current upward trend in cases rather than reduction. The Trust is committed to achieving the 65-week requirement as well as cancer waiting times over the coming months.

3.4 In terms of current position, the Trust reported 125 patients waiting over 65 weeks, which is considerably over the original trajectory submitted. The trajectory has now been re-based in order to produce a monthly reduction, in order to achieve this standard by year-end as originally planned.

3.5 The delivery of the Faster Diagnosis standard remains around 70% and the Trust is on-track to move this to 75% delivery by the end of the year. The Trust's 62-day backlog is around trajectory, however delivery of the 62-day standard and 104-day backlog are not where we would wish them to be and need to make further improvements against these standards.

3.6 Urgent and emergency care has come under some greater operational pressure in the last two months. For September and October, our monthly performance finished at 65.3% and 64.2% respectively, against an improvement trajectory of 68% and 70% performance. November 2023 (at the time of writing) performance is tracking above October 2023 performance. We remain committed to continuing to make improvements in our urgent and emergency care standards, including ambulance handover times, where we have been above the improvement trajectory requirements for 30-minute handovers throughout the year.

4. Strategic developments

4.1 <u>The Thirlwall Enquiry</u>

The Thirlwall Enquiry is the national enquiry following the sentencing of Lucy Letby, and has published its broad terms of reference.

These are to review:

A. The experiences of the Countess of Chester Hospital and other relevant NHS services, of all the parents of the babies named in the indictment.
B. The conduct of those working at the Countess of Chester Hospital, including the board, managers, doctors, nurses and midwives with regard to the actions of Lucy Letby while she was employed there as a neonatal nurse and subsequently
C. The effectiveness of NHS management and governance structures and processes, external scrutiny and professional regulation in keeping babies in hospital safe and well looked after, whether changes are necessary and, if so, what they should be, including how accountability of senior managers should be strengthened. This section will include a consideration of NHS culture.

All NHS Trusts have received a letter advising of these terms of reference, and a further letter requesting submission of first sets of data by 18 December 2023. Clearly, this will rightly bring a great deal of scrutiny on the way in which Trust Boards ensure that there are routes through which staff can raise patient safety concerns and for these to be thoroughly investigated.

I would like to assure the Trust Board, as members already well aware, that there are a number of well-established routes through which staff can raise concerns. I take seriously any concern raised by staff and personally seek assurance that our reporting methods are robust.

I believe there will be a number of lessons for all NHS organisations to learn from this national inquiry and I welcome the scrutiny on staff culture and professional behaviours.

4.2 Humber Acute Services– public consultation

At regional level, the public consultation on Humber Acute Services remains open to January 2024. I encourage all staff and stakeholders to take part; the easiest way to do so is to visit the consultation website at www.betterhospitalshumber.nhs.uk to find out more about the proposal and provide feedback. The public consultation, which is being undertaken by the Integrated Care Board, represents a significant milestone in this project, which has considered over 100 options and had significant public and stakeholder input of over 12,000 views to bring together the consultation options for the medium- and long-term future of urgent and emergency care services and paediatric services.

4.3 I am delighted to report the positive impact that our significant contribution to the consultation process is having, both in respect of facilitating sessions with harder-to-reach patients and families, as well as providing detailed briefing and analysis at public meetings with statutory bodies. The rich feedback being received throughout the touchpoint opportunities will enable us to help bring together a high quality output with our Integrated Care Board colleagues for the future of our region's clinical services.

5. Financial Performance

5.1 In respect of income and expenditure (I&E) performance, the Trust reported an in-month deficit of £1m for month 6, which is £200k adverse to plan, with a year-to-date position of a £15.4m deficit position at month 6, which is £1.6m favourable to plan. The I&E forecast outturn is still to achieve the planned £13.4m deficit position. The capital plan is £10.5m underspent, and the year-to-date cost improvement plan is currently forecasting a shortfall of £8.5m.

5.2 The Finance and Performance Committee received the detail of the full financial position, and understanding of key risks, which include unidentified cost improvements, potential non-delivery of Elective recovery Funding, slippage on cost improvements and trend on agency spending (currently £35.9m year to date).

6. Workforce Update

6.1 The Staff Survey closed on 24 November 2023. The Trust set an ambitious target to have 60% staff complete the survey. I am keen to hear as many views as possible, particularly as we go in to a new Group structure and launch our staff engagement exercise on our new Group values and behaviours, on which our Group Chief People Officer will update us.

6.2 In respect of the current workforce position, there Trust's turnover position has decreased further to 10.6%. Sickness has fallen for three consecutive months and is now at 5% against a target of 4.1% and Core mandatory training remains above target at 90.5% against a target of 85%.

6.3 However, our data also speak to a number of significant, on-going challenges: role-specific mandatory training remains below target at 80.1% against a target of 85% but has seen a 1% increase this month; the medical vacancy rate for consultants remains high at 19.8% against a target of 15% - this month has seen a 1.4% increase; the Registered Nurse vacancy rate stands at 10.6% against a target of 8% - for three consecutive months there have been slight decreases however this remains high.

6.4 I am giving particular focus to our current position with medical staff and asking our teams to work at pace to put in place a bank system for locum shifts, to implement a new shift booking system and to scrutinise senior medical staffing.

7. Equality, Diversity and Inclusion (EDI)

7.1 I am thrilled to have been asked to film an introduction for the Trust's UK Disability History Month - Lunch and Learn Event on 30 November 2023. The agenda for the session included Succeeding in Life with a Disability from Dr Ossie Stuart and the Trust's Project Search, our organistion's excellent project to significantly, positively improve the lives of younger people with learning disabilities.

7.2 During Black History month, across the ICB we promoted the amazing contribution of our Black Asian and Minority Ethnic (BAME) staff to the provision of care in the NHS. We employ thousands of BAME staff, some of whom have come from abroad to live here. I'm really pleased to promote our 'My Story' film to everyone in our Group, which highlights the sacrifices some of our staff have made to be here with us. It is a powerful and moving video and I hope you will all watch it as we celebrate the diversity in our Group, diversity which makes us a stronger and better organisation. You can find it through Pattie.

8. Good News Stories and Communications Updates

8.1 I was delighted to attend the Our Stars staff awards last month. It was a fantastic celebration of all the hard work our staff do – huge congratulations to all the winners and many congratulations for those who were shortlisted, too. I was particularly honoured to present the Group Chief Executive's Brightest Star award to Lynn Sherlock from Mortuary team at Scunthorpe – a very worthy winner. This was the final staff awards programme in this format. Starting next year, the staff awards will be across the Group and involve both NLaG and HUTH staff; planning for this has already started.

8.2 There have been some other fantastic achievements to also shout about recently. I wanted to select just a few highlights to share with you. Three of our nursing healthcare support workers recently received special Chief Nursing Officer for England awards in recognition of their hard work and dedication. We were also delighted to receive the National Preceptorship for Nursing Quality Mark from the NHS England National Preceptorship Programme. Well done to all involved. There has also been national award recognition for staff, including our Hospital at Home team at Grimsby being shortlisted for the Royal College of Nursing (RCN) Awards, and Louise Salt, Colorectal Clinical Nurse Specialist, who was a finalist in the Bowel Cancer UK Gary Logue Colorectal Cancer Nurse Awards 2023. This is brilliant recognition for the expertise and dedication of our colleagues, and I congratulate them all.

Jonathan Lofthouse
Group Chief Executive
28 November 2023

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
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 (covering October & November)
Purpose of the Report and Executive Summary (to include recommendations)	The Trust Board is to note the Quality and Safety Committee highlight report including the following recommendations: • The provision of accurate, timely and relevant information remains a concern. The Group Director of Performance is conducting a review of data provision in mitigation. • Weight recording on ePMA software solution timeline needs to be clarified. • The annual reports approved through QSC are: o Safeguarding. & Vulnerabilities o Patient Reported Outcome Measures o Infection Prevention and Control o Medication • The Serious Incident Annual report is recommended for Board approval
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)	N/A

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

*Board Assurance Framework (BAF) Descriptions:

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

Highlight Report to Trust Board

Report for Trust Board Meeting on:	December 2023
Report From:	Incorporating Quality & Safety Committees held on 24 October and 28 November 2023

Highlight Report:

Maternity Safety Oversight report illustrated recruitment through international and newly qualified, reducing the midwife vacancy rate. As part of this oversight, the Committee received a deep dive into the Clinical Negligence Scheme for Trusts (CNST) action plan progress. Of the 10 standards, it was reported that full compliance is expected by the submission date and risks to achievement were being mitigated. The duties of Patient Safety Champions and their contribution to assurance and escalation process was highlighted. The Local Maternity and Neonatal Service (LMNS), and NHS England & Improvement (NHSEI) Medical Director Simon Kendal visited the Trust in October, providing positive feedback. The Maternity and Neonatal Voices Partnership Lead has started, and so is able to contribute to service developments once again. Smoking cessation challenges were discussed along with other challenges to service provision. In exploring the improvement approaches, opportunities for closer working across the Group are being explored.

The Committee received four Annual Reports for Approval on behalf of the Trust Board:

- Annual Medication Report – approved on behalf of the Trust Board
    - Noting challenges of vacancies for Pharmacists, alternative service provision plans were discussed. Medicines reconciliation rates performance were reviewed in detail and were highlighted for regular review in the quarterly updates.
- Infection Prevention and Control (IPC) Annual Report – approved on behalf of the Trust Board
    - Noting improved environment in Emergency Departments (ED) and increase in isolation rooms, challenges for deep cleaning with high bed occupancy, benchmarked better than peer group performance for alert organisms.
- Annual Patient Reported Outcome Measures (PROMs) Report – approved on behalf of the Trust Board.
    - Noting improvement in hip scores and a slight reduction in knee replacement scores, with a longer-term view needed as some data is 18 months old which means it was impacted by the challenging COVID time period. In addition, some long waiting mutual aid patients potentially impacting negatively on scores.
- Safeguarding & Vulnerabilities Annual Report – approved on behalf of the Trust Board
    - Noting the challenges of increasing compliance with safeguarding training topics, collaborative working with the Local Authorities and comprehensive objectives for the coming year.

In addition the Serious Incident Annual Report was received for assurance. The Committee recommends the report for approval by the Trust Board. The Committee were assured noting the development of Patient Safety Incident Reporting Framework will change the methods of reporting moving forward, the timeliness of report completion requires improvement, and action plan completion assurance process through SI panel.

The Integrated Performance Report was discussed, recognising some challenges in information provision due to prioritised data-warehouse and Lorenzo PAS workstreams. Manual collection of data is required without access to the Business Intelligence improvement resources. The Committee were assured by the report that the newly appointed Group Director of Performance had instigated a review of data provision and the Committee await the outcome. Positive elements included Venous thromboembolism (VTE) and Summary Hospital-level Mortality Indicator (SHMI) sustained performance.

Two Quality Priority Deep Dives were received by the Committee:

- Safer Medications was presented by the Chief Pharmacist, with weight recording on Electronic Prescribing and Medicines Administration (ePMA) remaining a concern, although entered into the records in multiple places. The timeline for the software solution to link data from WebV Electronic Patient Record to ePMA was discussed, recognising its importance in improving compliance.
- Sepsis recognition, screening and management. Adult Screening on arrival has improved with patients presenting through emergency pathways. Paediatric screening audits have commenced in assessment areas and wards, showing actions are taken in line with guidance, although not always documented on the Trust screening tools. Intention to roll (out the audit in ED is planned. The Sepsis and Deteriorating Patient working group continues to monitor, review, using quality improvement methodology.

The End-of-Life Deep Dive reported on the workstreams associated to improving these services, with focus on the recognition of end of life by clinicians, improving pain assessment and reassessment, and the uptake of training. Placed based network leadership involvement and leadership was also highlighted. Service improvement projects continue with plans for further embedding the Bluebell model and symptom control.

The Quality Priorities for 2024/25 were discussed with the intent of focusing on the patient care improvement needs. It has been considered that the Quality Priorities for the current year remain a priority and are proposed to continue from 2023/24 with revised metrics. There are also other activities that are also designed to improve quality, including local Quality Improvement projects, Commissioning for Quality and Innovation (CQUIN) and Patient Safety improvements.

The Nursing Assurance reports provided details on the staffing levels with a Registered Nurse and Midwife vacancy rate of 10.84%. Recruitment plans with newly qualified, international and UK domestic routes, will improve this position. A referral was made to the Workforce Committee to alert them of this Committees concern of potential risks of high vacancy rates and we received assurance that the Workforce Committee have a high level of focus in this area. The Committee heard of increased risks in Methicillin-Susceptible Staphylococcus Aureus (MSSA) which is a national issue and is being closely monitored by the IPC team. 15 steps challenge visits, patient experience measures of Friends and Family Test (FFT) and Complaints management were illustrated as part of the Chief Nurse portfolio.

Serious Incidents (SI) updates were provided illustrating a case where a patient died following a suspected anaphylactic reaction. HM Coroner and police are investigating, with primacy of investigation. The Trust has taken immediate actions to raise awareness of risks around allergy recording and assessment and has commenced a documentary review awaiting the conclusion of the HM Coroner and police investigation in line with the requirements of their primacy of investigation. A Maternity SI was also reported regarding reduced fetal movement presentation, with investigations underway.

The themes from Complaints, Litigation, Incidents and Patient Advice and Liaison Service (CLIP) and wider quality governance activities were presented in the CLIP quarterly report, along with actions planned, monitoring arrangements. Assurance was provided on learning activities, illustrating supporting patient safety improvements.

The Care Quality Commission (CQC) action plan progress was reviewed with improved assurance ratings each month, reducing the limited assurance rating from 16 to 9 actions over October and November reports. Six assurance reports have been submitted to the CQC in the last meeting interval.

PSIRF implementation plans have been discussed, demonstrating Integrated Care Board (ICB) approval of the Trust plan and policy, following consultation within the Trust, LMNS and ICB.

The Mental Health Act and Strategy report was presented by the Lead Mental Health Professional, providing evidence of the working relationships with the respective Mental Health organisations as partners, supporting the legal requirements for any patients requiring detention under the Act while accessing The Trust's services. Assurance was provided on the progression against the objectives of the strategy.

Confirm or Challenge of the Board Assurance Framework:

Strategic Objective SO1-1.1 was reviewed in the October 2023 meeting. The Executives requested further time to review the actions and risks to represent the revised position as the Trust moves into a Group structure. The Committee approved the extension.

Action Required by the Trust Board:

The Board is asked to note:

- The provision of accurate, timely and relevant information remains a concern, although the Group Director of Performance is conducting a review of data provision to mitigate these concerns.
- The Weight recording on ePMA software solution timeline needs to be clarified.
- The annual reports approved through QSC are:
    - Safeguarding. & Vulnerabilities
    - Patient Reported Outcome Measures
    - Infection Prevention and Control
    - Medication
- The Serious Incident Annual report is recommended for Board approval

Fiona Osborne
Non-Executive Director

NLG(23)204

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	5 December 2023
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, Performance and Estates and 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. • Month 6 was the first month this financial year where the in-month deficit was averse to plan and that position continued in Month 7. • The Committee recommended the approval of the business cases for the Pathology Laboratory Information Management System (LIMS) and Immunocytochemistry. • The Committee was pleased to note the reduction in the Asbestos risk score from 20 to 15 and the discharge of the Water Improvement Notice at Scunthorpe. • The Committee remain concerned about the lack of progress with reducing the number of Cancer patients waiting more than 104 days but was pleased to see that the number of patients waiting for Magnetic Resonance Imaging (MRI) scans had reduced. • The Committee were not assured by the Patient Flow Improvement Group paper on Unplanned Care and requested further information. • The Committee recommended that the Board approved the Emergency Preparedness, Resilience and Response (EPRR) Annual Report and Core Standards submission. • The Committee were assured by the Winter plan, but noted the risk from demand exceeding the assumed increase. • The Committee discussed a number of instances where changes were needed to data and reports to meet the latest requirements, but changes were delayed due to lack of capacity whilst the Information Services team focussed on the launch of the Patient Administration System (PAS)/Lorenzo system in February.
Background Information and/or Supporting Document(s) (if applicable)	Minutes of the meeting
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.

HIGHLIGHT REPORT TO TRUST BOARD

Report for Trust Board Meeting on:	5th December 2023
Report From:	Finance & Performance Committee – 18-10-23 and 22-11-23

Highlight Report:

Review of NLaG Financial position (Finance Report) (SO3.1/SO3.2b)

- At month 6, the Trust reported an in-month deficit of (£2.8m), £0.4m adverse to plan; the first time an adverse position had occurred this financial year. The Trust reported a year-to-date deficit for month 6 of (£14.4m), £1.8m favourable versus plan. At month 7, the Trust reported an in-month deficit of (£1.0m), £0.2m adverse to plan. The Trust reported a year-to-date deficit for month 7 of (£15.4m), £1.6m favourable versus plan.
- The Trust is forecasting a £26.4m deficit before management action at the year end. Technical savings and improvements on Cost Improvement Programme (CIP) delivery would bring the position in line with the planned £13.4m deficit, providing the Trust delivers its original financial commitments and a number of significant risks are mitigated.
- The Trust's Capital expenditure is behind the year-to-date plan, but there are plans in place to achieve the plan by the year end.
- The Committee questioned the activity versus plan position as different achieved percentages had been reported. The Trust had been requested to deliver 107% of the 2019/20 baseline activity during 2023/24. This 107% target had been reduced to 105% due to the Industrial Action that took place in April 2023. The Trust's operational plan to achieve the target was back ended due to 3 theatres being refurbished at the start of the financial year and the Trust delivered 110% of that internal plan up to Month 6. NHSI however have a flat plan for NLaG across the year to deliver the same volume of activity by the year end. Against that plan of 105%, the Trust delivered 104.7% in Month 7. As a result, penalties of £123k had been included in the year-to-date position.
- The new NHSE operational and financial reset request as of month 7 has now reduced the target down to 103% so the Trust is now ahead of target, with a potential opportunity to do more activity to recover waiting lists and increase income

Financial Recovery Planning

- A review of vacancies was underway to explore the possibility of converting non-recurrent CIP savings into recurrent savings.
- The Committee also briefly discussed the actions in the recent financial checklist which the Trust had submitted and a referral to the Audit, Risk and Governance Committee was made to request confirmation that the controls declared in that checklist were operating to enable delivery of the best possible financial position.

Cost Comparisons

- The Committee were informed that the deadline for the submission this year had been amended three times which was why there had been a delay in the paper coming to the Committee this year.
- During testing, a number of data issues were apparent which the team are working through. Submitting accurate data was critical, to enable accurate benchmarking conclusions and identification of potential improvement opportunities.

- Current themes that are appearing through this work are Job Plans, timing of Outpatient attendances, Ward Rounds, Theatre Utilisation and the deployment of direct access for some tests.

Business Case Assurance

- Community Diagnostic Centres (CDC)
    - In view of overspending against plans for other recent projects, the Committee raised concerns about the adequacy of the 10-14% contingency provision for the CDC business case and questioned whether there was any optimism bias included within this. The Committee were informed that two of the four tender packages had been agreed with fixed prices, another was currently being evaluated and the last package was a smaller programme of works and should be the least expensive. The surveys at Scunthorpe had gone well and therefore this contingency was considered to be sufficient.
    - The Committee raised a referral to the Workforce Committee to consider the staffing strategy for the Community Diagnostic Centres in view of the shortage of qualified staff in some diagnostic areas.
    - The Committee were concerned about the potential future risk to the Trust's income and expenditure position if NHSE revenue support was not provided for CDCs beyond 2024/25.
- Pathology LIMS Replacement Tender
    - The Committee questioned how the LIMS replacement would sit alongside other internal software already in place in the Trust. The Committee was informed that Pathlinks sits as part of Midlands and East 2 (ME2) and the system as a whole is trying to move towards one LIMS system and that this move would help with that. The Committee were also told that a Pathology Integration Engine (PIE) would sit alongside the LIMS to aid the integration into the other software used. LIMS would be compatible with the new PAS system due to launch in February.
    - The Committee asked whether there were any plans to bring the Pathlinks service and Scarborough, Hull, York Pathology Services (SHYPS) together and whether the LIMS would aid that. The response given was that currently there is no intention to bring the services together.
    - The Committee approved the submission of the tender to the Board.
- Pathology Immunocytochemistry Procurement Approval
    - The Committee were presented with the procurement paper which was very comprehensive and approved the submission to Board.

Estates and Facilities – Asbestos, Water, Reinforced Autoclaved Aerated Concrete (RAAC) and Infrastructure

- The Committee were informed that the Asbestos risk score on the risk register had reduced from 15 to 10 due to the completion of survey work and red dot plans for the estate, detailing where Asbestos had been found.
- The Committee were assured by the appropriate volume of P405 trained personnel within each team and by the evidence from the asbestos incident log.
- The Committee were pleased to note that the Water Improvement Notice at Scunthorpe had been discharged.

- The Committee discussed the current RAAC position and the lack of available Structural Engineers. The Committee were informed that the Trust had approached a new structural engineering company and was waiting for suitable dates for a site visit to be provided. In the meantime, both areas affected had been taken out of service.
- The Committee were notified of the possibility that the Trust could be awarded £1.1m of RAAC funding from the Integrated Care Board (ICB) which could be used towards the repair of the physiotherapy gym at Scunthorpe.

Civils Infrastructure

- The Committee were informed that the new National Cleaning standards were generating additional work and adding to the backlog maintenance.
- Three high risk infrastructure backlog maintenance issues were discussed: building maintenance, roof replacement and windows. The Committee were notified that there would possibly be funding for roof replacements next financial year.

Unplanned Care

- The Committee raised concerns over the decrease in performance in the Emergency Department (ED) 4-hour, 12 hour waits and ambulance handover standards.
- Same Day Emergency Care (SDEC) was taking some of the pressure from the continued high level of ED attendances, with 43.7% of people discharged the same day, up from 29% last year.
- The Committee did not feel assured by the Patient Flow Improvement Paper on Unplanned Care and requested further detail and evidence to support a number of the general statements and evidence to explain the considerable daily variation in ambulance handovers over 60 minutes as most of the reasons in the paper applied every day.

Planned Care

- Any further industrial action remained a substantial risk to recovery plans.
- The Committee queried the Cancer 104+ Day Backlog. Little progress appeared to have been made as the number of patients had increased from 29 last month to 44. The Committee were informed that joint work with Hull University Teaching Hospitals (HUTH) was ongoing to try to reduce the backlog as well as actions to reduce the waits arising from the NLaG only element of the pathway.
- The Outpatient Follow Up Overdue position had deteriorated due to the requirement to reduce follow up appointments by 25% to create more capacity for new outpatient appointments. Increased use of Patient Initiated Follow Up (PIFU) would help to reduce these waiting lists.
- The Committee were pleased to note that the installation of 3 mobile units had led to a reduction in the MRI waiting list backlog from over 10,000 to less than 8,200 patients.
- The issues with data and delays caused by reduced resources in Information Services due to the Lorenzo project is negatively affecting the ability to create data and reports in a timely fashion to support performance monitoring and take forward improvement actions proactively. In particular, there was a need to be able to report

accurately on the measures included in the recent operational reset plan to enable assurance to be gained that plans were on track for delivery and to be able to report in real time on the new 9 indicators that would determine the Trust's Opel status.

EPRR Annual Report

- The Committee approved the submission of the EPRR Annual Report to the Board and were assured by the action plan update on the electrical failure at Scunthorpe in 2022/23.

EPRR Core Standards

- The Committee approved the submission of the EPRR Core Standards to the Board and were assured by the action plan to increase the compliance rating for next year. The Committee noted the drop in compliance to 40% was due to changes in the standards required and was in line with other acute trusts, whose scores ranged from 10% to 40%.

Winter Plan

- The Committee discussed the Winter Plan and were assured by its contents but did note that there was a risk around the level of non-elective demand assumed within the operating plan in comparison to the actual increase seen in-year.
- Using data that was up to 24 hours old could lead to an incorrectly calculated Opel score using the 9 new measures.

Confirm or Challenge of the Board Assurance Framework:

The Committee reviewed the Board Assurance Framework Strategic Objectives (SO) 1-1.2 and 1-1.6. The Committee questioned the likelihood of achieving the reduction of the risk in SO 1-1.2 from 20 to 15 by the end of the financial year due to the current performance. The risk score of 12 for SO 1-1.6 was agreed.

Action Required by the Trust Board:

The Trust Board is asked to note the key points highlighted above including the referrals to the Workforce and Audit, Risk and Governance Committees. The Trust Board is also asked to note the Committee's recommendation that the Trust Board approves the EPRR Annual Report and Core Standards submission. The Committee also recommended that the Trust Board approve the business cases for Pathology LIMS and Immunocytochemistry, as well as the CDC case when it is presented to Trust Board.

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

Name of the Meeting	**Trust Board of Directors – Public Board**
Date of the Meeting	05 December 2023
Director Lead	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Contact Officer/Author	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee
Title of the Report	**Escalation from the Workforce Committee**
Purpose of the Report and Executive Summary (to include recommendations)	The Committee recommended highlighting the following matters to the Board, namely: 1. Finance and Performance Committee Referral - Clinical Diagnostic Centres Medical Diagnostic Staff Recruitment Strategy. 2. Care Quality Commission Progress Report. 3. Workforce Integrated Performance Report – Workforce Turnover and Vacancies. 4. Freedom to Speak Up Strategy 2023/2024 - Annual Progress Report and Quarter 2 Report. 5. Staff Lottery Committee Annual Report 2022-2023. 6. Industrial Action. The Board is asked to receive and note the content of this highlight report.
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.
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

BOARD COMMITTEE HIGHLIGHT REPORT

Report for Trust Board Meeting on:	05 December 2023
Report From:	Susan Liburd, Non-Executive Director, and Chair of Workforce Committee

Escalation from the Workforce Committee – 21 November 2023

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

2. **Finance and Performance Committee Referral - Clinical Diagnostic Centres (CDC) Medical Diagnostic Staff Recruitment Strategy**
   Following an assurance request from Finance and Performance Committee in respect of CDC staff recruitment, the Workforce Committee undertook a deep dive.
   Assurance: Limited.
   CDCs were originally due to open in April 2024, this has subsequently been delayed with a revised anticipated opening date of June 2024 for Northeast Lincolnshire and July 2024 for North Lincolnshire. CDC staffing is noted by NHSE as being on the hard to fill list. Recruitment for the full complement of diagnostic centre posts has begun. The following principles are being adopted:
   - Existing staff will be shared across providers, hosted by the acute trust.
   - Local recruitment where possible with recruitment activity aligning with newly qualified staff university/college graduation dates.
   - Flexible and part time working to be considered.
   - Overseas recruitment from regions with highly skilled staff to include the Middle East (Dubai) and India.

   CDC staff recruitment will continue to be closely monitored by Committee.

3. **Care Quality Commission (CQC) Progress Reporting**
   Assurance: Limited.
   Seven reported actions have limited assurance. The actions relate to medical role specific and mandatory training. This training has been escalated as a concern by all divisions and discussed in numerous forums as there has been a persistent failure to achieve the standard of 85% compliance. Action plans and mitigations are in place, these include task and finish groups, targeted promotion of the training and ensuring training availability. Where remedial effort is spotlighted and targeted, there is improvement. Since last reporting to Board, the targeting of non-compliance for staff requiring level 3 safeguarding and mental capacity act training increased from 52% to 80%. This will continue to be closely monitored by Committee.

4. **Workforce Integrated Performance Report – Workforce Turnover & Vacancies**
   Assurance: Limited but improving.
   Workforce turnover position continues to decrease. The Medical vacancy rate for junior doctors is decreasing, however for consultants it remains high at 19.8% against a target of 15%. The Talent Acquisition Team is focusing recruitment activity on both Emergency Medicine and Acute Medicine. In addition, work is focusing on the competency-based process for those doctors who have not

followed an approved training programme. Utilising the Certificate of Eligibility of Specialist Registration (CESR) portfolio of evidence route, that demonstrates their training, qualifications, and experience.

5. Industrial Action
Nil industrial action is currently planned.

6. Freedom to Speak Up (FTSU)
The Committee received, considered, and approved the FTSU Strategy 2023/2024 - Annual Progress Report and Quarter 2 Report. Significant progress has been made to deliver against the FTSU strategic objectives. Anonymised feedback and trends feed into the Leadership development strategy and cultural transformation work. Going forward in next 12 months a 'Speak Up Champions' network in Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) will be launched. The NLaG FTSU Guardian continues to work closely with her HUTH counterpart.

7. Staff Lottery Committee – Annual Report 2022-2023
The Committee received, considered, and approved the Staff Lottery Committee Annual Report which detailed the activities of the Lottery for financial year 2022/2023. The total value of prizes paid out was £105,000. Membership numbers grew by an average of 45.8 per month, to an overall total of 3,283. The Staff Benefits Fund closed at £87,003.

Confirm or Challenge of the Board Assurance Framework:

Review of the high-level risk register.
Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours, and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

The risk: That the leadership of the Trust 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 its strategic objectives.

Challenge: Given the protentional of unforeseen or unintended consequences that may occur from a move to a Group structure, work being undertaken in realignment of workforce values, and changes to clinical pathways and ways of working, there is an increased risk of rises in levels of staff turnover, deterioration in staff morale and increased pressures and demands on leadership and management provision. The Group Chief People Officer has been asked to review the associated strategic risk. It is currently rated at 12 for the quarter two period 2023/2024 with a target of 8 by 31 March 2024.

Action Required by the Trust Board:

The Board is asked to:
- Receive and note the content of this highlight report.
- Approve FTSU and Staff Lottery annual reports.

Sue Liburd
Non-Executive Director and Chair of Workforce Committee

NLG(23)206

Name of the Meeting	**Trust Board of Directors - Public**
Date of the Meeting	5 December 2023
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 – November 2023**
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises the key matters presented to, and discussed by the Audit, Risk and Governance Committee at its meeting on 23 November 2023: 1. **Internal Audit Report – Theatre Data Quality** – 'Limited assurance' rating received as a result of differences in internally and externally reported data (the latter showing poorer performance). **Board to note.** 2. **Internal Audit Recommendations** – A positive position with only three overdue internal audit recommendations. **Board to note.** 3. **Counter Fraud Update** – Positive 91% compliance rate with mandatory fraud awareness training. Continuing theme of allegations of working elsewhere whilst off sick, despite lots of awareness material being issued. **Board to note.** 4. **Losses and Compensations Report** – Need to continue focusing on minimising loss of patient's belongings, particularly dentures and hearing aids. **Board to note.** 5. **IG Steering Group Highlight Report** – Good assurance received by the Committee from Trust's Data Protection Officer / IG Lead. **Board to note.** 6. **Salary Overpayments** – Increase in salary overpayments reported, in contrast to the downward trend reported to the Committee in previous updates. **Board to note.** 7. **Document Control** – 102 (4%) documents out of date and concern expressed with those with a high (6) or moderate (22) risk rating. ARG Committee Chair writing to relevant Directors with overdue high and moderate risk documents to ask for confirmation they are dealing with them. **Board to note.**
Background Information and/or Supporting Document(s) (if applicable)	Audit, Risk & Governance Committee Agenda Papers – 23 November 2023
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.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 December 2023
Report From:	Audit, Risk & Governance (ARG) Committee – 23 November 2023

Highlight Report:

1. **Internal Audit Report – Theatre Data Quality** – The Committee noted the 'Limited Assurance' level for this report and discussed the concerns identified around the accuracy of theatre data utilisation rates reported internally and externally. In May 2023 externally reported data was showing a lower utilsation rate (71.5%) than internally reported data (80.24%). The audit identified the Trust made changes to the data set in May 2023 and reviewed the data quality, leading to improved accuracy of reporting thereafter. The Committee discussed the need to have one set of accurate numbers as quickly as possible to ensure the Trust's performance is accurately reflected at a national level, and that implementation of the agreed actions was key. The Deputy Chief Operating Officer is being invited to the next meeting of the Committee in January 2024 to review the action plan and progress made.

2. **Internal Audit Recommendations** – The Committee was pleased to note that there were only three overdue internal audit recommendations reported and that these continued to be followed up.

3. **Counter Fraud Update** – The Local Counter Fraud Specialist (LCFS) informed the Committee of the positive 91% compliance rate since fraud awareness training became mandatory training in the Trust in January 2023. The Committee noted the continuing theme of allegations of working elsewhere whilst off sick from the Trust, acknowledging that this is a national issue, and that this is not as a result of lack of awareness of the issue (particularly considering that 91% of staff have undertaken fraud awareness training since January 2023 which includes information on this type of fraudulent conduct).

4. **Losses and Compensations Report** – The Committee discussed the report and the need to continue focusing on minimising the loss of patient's belongings, particularly dentures and hearing aids which can impact patients' dignity. The Committee acknowledged that such items tend to be lost in bedding when patients are moved etc. and it is impossible to say who they belong to when later found in the laundry.

5. **IG Steering Group Highlight Report** – The Committee concluded it had received good assurance from Trust's Data Protection Officer / IG Lead on the items detailed in the report and the responses given to questions from the Committee on a range of IG issues.

6. **Salary Overpayments** – The Committee had seen a sustained improvement over recent routine reports with reducing numbers/values of overpayments but noted an increase in the first six months of this year. The Committee discussed the ramifications

of salary overpayments and their disappointment that it had gone in the wrong direction recently, often as a result of leavers not being notified to the Payroll team and late change forms, acknowledging that just one or two significant overpayments could impact the figures considerably.

7. **Document Control** – Although it was positive to note that 96% of documents are in date, 102 (4%) are not and the Committee was concerned with those overdue with a high or moderate risk rating and whether these were having an impact within the Trust. It was discussed that document control issues used to be identified through the PRIMS process, and it was hoped it would also be picked up as part of the revised performance management regime. The ARG Committee Chair will be writing to the relevant Directors with overdue high (6) and moderate (22) risk documents to ask for confirmation that they are dealing with them.

Confirm or Challenge of the Board Assurance Framework:

The Q2 BAF was received by the Committee but it was noted that the BAF is to be revisited in its entirety as part of the new Group arrangements and therefore the Committee did not discuss it further.

Action Required by the Trust Board:

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

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

Name of the Meeting	**Trust Board**	
Date of the Meeting	5 December 2023	
Director Lead	Sean Lyons, Chair	
Contact Officer/Author	Linda Jackson, Vice Chair	
Title of the Report	**Group Development Committees-in-Common Highlight Report**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a summary of the matters considered by the Group Development Committees-in-Common at the meeting held on 30th November 2023	
Background Information and/or Supporting Document(s) (if applicable)	Minutes	
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:

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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 the Trust Board

NLAG Trust Board	05.12.2023
Report From:	Group Development Committees in Common

Highlight Report:

Place Partnerships
The committee was updated on the differing stages of maturity of the 4 Places and the challenges this presents the Group. The key focus in the next few months is to fully understand how we can best shape and influence the Places moving forward and focus on 3 key areas: workforce, anchor role and inequalities and better integration.

Collaborative of Acute Providers (CAP)
The committee were updated that the CAP has had a reset and restructured. The portfolios are now allocated as follows and the general consensus was to identify a few priorities in these areas and get traction:

- Urgent Care – Amanda Bloor
- Elective Recovery – Jonathan Lofthouse
- Cancer – Simon Morritt
- Diagnostics – Jonathan Coulter

Humber Acute Services Programme
The Humber Acute Service Programme has now reached a critical stage in its development. A Pre-Consultation Business Case (PCBC) has been developed and sets out a preferred option for the delivery of UEC and paediatric services with a primary focus on DPoW and NLaG. The Pre-Consultation Business Case has been subject to an NHSE Gateway Review and has been approved by the HNY ICB. Following HNY ICB approval a 14-week statutory consultation was launched. The consultation runs from 28th September 2023 until 5th January 2024.

Mid-point of the consultation has been reached and so the opportunity has been taken with partners to review the work undertaken to date, the feedback received and the proposed next steps. Just over 2,200 responses to the Consultation Questionnaire have been received; the majority being from the Scunthorpe and Goole areas. This has been supported by qualitative feedback gathered from a range of focus groups and engagement events.

A mid-point review has also been undertaken supported by the Consultation Institute, NHS England and our consultation partner ORS. The process to date has been cited as good practice.

The following further activities are planned during December:

- Media relaunch
- 3 further exhibition events – 2 in Scunthorpe and 1 in Gainsborough
- 10 pop up events in multiple locations
- Staff engagement sessions and drop ins
- 4 focus groups
- 4 further children's workshops

The qualitative feedback from the work undertaken has been invaluable and has provided thoughts on transport and access, impact on children and families and emergency response times.

The feedback from the consultation will feed into the final Decision Making Business Case which it is hoped will be present to the ICB Board in March 2024.

Community Diagnostic Centres
We have received funding for a Community Diagnostic Hub in Scunthorpe (£19.4m) and Spoke in Grimsby (£10m)

The Scunthorpe Hub will be located on the Lindum Street Car Park site and will provide a range of services including CT, MRI, Non obstetric ultrasound, Xray and multiple pathology and physiological tests. Patients will be directly referred to the CDC via their GPs and the increased capacity will reduce waiting times for appointments. By locating within the town centre the CDC will be more accessible and also support the regeneration of the local area.

Planning permission has been granted and work has commenced on site. The service is anticipated to go live in June/July 2024.

The Grimsby Spoke will be located in the Freshney Place shopping Centre and will provide a range of physiological and pathology tests as well as non-obstetric ultrasound.

The assumptions underpinning the schemes are subject to frequent change by NHSE England; this includes activity and financial tariffs that accrue for that activity. This is proving particularly challenging and the modelling of that is a continuous process and has an impact on the proposed patient pathways and staffing models planned. Similarly the scheme is planned to open in June/July 2024.

Strategic Digital Update – Electronic Patient Record
A business case has now been submitted to the ICB which details what the group will need moving forward. There is a challenge with the financial envelope which will be reviewed as part of the process. No business cases for digital investment nationally are now moving forward until the new financial year as part of NHSE's quarter 4 financial reset initiative. The Executive Team are going to look at a potential scanned document management solution as a possibility to deliver easier access to patient records whilst there is not a shared platform in place.

Group Leadership Structure
The committee received an update on the appointment to the Group Executive positions. The internal process has been concluded for most of the Tier one positions (Direct reports to the Group Chief Executive). Between now and mid-January 2023 interviews will be taking place for the roles of Group Chief Clinical Design Officer, Group Transformation Director, Group Digital Information Officer, Group Director of Assurance, Group Director of Clinical Governance and Group Chief Nurse.

The committee received an update on the Group Operating Structure which is on its 18th iteration after considering and responding to the feedback received from senior leadership, operational and clinical teams. The formal consultation period for the 14 Care Groups commenced on 21st November and closes on 21st December with a planned implementation date of February 2024.

Interviews for the site-based Managing Directors, Medical Directors and Chief Nurses are planned for early December 2023.

The committee received a paper on the alignment of the Board Committees and the alignment of the Board Reporting Framework. It was noted that work is still ongoing with Executive and Non-Executive colleagues to finalise the Committees in Common work plans and terms of reference for the final approval on the 12th December along with a final cross reference to the revised Board Reporting Framework. Legal advice had been obtained to ensure that the arrangements proposed ensure that the two Trusts are able to continue to fulfil their statutory roles. Work yet to be completed includes a review and updating of Standing Orders, data sharing arrangements and Schemes of Delegation, along with a review of the management groups that sit below committee level.

Future of the Group Development Committee in Common

The Group Development CiC was originally set up to oversee the Humber Acute Service Review (HASR) and its core three programmes of work. This committee then took on additional responsibilities once NLAG's Strategic Development Committee was disbanded along with the oversight of the NLAG/HUTH group model. With the evolution of the Group model and the alignment of the Board Committees and Board Reporting Framework a proposal was tabled to disband the committee

The committee supported the proposal and the planned reallocation of responsibilities. The table below summarises the proposed transfer of responsibilities:

Responsibilities	Transfer of Oversight
Group Model development	Group CEO Trust Board report for leadership structures Chair's Trust Board report for group governance arrangements
External Stakeholders (Place, ICB, CAP)	Standing Trust Board agenda item
Significant service changes (>£1m income) Digital Strategy Strategic Capital	Capital and Major Projects CiC
Humber Clinical Collaboration Programme (formally interim clinical plan)	Chief Delivery officer addressing via the group operating model. Reporting of progress will be via the Performance, Estates and Finance CiC
Consultant Engagement	Workforce Education and Culture CiC

Action Required by the Trust Board

The NLaG Trust Board is asked to approve the disbanding of the Group Development Committee-in-common with the transfer of oversight of key responsibilities as indicated above

Sean Lyons
Chair

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Lee Bond, Group Chief Financial Officer
Contact Officer/Author	Ellie Monkhouse, Chief Nurse: Joint Clinical Champion Dr Kate Wood, Chief Medical Officer: Joint Clinical Champion Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee: Author
Title of the Report	**Health Tree Foundation Trustees' Committee (HTF) Highlight Report –** 9 November 2023
Purpose of the Report and Executive Summary (to include recommendations)	The attached highlight report summarises key issues presented to and discussed by the Health Tree Foundation Trustees' Committee at its meeting on 9 November 2023 and worthy of highlighting to the Public Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	Health Tree Foundation 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)	Only on Health Tree Foundation Charitable Funds
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ✓ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other: Click here to enter text.

Highlight Report to the Trust Board

Report for Trust Board Meeting on:	5 December 2023
Report From:	Health Tree Foundation (HTF) Trustees' Committee held on 9 November 2023

Highlight Report:

AAU & SDEC Skylight Panels

Further to the report provided to the Trust Board for their last Public Meeting concerning AAU & SDEC Skylight Panels, Trustees are pleased to advise that the Health Tree Foundation will now fund Feature Ceiling Panels at both SGH and DPOW. This decision was taken following further discussions about the work required and cost thereof.

Signage and Wayfinding

- HTF has been approached with a Wish to fund a Trust-wide Signage and Wayfinding project. Because of the work involved in scoping this project, Trustees were asked to confirm that they would be inclined to support such a scheme, based upon an expired 2020 financial quotation. Following lengthy discussion, Trustees were unanimous in supporting the Wish, citing clear patient benefit. Other points made included: the need to take account of developing services across the Group; the potential for shared funding with the Trust; possible building upon relationships with local colleges to involve appropriate student groups in the various designs; the need to scope the work in phases, culminating in future-proofed digitization and the requirement for HTF to work closely with the current Trust's Signage & Wayfinding Group. Finally, it was agreed that the normal Wish process would be followed for the extant Wish, acknowledging that this would be a lengthy, complicated process.

HTF Annual Report & Accounts 2022/23

- The HTF Annual Report was presented to Trustees, who were pleased to approve the record of the year's activity. The quality of the Report was one of the clear benefits of having Smile manage the Trust's Charity. Trustees wished the report to be sent to the Trust Board for their information.

Confirm or Challenge of the Board Assurance Framework:

Action Required by the Trust Board:

The Trust Board is asked to note the decisions made by Trustees.

Neil Gammon
Independent Chair of Health Tree Foundation Trustees' Committee

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	Tuesday 5 December 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Nicola Foster, Associate Chief Nurse – Midwifery, Gynaecology & Breast Services
Title of the Report	**Maternity & Neonatal Oversight Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this new highlight report is to provide the Trust Board with oversight of the Trust's maternity services. Highlights of key areas are summarised for assurance and information. The Committee is asked to note this report and its contents. **1. Workforce** Midwifery vacancy rate remains a challenge in October. Seven international midwives joined the maternity service and a further 4 will be supported in December 2023. Newly qualified midwives recently have been recruited and are positively impacting on midwifery vacancies. **2. Clinical Negligence Scheme for Trusts (CNST) V5** Fortnightly CNST meetings to monitor and ensure compliance with action plan continue. **3. Quality Improvement** Current ongoing QI (Quality Improvement) projects within maternity services include: Induction of Labour; Neonatal Thermoregulation; Antenatal clinic/Antenatal Day Unit. Phase 2 of the Maternity Triage Service has gone live as planned on 16 October 2023. **4. Patient Experience and Service User Feedback** The Maternity Service continues to receive relatively low numbers of new complaints and PALS (Patient Advice & Liaison Service) concerns. MNVP (Maternity and Neonatal Maternity Voices Partnership) Lead commenced in September and maternity services have commenced co-production of maternity services. **5. Maternity Safety Support Programme** The Trust has confirmation that the Maternity Safety Support Programme will be exited in February 2024 following governance agreement at local, regional and national levels. **6. Maternity Safety Champions** Locally there are embedded monthly walk arounds across the maternity and neonatal services by the Safety Champions alternating the site venue each time. There is also a Shout Out Wednesday event each month which enables escalation by all staff of any safety concerns as well as the safety mailboxes open to all. An action log is collated ensuring learning and improvement opportunities are captured and progress monitored. Actions are progressing as planned.

	7. CQIM (Clinical Quality Improvement Metrics) Work is in progress to address the six metrics highlighted **8. External Visits** • LMNS (Local Maternity & Neonatal Systems) assurance visit – 23 October 2023 • Simon Kendall, Medical Director – NHSEI (NHS England/Improvement) visited Scunthorpe maternity unit on 20 October 2023	
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
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

Maternity & Neonatal Oversight Report – November 2023 (Sept 2023 data)

1 Workforce/Staffing

Vacancies

Vacancies in maternity are as follows:-

	Registered	Unregistered
DPOW – Diana, Princess of Wales Hospital, Grimsby	12.68 WTE	2.28 WTE
SGH – Scunthorpe General Hospital	14.86 WTE	-1.93 WTE

WTE -Whole Time Equivalent

Recruitment

- 13.96 WTE newly qualified midwives have commenced in post or are due to start in October, with a further 1.08 WTE to start in November/December. A further 4 internationally educated midwives will join the Trust in December
- Pastoral and Retention midwife role of supporting midwives (specifically early career) continues to impact positively on the service
- Pastoral and Retention midwife is providing monthly cross site wellbeing sessions and career clinics monthly have commenced (alternating sites)

Fill rates & CHPPD (Care Hours Per Patient Day) for maternity services is outlined below

Maternity Wards Fill Rates and CHPPD Sep 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**77.2%**	**-17.2%**	**62.0%**	**-18.3%**	**9.0**	**-5.89**
Registered Nurses and Midwives	72.5%	-17.9%	58.5%	-15.7%	5.6	-3.47
Care Staff	86.4%	-14.9%	68.9%	-22.2%	3.4	-2.42
Central Delivery Suite	**92.5%**	**5.4%**	**64.2%**	**7.6%**	**31.7**	**-0.39**
Registered Nurses and Midwives	94.1%	5.2%	63.5%	10.8%	25.9	-0.42
Care Staff	86.2%	6.4%	67.0%	-5.6%	5.8	0.03
Jasmine & Honeysuckle	**86.9%**	**-3.6%**	**74.0%**	**-1.0%**	**14.1**	**2.67**
Registered Nurses and Midwives	80.2%	-3.1%	67.2%	-0.8%	8.7	1.68
Care Staff	100.9%	-4.8%	87.9%	-1.5%	5.3	0.99
Ward 26 SGH	**80.7%**	**2.5%**	**47.8%**	**0.6%**	**7.3**	**0.31**
Registered Nurses and Midwives	77.8%	4.7%	43.4%	7.4%	5.1	0.36
Care Staff	88.4%	-3.4%	59.9%	-18.0%	2.1	-0.06
Total	**83.9%**	**-4.3%**	**62.6%**	**-3.7%**	**11.6**	**-0.95**

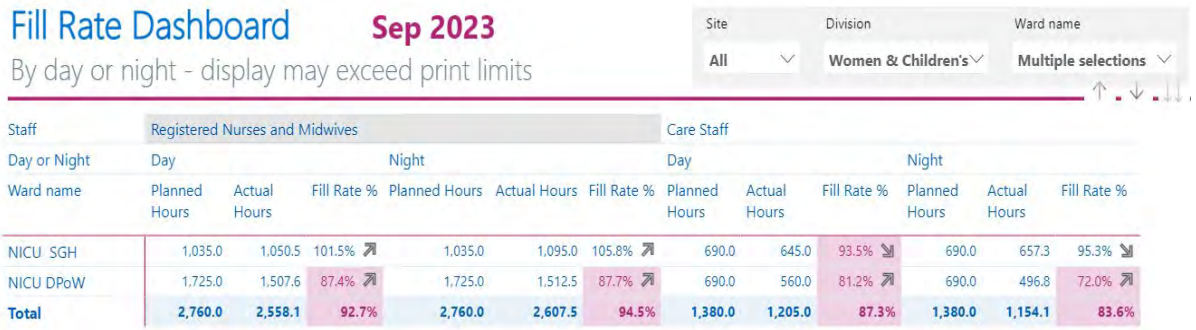
Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	62.4%	1.4%
Central Delivery Suite	81.8%	-0.3%
Jasmine & Honeysuckle	62.0%	0.2%
Ward 26 SGH	70.5%	2.1%
Total	**68.7%**	**1.3%**

SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital, Grimsby

Midwifery staffing is reviewed daily (weekdays), and a weekend plan cascaded widely. Maternity OPEL (Operational Pressures Escalation Level) levels are reported internally and regionally, ensuring escalation as per the Staffing Escalation policy and to request or support with regional mutual aid as required to maintain safety. Mutual aid, escalation and provision currently under review by the LMNS (Local Maternity and Neonatal Systems) and regional induction of labour/escalation meeting planned for 4 December 2023.

Fill rate and CHPPD data for the two neonatal units is outlined below



Fill Rate Dashboard Sep 2023

By day or night - display may exceed print limits

Site: All | Division: Women & Children's | Ward name: Multiple selections

Staff	Registered Nurses and Midwives						Care Staff					
Day or Night	Day			Night			Day			Night		
Ward name	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %	Planned Hours	Actual Hours	Fill Rate %
NICU SGH	1,035.0	1,050.5	101.5%	1,035.0	1,095.0	105.8%	690.0	645.0	93.5%	690.0	657.3	95.3%
NICU DPoW	1,725.0	1,507.6	87.4%	1,725.0	1,512.5	87.7%	690.0	560.0	81.2%	690.0	496.8	72.0%
Total	**2,760.0**	**2,558.1**	**92.7%**	**2,760.0**	**2,607.5**	**94.5%**	**1,380.0**	**1,205.0**	**87.3%**	**1,380.0**	**1,154.1**	**83.6%**

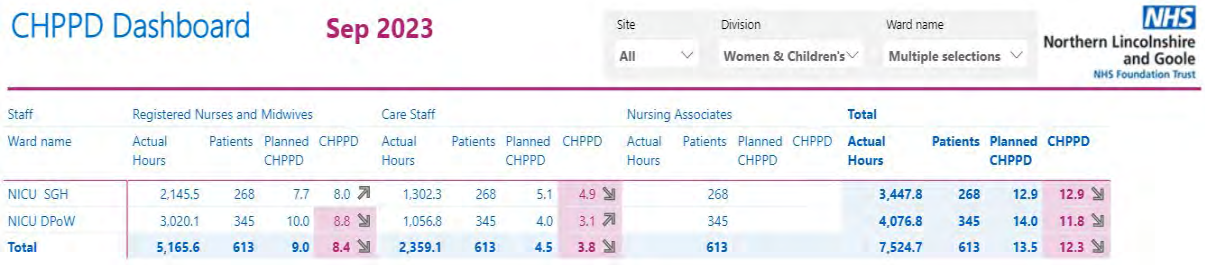
NICU – Newborn Intensive Care Unit
SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital, Grimsby

The fill rate for RN (Registered Nurses) at Scunthorpe NICU is above the target of 95% for both days and nights.

At Grimsby the fill rate is less due to an increase in the establishment which is being recruited to with newly qualified nurses expected to start in the autumn. Bed occupancy is reviewed daily and shifts are only covered when necessary if there is full cot occupancy.

The fill rate for HCAs (Health Care Assistants) has remained improved at SGH due to vacancies being recruited to and a reduction in sickness absence. There is an improved position on the Grimsby Site due to recruitment and a reduction in sickness absence, although remains below expected target.

This position is mitigated due to the daily review and movement of staff between Children and NICU to keep areas safe and some vacancy and long-term sickness gaps which are being managed appropriately.



CHPPD Dashboard Sep 2023

Site: All | Division: Women & Children's | Ward name: Multiple selections

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Staff	Registered Nurses and Midwives				Care Staff				Nursing Associates				Total			
Ward name	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	Actual Hours	Patients	Planned CHPPD	CHPPD	**Actual Hours**	**Patients**	**Planned CHPPD**	**CHPPD**
NICU SGH	2,145.5	268	7.7	8.0	1,302.3	268	5.1	4.9		268			**3,447.8**	**268**	**12.9**	**12.9**
NICU DPoW	3,020.1	345	10.0	8.8	1,056.8	345	4.0	3.1		345			**4,076.8**	**345**	**14.0**	**11.8**
Total	**5,165.6**	**613**	**9.0**	**8.4**	**2,359.1**	**613**	**4.5**	**3.8**		**613**			**7,524.7**	**613**	**13.5**	**12.3**

The CHPPD does fluctuate due to the number of occupied cots and the reviewed staffing levels to ensure patient safety. The care staff CHHPD is lower due to a planned higher ratio of RN to HCA.

The latest Trust wide Maternity Dashboard is shown in **Appendix I.**

The latest midwifery staff data is show in **Appendix II**.

National Maternity Dashboard/CQIM (Clinical Quality Improvement Metrics)

The latest clinical quality Improvement Metrics are shown in **Appendix III**. Current interventions for metrics where the Trust is an outlier are as follows:-

Babies who were born pre term (Rate per 1000)	83.0	61.0	• Preterm birth prevention clinics (consultant led) • LMNS supporting healthy lifestyles midwives (healthy eating, alcohol and smoking) • Information provided for women
Babies with a first feed of breastmilk (percent)	50.9	72.0	• Infant feeding leads supporting with antenatal education • Highlighted importance of first feed in mandatory training (Infant feeding)
Babies with an Apgar score between 0 and 6 (rate per 1000)	16.0	13.0	• Optimum condition for birth – antenatal care – preterm birth clinics, smoking cessation support and CO (Carbon Monoxide) monitoring, healthy lifestyles support, Fetal monitoring staff training, Domestic abuse questions and support, drug misuse support, fetal growth scanning (if required)
Women who had a PPH of 1500mls or more (per 1000)	34.0	31.0	• Guideline reviewed and practice changed in accordance with MatNeoSip (Maternity & Neonatal Safety Improvement Programme) • MDT PPH (Multi-disciplinary Team Postpartum Haemorrhage) reviews are undertaken for all cases
Women who were current smokers at booking (percent)	16.2	9.0	• Smoking cessation service offered for women and partners • Bespoke tobacco dependency service and offer of nicotine replacement therapy • 'Baby clear' smoking cessation pathway followed • CO monitoring • Fetal growth scanning pathway
Women who were current smokers at delivery (percent)	13.1	7.7	• Smoking cessation service offered for women and partners • Bespoke tobacco dependency service and offer of nicotine replacement therapy • 'Baby clear' smoking cessation pathway followed • CO monitoring • Fetal growth scanning pathway

2 Patient Experience/Service User Feedback

The following section details the feedback received via Formal Complaints, PALS (Patient Advice and Liaison Service) concerns, Compliments and the FFT (Friends and Family Test). This information is taken from September 2023 information and includes performance data and themes.

Formal Complaints and PALS Data

* **KPI** -Key Performance Indicator

Table A

Obstetrics	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sept-23
Number complaints open/ongoing	4	3	5	6	5	5
Number of open complaints out of timescale	0	0	0	1	1	1
Number complaints closed this month	1	2	0	1	2	3
Number of new complaints	2	2	2	3	1	3
	Apr-23	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sept-23**
Number of PALS open	0	3	2	3	3	2
Number of PALS out of timescale	0	3	1	2	2	2
Number of PALS closed this month	3	3	9	5	4	6
Number of new PALS	1	6	7	6	4	5
	Apr-23	**May-23**	**Jun-23**	**Jul-23**	**Aug-23**	**Sept-23**
% of complaints closed within timescale (KPI 85%)	100%	100%	0	100%	50%	33%
Average length of time to respond to complaints closed (working days)	60	50	0	29	32	55
% of PALS closed within timescale (KPI 60%)	33%	33%	33%	80%	25%	66%
Average length of time to respond to PALS closed (working days)	10	10	12	4	17	7

Children & Young People including Neonates	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Number complaints open/ongoing	4	5	5	3	5	5
Number of open complaints out of timescale	0	0	0	0	0	2
Number complaints closed this month	2	0	1	2	2	1
Number of new complaints	4	1	2	1	2	1
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
Number of PALS open	2	4	5	7	7	3
Number of PALS out of timescale	1	4	2	4	4	0
Number of PALS closed this month	6	6	11	7	12	9
Number of new PALS	4	8	11	9	12	5
	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23
% of complaints closed within timescale (KPI 85%)	100%	0	100%	100%	50%	0%
Average length of time to respond to complaints closed (working days)	27	0	54	44	32	64
% of PALS closed within timescale (KPI 60%)	33%	33%	18%	71%	17%	33%
Average length of time to respond to PALS closed (working days)	13	9	14	5	12	17

September saw 3 formal complaints closed in Obstetrics, with 1 closed in timescale (33%), and 5 ongoing complaints open. Three new complaints were logged. Previous identified delays in the formal complaint process are escalated and the central team are working with the Divisional Medical Director and Associate Chief Nurse for Family Services to address these.

There were 5 new PALS concerns, 3 of which being Values/Behaviour related. 66% of closed PALS concerns achieved the 5-day timescale for closure, improved from previous month (25%) and meets KPI (Key Performance Indicator) for this report. Two concerns remain open, both of which are out of date.

Children and Young People received 1 new complaint, related to paediatric care (unable to obtain GP Appointment & incorrect care on admission to Rainforest). 1 complaint was closed out of timescale, 5 currently remain open with 2 also being out of timescale for this month.

Five new PALS concerns were logged, main theme related to delays in appointments (3). These are all related to paediatric areas and not neonatal areas. Only 33% of the 12 PALS closed were in timescale, with an average of 17 days to close a concern being noted.

As noted in the previous month's report consideration should be given that Family Services complaints and concerns tend to be complex and emotive which can make timescale delivery challenging, especially for PALS. Weekly meetings are in place to ensure the divisional leads are sighted on progress for both these measures.

Four compliments were formally logged on Ulysses in September: 2 paediatric in-patient (Grimsby and Scunthorpe), 1 Grimsby Neonatal and 1 Scunthorpe Antenatal. They relate to kindness, support and the excellent care given.

Maternity collected 31 pieces of FFT feedback, these were predominantly at Grimsby, all were rated positive. Children and Young people collected 5 positive pieces; all of these were at Grimsby. Our new FFT system is due for trial and roll out in November/December for Maternity, so we should start to see an increase in numbers in the coming months.

3 Assurance

Two 15 Steps Challenge visits took place within Maternity Services and Neonatal Services during September 2023. Jasmine, Honeysuckle, Blueberry and Holly Wards at Diana Princess of Wales Hospital (DPOW) received ratings of good.

Acute 15 Steps Challenge Visits			
Date of visit	Ward/ Department	Rating 2023	Previous Rating
05/09/2023	Blueberry & Holly Ward DPoW	07/07/2022	05/07/2022
05/09/2023	Jasmine & Honeysuckle Ward DPoW	07/09/2022	05/07/2022

DPOW – Diana, Princess of Wales Hospital, Grimsby

*Rating Guidance

Outstanding	Good	Requires Improvement	Intensive Support

Supportive visits continue across Women and Children's Services to review individual 15 Steps improvement plans and gain further assurance with ongoing actions.

Zero Ward Assurance Tool surveys completed for Matrons on Ward 26 or Delivery Suite Scunthorpe. This has been discussed with the Divisional team and is being addressed individually.

No data to report for Ward 26 and Central Delivery Suite at Scunthorpe for Matron due to zero surveys completed. Honeysuckle and Jasmine Ward fell below 90% compliance on Matron and Manager surveys. This has been discussed with the Divisional team and is being addressed individually.

Scunthorpe NNU (Neonatal Unit) fell below 90% compliance on Matron surveys.

4 Feedback

Maternity & Neonatal Safety Champions
The role of the Trust Board Safety Champion is to act as a conduit between staff, frontline safety champions (obstetric, midwifery and neonatal) service users, LMNS (Local Maternity & Neonatal System) leads, the Regional Chief Midwife and Lead Obstetrician and the Trust Board to understand, communicate and champion learning, challenges and successes. There are embedded monthly walk rounds across the maternity and neonatal services by the Safety Champions alternating the venue each time. It provides an opportunity for the Safety Champions to speak with staff to understand concerns and safety issues they may have and to provide the 'floor to board' communication.

The walkaround for October was undertaken at Grimsby. This was a positive walkaround and staff were keen to share the positives about their area.

Escalated Issues:-

- Antenatal clinics over running. A new quality improvement project will focus on improving antenatal processes.

Safety Mailbox and Shout Out Actions
Staff can raise safety concerns through a Safety Mailbox and via Shout Out Wednesday, which occurs monthly cross site. This is a short gathering on the clinical areas where all grades of staff are encouraged to attend to express any safety concerns that they may have. A summary of concerns raised actions and evidence of progress is detailed in the Safety Champions Action Log **(Appendix IV).** All are progressing and there are no areas for escalation.

5 Quality Improvement

Transforming Maternity Triage Services

The Ockenden report outlines a number of recommendations in relation to how maternity services should conduct triage for pregnant women with medical related concerns who are 16 weeks plus. These recommendations outline the need to follow a recognised model of triage to priorities timely assessment, i.e. the Birmingham Symptom Specific Obstetric Triage System (BSOTS).

The aim of this Quality Improvement Project is to implement a fully operational Maternity Triage Service across the whole of the Maternity Service in NLAG (Northern Lincolnshire & Goole NHS Foundation Trust) that utilises a nationally recognised Triage Model (BSOTS) in order to enhance the patient experience and care.

Phase 1 & 2 (telephone triage) and phase 3 (face to face triage) have now been successfully implemented at both Scunthorpe and Grimsby. Phase 3 went live on 16 October. At the time of writing 1219 calls have been telephone triaged answers with 292 women been triaged face to face at Grimsby and 171 women been face to face triaged at Scunthorpe. Patients who have been through the new service have been prompted to complete a patient experience survey. Of those patients that completed the survey 70% rated the service as “Excellent” and a further 20% rated the service as “Good”.

Challenges remain at both sites in relation to staffing levels to consistently staff maternity triage however this has been actively managed by the service with a contingency process in place where staffing levels are low to maintain patient care, however this falls outside the BSOTs model. In addition, timely availability of clinical review within the BSOTs timescales is proving difficult at certain times i.e. when clinicians are in theatre. This will continue to be monitored with data collected over the next month for review and exploration of possible solutions.

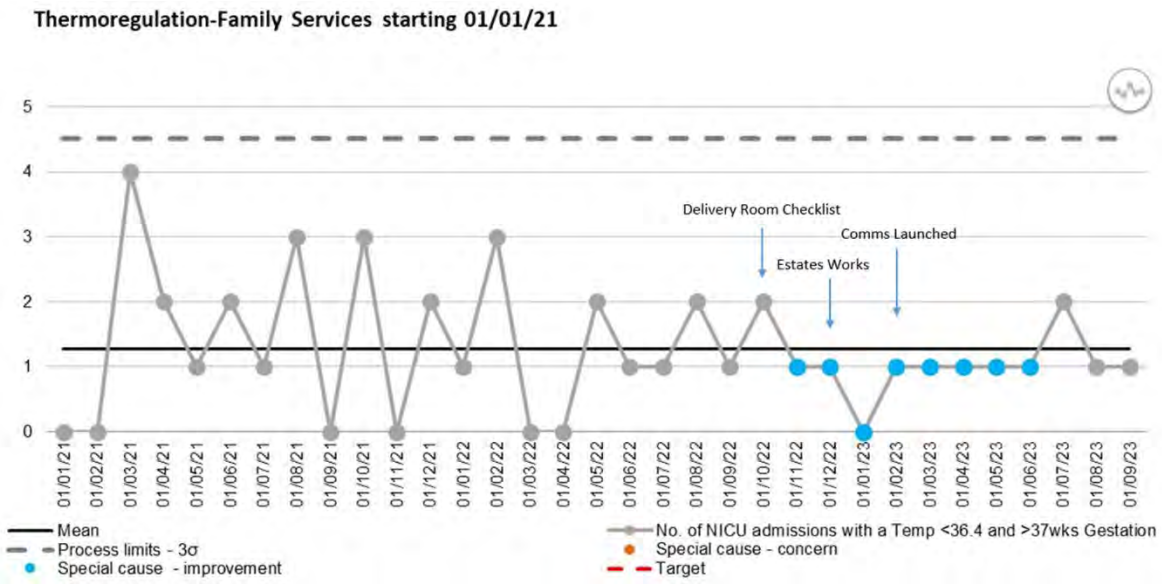
Reducing Thermoregulation

New-born babies following birth are at risk of thermoregulation (loss of body temperature) which can lead to other health related issues requiring admission to NICU (Newborn Intensive Care Unit).

The aim of this quality improvement project is to have no more than 10% of NICU admissions as a result of babies with a temperature outside of the optimal limits (<36.4) for babies >37 week gestation by 31st March 2023 (based on a baseline mean of >1 Jan 2021 – Jan 2023 equating to 97 babies).

Whilst the baseline (mean) position is >1 the SPC (Statistical Process Control) chart below shows the larger variation and impact from 0 to >4 babies over 37 weeks gestation been admitted to NICU with thermoregulation.

The below SPC chart below shows improvement between November 2022 and June 2023, with 2 babies going to NICU in July 2023 breaking to improvement trend. This has however returned to 1 baby going to NICU in August and September respectively. Monitoring will continue over the winter months to ensure sustainability of the initial improvement can be achieved.



Antenatal Clinic (ANC) Quality Improvement (QI) Project

The divisional Senior Management Team have agreed for the commencement of a new quality improvement project focusing on improving the Antenatal Clinics (ANC) processes at both Grimsby and Scunthorpe. This work has been prioritised after initial scoping showed opportunity to improve the service across a number of quality and performance metrics including patient and staff experience, reducing clinic over runs, aligning ANC and scanning capacity and reviewing both midwifery and medical roles within the ANC. Engagement session at both Scunthorpe and Grimsby have been conducted to capture the root causes of the problems from our frontline teams, by way of a cause and effect diagram. This information is being reviewed with the service leads to agree priorities and next steps.

6 Serious Incident (SI) Reporting

Open Maternity Serious Incident Investigations as at 14.11.2023
There are currently 7 Maternity Serious Incidents open in the Trust. One of these incidents are being investigated by HSIB (Healthcare Safety Investigation Branch).

Please note that the cases described in this report may be represented in the Serious Incident report to the Quality and Safety Committee, but in a summary form, tracking the investigation process. The table below provides immediate actions taken during the initial investigation stage, to demonstrate response to risks identified.

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
2023 20199	DPOW	Delayed delivery following abnormal CTG (cardiotocography) reading	Investigation	•Registrar to have 1:1 with the fetal monitoring lead. •Line manager and College Tutor to be informed and discuss with the registrar involved. •Coordinator to have 1:1 with fetal monitoring lead. •Labour Ward Coordinator manager to have discussion with coordinator •Discuss at Obstetric and Gynecology Governance Fetal growth was fluctuating and questions around appropriate management of fetal surveillance – plan.	25.01.2024
2023 18396	SGH	NVF (non-viable foetus) shared cremation error	Investigation	• Discussed at Managers weekly meeting and Maternity Safety huddles • Patient Safety Midwives educating unit/ward staff on the appropriate paperwork. • The form has been updated. This was agreed and will be shared to Family	22.12.2023

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
				Services Governance team and is part of the education. • Flowcharts to be completed that will aide our staff on the 3 different processes- again this will be shared at Family Services Governance team and is part of the education. • Bereavement Midwives will continue to closely work with our mortuary staff to check all paperwork for accuracy and consistency and will be able to rectify any potential issues- at the beginning of this process. • The Bereavement Midwives will be responsible for scanning all the correct documents directly to the crematorium and will be the point of contact. • Chaplaincy actively support families in their loss when requested to do so. • North Lincs Registrars are assured with our change in process and confirmed that the temporary suspension would be lifted. • Backlog of DPoW cases urgently reviewed on 26.09.23 and DPoW's Mortuary Assistant and DPoW Chaplain	

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
				supported by Family Services and are assured that each case had been dealt with totally appropriate with no concerns raised on consent.	
2023 8658	DPOW	Maternal Cardiac Arrest	Investigation	Reviewing the issues relating to referral and acceptance for Interventional Radiology (HUTH) Investigating the decision making and potential disagreements between staff during the cardiac arrest.	04.01.2024
2023 10062	DPOW	IUD	Investigation	Matron discussed the case with the midwife regarding escalation. Educational supervisors discussed the case with the two registrars involved.	01.12.2023
2023 12695	SGH	Lower Segment Caesarean Section (LSCS) admitted to ITU (Intensive Therapy Unit)	Investigation	Statements being requested and interviews planned	17.11.2023
2023 13122	DPOW	Maternal death	Investigation	This case was reported to MBRRACE as a maternal death and from the review of the case, there was no immediate learning identified.	24.11.2023
2023 13399	DPOW	HSIB - Maternal death	Investigation	Review of the postnatal care due to the large gap between reviews Email sent to all midwives for student midwives not to be given care without supervision Email sent to Consultants and	Not applicable due to HSIB investigating

STEIS Ref	Site	Description	Stage	Immediate Action	Deadline date
				Coordinators to ensure patients with safeguarding concerns to only be considered for transfer out when an absolute must eg <27 weeks gestation	

SGH – Scunthorpe General Hospital
DPOW – Diana, Princess of Wales Hospital, Grimsby
HUTH – Hull University Teaching Hospitals
MBRRACE – Mothers & Babies Reducing Risk Through Audits and Confidential Enquiries
HSIB – Healthcare Safety Investigation Branch

Maternity Serious Incident Completed Reports (2023) – 1

STEIS Ref	Site	Description	Lessons Learnt	Action Plan Due Date
2022 20796	DPOW	HSIB - Unexpected baby death	•Staff to use checklists during antenatal counselling for women who have had a previous caesarean section. •Multidisciplinary teams to communicate regularly over mothers throughout the day and night, both at and between handovers. •Ensure there is an obstetric plan of care for all women aiming for a VBAC (Vaginal Birth after Caesrean). •Staff must clearly document discussions with all mothers who choose not to have recommended care, to check understanding of the information, including risk and benefits of their choice.	**April 2024**

Risks and themes

- Within the last 12 months, there have been two similar cases where fetal monitoring of a baby has been performed and fetal demise has occurred

7 Sustainability Plan

The MSSP (Maternity Safety Support Programme) will be exited in February 2024, following governance agreement at local, regional and national levels.

The Maternity Sustainability Plan **(Appendix V)** is monitored through the Maternity Quality Improvement meeting and Maternity Transformation & Improvement Board.

Ongoing Maternity Sustainability

Key Areas of Focus

- Leadership/Culture stability and QUAD
- Safety (embedding maternity and neonatal safety champion processes)
- Incident review process (rapid reviews/PSIRP) (Patient Safety Incident Response Plan)
- Reviewed and strengthened governance structure
- Learning – identifying and sharing
- Quality Improvement
- Audit Plan

Next Steps

- Safety and Quality – continue to monitor embedded processes and seek opportunities for service improvement
- Co-production with new MNVP (Maternity & Neonatal Voices Partnership) Lead (including Maternity Strategy)
- Keep QI (Quality Improvement) high on maternity agenda (identifying new projects)
- Maintain senior leadership team visibility
- Continue supporting and developing our teams/engagement with teams/succession planning
- Culture – repeat SCORE survey February 24
- Maternity and Neonatal Safety Conference – Winter 23
- PMA (Professional Midwifery Advocates)

8 External Visits

- LMNS (Local Maternity and Neonatal Systems) Assurance Support Visit - 23 October 2023
- Simon Kendall, Medical Director – NHSE/I (England/Improvement) visited Scunthorpe maternity unit on 20 October 2023 – positive feedback

9 Conclusion

The oversight report highlights all the work being undertaken within the maternity services.

Workforce/Staffing – Seven internationally educated midwives continue at the Trust and maternity services will be supporting a further 4 international midwives in December. Newly qualified midwives have commenced cross site, which has positively impacted on midwifery vacancies.

Both the Pastoral and retention midwife and Legacy mentor midwife are specifically working with both the international midwives and the early career midwives.

Patient Experience – complaints and PALS (Paediatric Advice & Liaison Service) remain relatively low. FFT (Friends and Family Test) results show excellent feedback and positive experience. Overall themes related to communication and kindness, with much of the positive comments relating to this.

Assurance

- One 15 Steps Challenge was completed within Maternity Services and Neonatal Services during September 2023. Jasmine and Honeysuckle at Grimsby received a rating of good
- Positively the MNVP (Maternity and Neonatal Voices Partnership) Lead Role commenced September 2023 and we have commenced coproduction of maternity services

Maternity Safety

- The Maternity Safety Champions have an embedded walk round programme visiting different areas each time and it provides assurance of a 'floor to board' communication
- Planning a Maternity Safety Conference – Winter 2023, based on the Ockenden Report – multidisciplinary and highlight on maternity safety

Quality Improvement
There are a number of on-going Quality Improvement projects including maternity triage services, induction of labour, neonatal thermoregulation and the Antenatal day unit/clinic review. All projects have full support from all the team and feedback from staff and service users is excellent.

Stage two of triage (final phase) commenced cross site on 16 October and is being closely monitored. Initial feedback from both women and staff experience is positive.

CNST (Clinical Negligence Scheme for Trusts)
Fortnightly CNST meetings to monitor and ensure compliance with action plan continue.

Assurance and monitoring provided by:

- Family Service quad oversight and escalation as required
- Quality & Safety Committee and Trust Board oversight
- Multidisciplinary CNST meetings taking place fortnightly
- Introduction of Maternity Audit and Compliance Manager
- Development of CNST/Saving Babies Lives annual audit calendar in collaboration with central audit team
- Introduction of Saving Babies Lives implementation tool – allowing consistent ICB (Integrated Care Board) reporting/LMNS (Local Maternity & Neonatal Systems) oversight

Ockenden Report
Action plan following the initial Ockenden Report is now complete and work is progressing on the immediate and essential actions to improve maternity care, supported by the multidisciplinary team; 57 green, 28 amber and 0 red actions.

Serious Incidents/Investigations
SI (Serious Incidents) and MNSI (Maternity and Neonatal Safety Investigations) formally HSIB (Healthcare Safety Investigation Branch) cases remain low with no reported SI in September 2023.

The MNSI team visited the Grimsby and Scunthorpe sites on 3 November 2023 and presented the Quarterly Review Meeting (QRM) at the multidisciplinary cross site Maternity Forum and plan to continue this format for future QRM's.

Complaints/PALS (Patient Advice & Liaison Service)
As with complaints and PALS), due to the limited number there are no themes, however all learning is widely shared across all areas and reported into the LMNS (Local Maternity and Neonatal Systems), PQSAG (Perinatal Quality Safety and Assurance Group) and PQSOG (Perinatal Quality Safety Oversight Group) meeting.

Mandatory Training

K2 and PROMPT compliance	
<u>K2 Perinatal Training Programme (PTP) – Fetal Monitoring</u>	
Obstetric (Obs) Consultant	94%
Medical staff Obs Rota	94%
Midwives	94%
<u>Practical Obstetric Multi-Professional Training (PROMPT)</u>	
Obstetric Consultant	94%
Medical staff Obs Rota	90%
Anaesthetic Consultant	92%
Anaesthetic staff on Obs Rota	95%
Midwives	92%
Health Care Assistants (HCA)	98%

Appendix I

Trustwide Maternity Dashboard

Indicator	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023
Midwife to Birth Ratio	24.8	22.9	24.2	23.7	23.4	22.2	22.4	22.3	23.0	23.1	23.3	22.8
Red Flags	17.0	11.0	20.0	3.0	1.0	4.0	6.0	15.0	25.0	2.0	7.0	14.0
(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)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0	0.0	3.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0	0.0	3.0	1.0	0.0	3.0	2.0	3.0	0.0	0.0	3.0	3.0
(c) Missed medication during an admission to hospital	0.0	3.0	0.0	0.0	0.0	0.0	2.0	0.0	2.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	1.0	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	5.0	3.0	9.0	1.0	1.0	1.0	1.0	3.0	5.0	0.0	1.0	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	11.0	4.0	6.0	1.0	0.0	0.0	0.0	6.0	16.0	2.0	2.0	5.0
Continuity of Carer %	14.0											
In Receipt of %	8.0											
CoC In Receipt of %	66.0											
Continuity Team Caseload	311.0											
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	89.0	96.2	91.0	93.1	92.3	97.2	97.8	98.2	94.8	94.2	92.8	94.5
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	100.0
1:1 Care in Labour %	100.0	100.0	100.0	100.0	99.5	100.0	100.0	100.0	100.0	100.0	100.0	99.5
Vacancies	41.6	41.1	40.4	42.2	41.7	34.4	16.0	10.5	14.5	14.9	15.5	15.4
Vacancies - Registered	39.8	34.4	34.4	36.0	37.3	30.5	17.6	13.9	18.0	17.6	19.1	15.9
Vacancies - Unregistered	1.8	6.7	6.0	6.1	4.4	3.9	-1.6	-3.4	-3.5	-2.7	-3.6	-0.4
Serious Incidents	0.0	0.0	2.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0	0.0	0.0
Complaints	3.0	2.0	0.0	1.0	2.0	1.0	1.0	1.0	2.0	3.0	0.0	0.0
PALS	6.0	4.0	3.0	3.0	3.0	3.0	1.0	6.0	6.0	6.0	0.0	0.0
Sickness Absence (Division) %	6.5	5.0	6.7	5.6	5.5	5.9	6.0	5.7	5.2	5.5	5.7	

Appendix II – Latest Midwifery staff data

Maternity Services						
CQC Maternity Ratings	**Overall**	**Safe**	**Effective**	**Caring**	**Well-led**	**Responsive**
	RI	RI	Good	Good	RI	Good
	Good	Good	Good	Good	RI	Good
	RI	RI	Good	Good	RI	Good

Maternity Safety Support Programme	Yes	Fiona McDonagh / Jasmine Leonce

	Aug-23	**Sep-23**	**Oct-23**	**Nov-23**	**Dec-23**	**Jan-24**
Findings of review of all perinatal deaths using the real time data monitoring tool	During Q1 the multidisciplinary team has reviewed care and completed the PMRT tool for 1 neonatal death, 1 antepartum late fetal loss and 3 antepartum stillbirths. Actions have been taken to address concerns/issues identified and 1 serious incident investigation is underway.					
Findings of review of all cases eligible for referral to MNSI	1 referral to HSIB	0 referrals to HSIB	0 referrals to MNSI			

Report on:						
The number of incidents logged graded as moderate or above and what actions are being taken	**Reported (N=3)**	**Reported (N=4)**	**Reported (N=0)**			
	Actions Taken: 1) Direct feedback to operating consultant involved Instrument removed from theatre. 2) Safeguarding review completed Concise RCA investigation currently ongoing. 3) Duty of candour given, doctors contacted and lessons learnt, matron to feedback to midwifery team to cross check plan before discharge.	1) Readmission to maternity services via A&E- Undiagnosed hypoplastic aortic arch and VSD on USS. Action Taken: Transferred to LGI awaits operation, process reviewed for management of high BMI. 2) Cat 1 EMCS abruption, PPH 2746ml, EUA, hysterectomy. Action Taken : Currently being investigated. 3) Cat 1 EMCS for abruption PPH 2746ml returned back to theatre EUA Action Taken : Action Taken: Currently being investigated. 4) Notified that the baby was cremated within a shared cremation however this baby was registered as a neonatal death. Action Taken: NVF service has been discontinued until processes have been fully reviewed and the governance is such to ensure this would not happen again. SI investigation underway.				
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training:						
Core competency – S&G Maternity (all staff groups)	82.9%	82.0%				
Core competency – DPOW Maternity (all staff groups)	92.1%	92.7%				
Role Specific Training – S&G Maternity (all staff groups)	76.8%	77.0%				
Role Specific Training – DPOW Maternity (all staff groups)	86.6%	86.6%				
Other competencies – S&G Maternity (all staff groups)	64.9%	58.9%				
Other competencies – DPOW Maternity (all staff groups)	74.3%	69.1%				
K2 Training	94.3%	94.0%				
PROMPT	95.6%	93.5%				
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual cover:						
Midwifery staffing (source: safer staffing dashboard, Power BI)						
Blueberry/Holly – DPOW	Planned hrs: 2,939.1	Planned hrs: 3,204.3				
	Actual hrs: 2,657.0	Actual hrs: 2,323.6				
	Fill Rate: 90.4%	Fill Rate: 72.5%				
Central Delivery Suite – SGH	Planned hrs: 2,933.8	Planned hrs: 2,839.2				
	Actual hrs: 2,608.8	Actual hrs: 2,670.9				
	Fill Rate: 88.9%	Fill Rate: 94.1%				
Jasmine and Honeysuckle – DPOW	Planned hrs: 2,933.8	Planned hrs: 2,839.2				
	Actual hrs: 2,441.9	Actual hrs: 2,275.9				
	Fill Rate: 83.2%	Fill Rate: 80.2%				
Ward 26 – SGH	Planned hrs: 2,567.1	Planned hrs: 2,484.3				
	Actual hrs: 1,876.9	Actual hrs: 1,933.3				
	Fill Rate: 73.1%	Fill Rate: 77.8%				

Obstetrician staffing – cover on the delivery suite, gaps in rotas						
Delivery Suite – SGH	100.0%	100.0%				
	0 gaps identified	0 gaps identified				
Delivery Suite – DPOW	100.0%	100.0%				
	0 gaps identified	0 gaps identified				
Service User Voice Feedback	MNVP Lead – vacancy 15 Steps – Antenatal clinic at SGH received 'Good' Friends of Family Q2 Results: 40 responses submitted – 100% positive feedback received	MNVP Lead now in post 15 Steps – Antenatal clinic at SGH received 'Good' Friends of Family Q2 Results: 40 responses submitted – 100% positive feedback received				
WAT Tool Ward Area Compliance (July to September)	96.70%	96.70%				
Staff feedback frontline champions and walk abouts	5 open actions – action plan in place and monitored (Reported to Board / Q&SC)	7 open actions – action plan in place and monitored (Reported to Board / Q&SC)				
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with the Trust	0	0				
Coroner Reg 28 made directly to the Trust	0	0				
Progress in acheivement of CNST SA 10	On track	On track				

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their Trust as a place to work or receive treatment (reported annually)	Activity Planned Dec 23
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours (reported annually)	Activity Planned Dec 23

Family Services Operational Dashboard - Power BI

Appendix III - NLAG Clinical Quality Improvement Metrics (CQIM)

NLAG Clinical Qualty Improvement Metrics (CQIM)				Month	Aug-23
Metric	**Upper threshold**	**Lower threshold**	**NLAG**	**National**	**MBBRACE Group**
Babies who were born preterm (Rate per 1,000)	102.5	18.5	83.0	61.0	65.0
Babies with a first feed of breast milk (Percent)	100.00	40.8	50.9	72.0	66.2
Babies with an APGAR score between 0 and 6 (Rate per 1,000)	27.5	0.0	16.0	13.0	14.0
Caesarean section rate for Robson Group 1 women (Percent)	15.1	0.0	0.0	7.1	7.3
Caesarean section rate for Robson Group 2 women (Percent)	80.7	18.8	47.5	56.8	56.2
Caesarean section rate for Robson Group 5 women (Percent)	100	61.6	77.3	80.6	82.8
Women who had a 3rd or 4th degree tear at delivery (Rate per 1,000)	51	3.0	17.0	24.0	22.0
Women who had a PPH o 1,500 ml or more (Rate per 1,000)	56.5	4.5	34.0	31.0	33.0
Women who were current smokers at booking appointment (Percent)	24.5	0.0	16.2	9	9.7
Women who were current smokers at delivery (Percent)	24.1	0.0	13.1	7.7	8.3
Women with a vaginal birth following a ceaserean sectin (Percent)	33.7	0.0	18.8	14.4	11.9

Appendix IV – Safety Champions Action Log

Safety Champions Action Log - Maternity and Neonates

Northern Lincolnshire and Goole NHS Foundation Trust

Overdue or Incomplete
In Progress
Completed

Date Raised	How concern was raised	Site DPOW/SGH/ Trustwide	Concern Raised	Actions Required	Responsible Person	Action by Date	Status	Evidence Of Completion
19/10/2022		DPOW	Holes in theatre floor – previously been reported but no action has been taken as yet. Tracy Martin has liaised with Iona Johnson who was chasing up estates.	Has been reported previously to estates and Iona Johnson	Tracy Martin	30/11/2023		28/10/22 Further email sent to Iona Johnson to advise that repairs have still not been completed and is an infection control risk. 28/10/22 Iona will liaise with facilities regarding this. 6/12/22 update requested. 28/02/23 email sent for further update. 08/03/23 update from Tracy Martin that this is still ongoing. 27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply. 27/06/23 Natalie Jenkin working with Claire Shipley regarding this. 10/8/23 TM has meeting with Claire Shipley next week to discuss due to 18 month timesclae suggested by E&F. 16/08/23 Update from TM, Claire Shipley is discussing with facilities tomorrow and maybe part of a bigger project regadring theatres, face to face visit planned 13/09/23. This is now on E&F action plan. Meeting with Heidi Metcalf on 16/10/23 to discuss prioritisation
21/12/2022		DPOW	Stores cages left obstructing maternity theatre corridor, not enough room to fit a bed through and dangerous in an emergency situation. This has previously been raised as a concern. Photo's taken and emailed to Bill Parkinson.	Email sent to Bill Parkinson & Iona Johnson (Iona already aware of situation as previously raised by a coordinator)	Bill Parkinson Iona Johnson Tracy Martin	30/11/2023		22/12/22 email from Iona to Keith Fowler & Keith Leech regarding providing further storage but also porters practices. Meeting arranged for 07/02/23, will request update. 28/02/23 email sent to ask for update on issue. 08/03/23 furteher update from Tracy Martin that this is still ongoing. 27/04/23 Update from Iona, Claire shipley is now dealing with this and will be chasing up. 24/05/23 email sent to Claire Shipley for further update, still awaiting reply. 27/06/23 Natalie Jenkin working with Claire Shipley regarding this. 29/7/23 on Safety Walkabout, Shaun Stacey to contact E&F to escalate issues further. 16/08/23 update from TM, qoute sent to Health tree foundation for storage cupboards, awaiting board approval. Sonia Last meeting with Katherine Green 12/10/23 to review the space

18.04.22		SGH	The tiles on the wall in the sluice are falling off and have narrowly missed hitting a member of staff. They have been on since 1992 and the estates have said the recent hot weather has probably affected them	emailed ward manager to ask if it could be followed up for remedial work to be carried out for safety of staff using the area	Claire Brothwell & Shaliny Majara	31/12/2023		managers emailed 17/08/22 6/12/22 update requested. There is a mini refurbishment for ward 26 and should have this issue resolved. 18.01.23 update from manager- coflict in avalibility of funds between estates and division buisness manager so no further progress. 15.03.23 The mini refurbishment of ward 26 is underway and the wall area will have been resolved. 18.04.23 The tiles have not been replaced as planned and concerns are the old tiles will continue to fall off. Ward manager will issue a job requestion again to have the area made safe. 21.04.23 tiles have been re-secured but a request is being entered to replace with the plastic boarding which will be safer. 21.06.23 Ward 26 manager has applied for the perspex wall covering to replace all the remaining tiles. 17.07.23 awaiting repairs. 10/8/23 Claire Brothwell has not heard from Katherine Green regarding this since escalation - plan to obtain quote from E&F 12/9/23 New request sent to E&F for a quote for the works. 20.10.23 No futher news at present
17/05/2023		DPOW	Ward mobile phones should be taken into delivery rooms when caring for labourers, co-ordinators are receiving calls other staff members without correct information and sbar.	Email sent to ward managers	Vicki Booth Carla Siviter	30/11/2023		This is being discussed at the team meeting with all staff and ward managers are purchasing a second phone for each ward. 24/05/23 Vicki Booth in discussion with Keeley Gaunt & Wayne Woolrdige re purchasing further phones and improving the quality of the network. 9/8/23 TM continues to communicate with the Communications Dept to acquire more mobile phones. 12/9/23 Vicki Booth continues to chase for updates. Appointment with W Wooldrige to review the connectivity. 08/11/23 Update from V. Booth, W. Woolridge recommends static phones in the delivery rooms due to the increased demand on the wifi, the mobile phones are not reliable for our needs. He advises linking in with the networking project team to ensure we will have the data points and then IT can sort 15 phones for the delivery rooms. These phones will be locked so no external calls can be made. Wayne to liaise with Heidi Metcalf to discuss feasibility.

19/09/2023	Safety Mailbox	Trustwide	Discrepancies between the Placenta Praevia Guideline, the Fetal Medicine Referral Form and the Pathway to Leeds FMC	Editable versions of the documents requested	Natalie Jenkin	31/12/2023		11/10/23 Working with FM Lead to ensure no discrepancies
20.10.2023	Shout out Wednesday	SGH	The Nurses station is in disrepare on CDS. A part of the desk has become separated and needs fixing in place underneath and the large end of the desk has beome separated and needs either securing or replacing.	Needs replacing or repairing	K Thomas	31/12/2023		20.10.23 Requisiton sent to eastates to assess and repair/replace
26.10.23	Safety Champions Walkaround	DPOW	Antenatal Clinics frequently running over due to overbooking of the clinics	To be reviewed as part of the QIP for ANC/A	Natalie Jenkin	30/09/2024		10/11/23 Identified issue during the QI meeting

Appendix V – Maternity Sustainability Plan

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
SAP1	Developed maternity risk management strategy	Periodic review as per document control policy	17/5/23 - Strategy in development 15/6/23 Strategy in governance approval process - currently out for comment 23/6/23 Ratified at O&G Governance meeting June 23	Strategy ratified at Obstetric Governance Meeting and available on the Trust intranet		Chief Nurse	Associate Chief Nurse	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement 7/9/23 Evidence re Trust - document control
SAP2	Benchmarked against maternity self-assessment tool with a QI plan to be reviewed quarterly at the maternity transformation board chaired by Chief Nurse attended by the NED and MVP lead to be reviewed quarterly	Self-assessment tool action plan - monitored at QI and Monitoring Group, Maternity Transformation Board and presented at Trust Board.	9/5/23 Ongoing 15/6/23 Ongoing 23/6/23 Progress continues 14/7/23 Progress on action plan continues	Minutes of QI and Monitoring Group, Maternity Transformation Board and Trust Board. Completion of action plan.		Chief Nurse	Associate COO	Jul-23	10/8/23 Provide minutes of Trust Board meeting (Aug 23) and 3 months of MTIB minutes 5/9/23 - Email from Sarah Meggitt (PA) Trust Board minutes will be available after 3 October (date of Board) 5/9/23 Requested minutes from SM
SAP3	To develop and refine the SMART approach to QI plans in response to learning from incidents and complaints	Incident review meeting - action log, Action plan re Complaints (monitored at QI and Monitoring Group Meeting) Embed process for triangulation of themes and trends for incidents, complaints and claims.	9/5/23 Action log commenced for Incident Review Meeting and Complaints Action plan monitored at the QI and Monitoring Group. Work in progress to embed triangulation of themes. SOP in place. 15/6/23 Work ongoing 14/7/23 Work continues - Quarterly Report will commence July (O&G Governance meeting for information)	Incident Review Action log and Minutes from the QI and Monitoring Group.		Chief Nurse	Associate Chief Nurse	Jul-23	In w/family services/divisional managers/maternity/self assessment tool Incident review action log, minutes QI and monitoring group. QI highlight reports.QI Strategy. 10/8/23 Provide further evidence, including action log, safety bulletin, PMRT newsletter, safety huddles, LMNS (PQSAG/PQSOG)up2date,incident learning lessons Review SOP section 5.0 monitoring compliance and effectiveness
SAP4	Develop a PMA QI plan around A-Equip model	Service reconfiguration re: team model. Consider benchmarking against Birmingham A Equip model	9/5/23 Meeting planned with Lead PMA. Pastoral support , recruitment and retention midwife in post 15/6/23 Gap analysis against the national steering group's 'principles for successful implementation of PMA teams' completed and completion of action plan in progress by PMA team.	Model implemented		Chief Nurse	Associate Chief Nurse	Jul-23	PMA strategy, PMA Guideline DCT168, PMA team implementation gap analysis. 10/8/23 PMA annual report to Trust Board (presented by PMA) Follow up offer from CK to support PMA Evidence of PMA action plan 7/11/23 PMA action plan

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
SAP5	Develop the Matrons and their role as visible leaders supporting the senior team to implement the quality improvements	QI course completed by Maternity Matron (DPOW) Further Matron post - Gynaecology and Breast to support maternity services.	9/5/23 Matron post - Gynaecology and Breast is currently advertised (planned date for interview 13/6/23) Plans for Matrons and managers within the Division to attend Trust 'Leading with Kindness, Courage and Respect Programme' 15/6/23 Matron - Gynaecology and Breast interview 16/6/23. Plan for matrons and B7 managers to attend the 'Leading with Kindness, Courage and Respect Programme' 26/6/23 Matrons booked onto course for September 2023 26/6/23 Matron posts for maternity and gynaecology and breast both	Matron for Gynaecology and Breast in post and Matrons booked onto the course.		Chief Nurse	Associate Chief Nurse	Jul-23	Email from Tori Hordon confirming course booking
SAP6	Support plans to increase establishments of the governance team and reduce portfolios of the senior clinical teams so the maternity services have capacity to have senior oversight and messages to the executive team are not diluted under the umbrella of family services	Work on-going. Review completed - March 2023	9/5/23 Recruitment agreed for Maternity audit and compliance manager and Governance Deputy posts. 15/6/23 Recruited into Maternity audit and compliance manager post 9/6/23 (post will commence from August 23) Deputy Governance Lead post interview planned for July 23	Maternity audit and compliance manager and Governance Deputy in posts.		Chief Nurse	Associate COO	Jul-23	
MSAT1	Leadership development opportunities	Leadership and development programme for potential future talent (talent pipeline programme)	Evidence required. Leadership Development Strategy.15/6/23 Leadership Development Strategy				Tori Hordon, Organisational Development Business Partner	May-23	Leadership Development Strategy.Perinatal culture and leadership (QUAD attending and 2nd cohort booked)
MSAT2	Maternity strategy, vision and values	Maternity strategy in place for minimum 3-5 years	14/4/23 Draft document, awaiting illustration to be added prior to wider circulation for comments. 15/6/23 Strategy written and in governance process - due for ratification O&G Governance June 23. 23/6/23 Ratified T O&G Governance meeting June 23 (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service user focus groups will be planned 14/9/23 North and North Lincs MNVP- On line listening events weekly - plan to
MSAT3	Maternity strategy, vision and values	Strategy aligned to national Maternity Transformation Programme, local maternity systems, maternity safety strategy, neonatal critical care review, National Ambition for 2025 and the maternity and children?s chapter of the NHS Long Term Plan	14/4/23 as above 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT4	Maternity strategy, vision and values	Maternity strategy, vision and values that have been co-produced and developed by and in collaboration with MVP, service users and all staff groups.	14/4/23 as above 15/6/23 As above.23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 To provide further evidence of process for document control ratification and staff engagement
MSAT5	Maternity strategy, vision and values	Maternity strategy aligned with trust board LMNS and MVP?s strategies	14/4/23 as above 15/6/23 As above. 23/6/23 Ratified T O&G Governance meeting (CN forward to be added)				Division Tri	Jun-23	Strategy. 10/8/23 Review of maternity services strategy in partnership with MNVP, LMNS and staff, with focus on four pillars of SDP.Have discussed with KJ MNVP LMNS lead and service
MSAT6	Non-executive maternity safety champion	NED appointed as one of the board level maternity safety champions and working to national role descriptor	14/4/23 NED in post, working to national role descriptor. Core member of Safety Champion monthly walk-rounds				Chief Nurse	Apr-23	In hframily services/divisional managers/maternity/self assessment tool. Sharing of Safety Intelligence from floor to board on safety and quality issues standard operating procedure DCR246 10/8/23 Safety champions – Gateshead good board - have emailed TC and CK today to ask for contact from Gateshead. 5/9/23 TEAMs chanel accesible to all staff re: Maternity and Neonatal Safety Champions. 12/9/23 Maternity
MSAT7	Multi-professional engagement workshops	Planned schedule of joint multi-professional engagement sessions with chair shared between triumvirate, i.e. quarterly audit days, strategy development, quality planned safety days. improvement	Evidence required 23/7/23 Proposed date for Maternity Safety Conference (multidisciplinary and cross site) 18/10/23 - followed by quarterly sessions	Maternity and Neonatal Safety Conference			Division Tri	01/06/2023 Amended target date 31/12/23	
MSAT8	Multi-professional inclusion for recruitment and HR processes	Organisational values-based recruitment in place	Evidence required. DS provided evidence				Dave Sprawka	Feb-23	Values based recruitment
MSAT9	Multi-professional approach to positive safety culture	Schedule in place for six-monthly organisation-wide safety summit that includes maternity and the LMNS	Evidence required 15/6/23 RD to contact BC (LMNS) 14/7/23 Intention for a 6 monthly review of the maternity patient safety profile and its link to the Patient Safety Incident Response Plan. Risk Profile and theming being taken forward, with a view to arrange a meeting with LMNS to progress during July/August and when inital plan agreed, to review 6 monthly with with learning and review of safety profile. PSIR policy in draft, setting out the PSIRP monitoring approach and orgnisation				Richard Dickinson, Associate Director of Quality Governance	Sep-23	12/9/23 Maternity PSIRP. Attended national webinars and now developing PRSIP plan for maternity. Meeting between maternity and governance team 30/8/23. Need evidence KB.25/9/23 Patient safety incident response plan (draft) 7/11/23 Plan for PSIRF to commence Trustwide this month

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT10	Clearly defined behavioural standards	Schedule of focus for behavioural standards framework across the organisation	Evidence required. Divisional framework in development. 15/6/23 Evidence required from GD 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing change/change				HRBP	Jul-23	Leadership and management behavioural framework 12/9/23 NMC Code Quad attending Perinatal Leadership Course and second cohort planned. SCORE survey to be commenced Feb 2024. Managers all currently completing 'Leading with Courage, Kindness and Respect'
MSAT11	Clearly defined behavioural standards	Application of behavioural standards framework in trust-wide and directorate meetings, with specific elements the focus each month	Evidence required. In progress at divisional level. 15/6/23 Evidence required from GD. Have maternity behavioural charter 5/7/23 •Leadership and management behavioural framework available through the leadership academy at national level (attached) •In line with our Trust strategic plac (p9) our Values based leadership development programme focusses on compassionate & inclusive leadership : oLeading self (self awareness, unconscious bias, personal values) oleading others (situational leadership, just and learning culture), oachieving results (clear direction, coaching & feedback, inclusive leadership), oleading and managing				HRBP	Jul-23	12/9/23 Strategic plan for NLaG, Values, Maternity specific behaviour charter, stress/civility,
MSAT12	Maternity governance structure	Maternity governance and leadership team roles review	Review underway supported by MIA. Recruitment in progress for additional leadership roles 15/6/23 Review undertaken. Appointed to Maternity Audit and Compliance Manager role and Deputy Governance Lead post currently out to advert. 22/7/23 Deputy Governance				Division Tri	May-23	

Acti ID	Sustainability Action Plan	Specific actions to be implemented to ensure	Progress	Measurement	RAG Rating	SRO	Action Owner	Target Date / Timeline	Evidence
MSAT13	Proactive shared learning	Well-developed and defined trust wide communication strategy to include maternity services in place and in date. Reviewed annually as a minimum.	Evidence required 15/6/23 Update from RD - Sharing Learning document currently under review 14/7/23 Existing Learning Strategy document reviewed, consulting on through Quality Governance Group and PSIRF implementation Group. Awaiting responses as of 7/7/2023. Annual review date being applied to this version as last version was in 2020 on a 3 year cycle. Relaunch of Trust learning group to follow, with refreshed membership and focus.7/11/23 Trust learning group relaunched October				Richard Dickinson, Associate Director of Quality Governance	Aug-23	http://nlgnet.nlg.nhs.uk/DocumentControl/Documents/Learning%20Strategy%20(DCP363).pdf#search(learning%20strategy / Learning Strategy 10/8/23 Review action with focus on maternity services
MSAT14	Safety huddles	Audit of compliance against safety huddle guideline/SOP	Evidence required 15/6/23 JL/TM completing SOP and audits. 30/6/23 SOP in governance process (out for comments to governance group)7/7/23 SOP ratified and on HUB - audit	SOP ratified and available on the HUB			Division Tri	Jun-23	13/9/23 Plan for MNVP lead coproduction/attendance at maternity study days.
MSAT15	Trust wide Swartz rounds	Annual schedule for Swartz rounds in place	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within
MSAT16	Trust wide Swartz rounds	Multi-professional attendance recorded and supported as part of working time	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within
MSAT17	Trust wide Swartz rounds	Broad range of specialties leading sessions	Launched Jan 23. Evidence required				Cate Neal	Feb-23	Evidence\Swartz 10/8/23 Consider promotion of and contribution to trust wide Swartz rounds Evidence restorative supervision within division. Encourage

Red	Overdue
Amber	On track
Green	Completed

NLG(23)210

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	05 December 2023	
Director Lead	Simon Nearney, Group Chief People Officer	
Contact Officer/Author	Liz Houchin, Freedom to Speak Up (FTSU) Guardian	
Title of the Report	**Freedom to Speak Up (FTSU) Guardian – Quarter 2 Report 2023-24**	
Purpose of the Report and Executive Summary (to include recommendations)	The Quarter 2 Report for 2023-24 gives an update from the last report, including an overview of the number of concerns raised, national and regional updates, the proactive work undertaken by the Trust's FTSU Guardian, and future FTSU plans. The report is for assurance.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Workforce Committee 21 November 2023
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

Northern Lincolnshire and Goole NHS Foundation Trust

Freedom to Speak Up (FTSU) Guardian – Quarter 2 Report July to September 2023

Liz Houchin
08 November 2023

Contents

1. Executive Summary

1.1 This paper provides an update regarding Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (NLaG) activity for Q2 2023-24 (which covers the period July-September 2023). Within this paper the results of the National Guardians Office (NGO) publications are presented alongside NLaG information to provide national and regional comparison and context.

2. Strategic Objectives, Strategic Plan and Trust Priorities

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

3. Introduction / Background

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

Appendix A provides an update to the improvement plan from the NGO self-assessment and planning tool discussed at Board in December 2022.

4. Assessment of FTSU Concerns Raised

4.1 In Q2 2023-24 the number of concerns received were 76

- 7 concerns were raised anonymously in Q2. A high percentage of these have come through the Staff App.
- In Q2 11 concerns involved an element of patient safety. This puts the Trust in the high quartile nationally, the peer figure being 9 (figures accessed from Model Hospital data October 2023).
- In Q2 11 concerns involved an element of bullying and harassment which puts the Trust in the mid-high quartile nationally, the peer median figure being 6.

4.2 The Q2 figure of 76 is significantly higher than Q2 in 2022-23 which was 50.

4.3 The main themes raised were around behaviours, patient safety, bullying and harassment and process.

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

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

Concerns		Q1.2023-24 (April-June 2023)	Q2. 2023-24 (July-September 2023)
		68	**76**
Themes	Behaviour / relationships	26	38
	Bullying & Harassment	9	11
	Culture	0	2
	Leadership	1	0
	Patient Safety	11	11
	Process/Systems	29	29
	Personal Grievance	0	0
	Worker Safety	13	10
How raised	Openly	12	10
	Confidentially	49	59
	Anonymously	7	7
Perceived detriment		0	0

NB. Please note some concerns may have more than one element.

Report Breakdown by Role

Q1. 2023-24 (April-June 2023)		Q2. 2023-24 (July-September 2023)	
Role	**Number**	**Role**	**Number**
Doctor/Dentist	6	Doctor/Dentist	9
Nurse/Midwives	17	Nurse/Midwives	18
HCA	9	HCA	13
Healthcare Scientists	2	Healthcare Scientists	0
Admin	12	Admin	11
AHP	3	AHP	9
Other	12	Other	9
Not Known	7	Not Known	7

4.6 FTSU Guardian Feedback /Evaluations received:

Feedback forms are sent to those that speak up, except for those who speak up anonymously. The FTSU Guardian recently changed to MS forms which can be completed online to encourage a higher response rate. The feedback has been provided by staff that have spoken up and has been predominantly positive.

Quarter 2023-24	Feedback received	Would you speak up again? Yes
Q1	8	7
Q2	7	7
Q3		
Q4		

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

Liz made me feel listened to, assured, and comforted.

Excellent updates throughout the process and kept me involved throughout.

I am so grateful to have been informed about the service, although I do feel that through the actions of others, I had no alternative than to go to the guardian, Liz was extremely friendly and efficient.

4.7 Case Study

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

The FTSU Guardian received several separate concerns relating to the behaviours and management style of a manager, colleagues gave examples of behaviours and the impact this had on them and how they no longer felt empowered to do their roles. The FTSU Guardian listened and gave advice, some decided that they wanted Guardian support to raise this with the management team, others wanted the Guardian to send an initial email and would then arrange to meet the management team to discuss in person. The FTSU Guardian asked the management team for an update, and a plan of how they were going to address these issues. This was shared with the FTSU Guardian for assurance. Colleagues felt relieved that they had been listened to and hopeful that the situation would improve.

5. Regional and National Information and Data

5.1 National update

The National Guardian's Office reported 25,382 cases were brought to Guardians in 2022-2023, an increase from the previous year. There are now over 1000 Guardians in post across the country. Nearly a third of cases nationally included an element of inappropriate behaviours and attitudes and over a quarter included an element of worker safety or wellbeing.

All FTSU Guardians now must take an annual competency test, the FTSU Guardian has passed this for 2023.

Q2 data for 2023-24 has been submitted to the NGO by the Guardian.

5.2 Regional update

The FTSU Guardian continues to attend virtual regional meetings. Recent discussions included how the NGO support Guardians in light of the 'Countess of Chester' case and sharing ideas for Speak Up month.

6. Proactive work of the FTSU Guardian during Q2

- Monthly 1 to 1's with DOP/CEO
- Bi-monthly meetings with NED for FTSU and Trust Chair
- Monthly 'buddy' calls
- Attendance at Health & Wellbeing Steering Group and Culture Transformation Board
- Attendance at all Trust inductions
- Attendance at Junior Doctors Forum
- Attendance at Regional FTSU Guardian meeting

Future Plans

- Recruit and train 'Speak Up' Champions from all areas of the Trust
- Continue to work with the Divisions to ensure that learning from concerns is embedded into practice.
- Continue to raise profile of the Guardian
- Attendance at all relevant meetings

7. Conclusion

7.1 The role of the Guardian is an important one in the Trust and this report demonstrates the activity of the Guardian, and how this work supports the overall strategic objective of being a good employer.

8. Recommendations

The Trust Board is asked to:
a) Note the report for assurance

Compiled By: Liz Houchin
Date: 08 November 2023

9. Appendix A

NGO Reflection Planning Tool – Development Actions Update

Development areas to address in the next 6-12 months	Target date	Action owner	Progress Update
1. Board development session to get all Board members to agree a vision for Speaking Up (including role modelling values of the organisation) and to commit to it	June 2023	HRD/Vice Chair	Board development session to be planned once new Group Executive team in post in 2024
2. Discussion at Board level on what more could be done to encourage a culture of speaking up as a matter of course	June 2023	HRD/Vice Chair	Will form part of the board development session in 2024
3. Ensure leaders listen and welcome those who speak up and to instil the values and behaviours of the organisation (through values-based leadership programme) – Review FTSU input after 12 months delivery	January 2024	OD/FTSU Guardian	All leaders undertaking the leadership development course complete 'listen up' training. Programme is designed to develop compassionate leaders with elements about creating a speak up environment
4. Ensure that we identify FTSU data and streamline with other data to identify themes and trends through cultural transformation board- review in 6 months	June 2023	HRD/CIO	FTSU information sent to divisional management teams quarterly
5. Update and Communicate new policy to staff	March 2023	HRD	New policy launched in Feb 2023, using Fb, Hub, and Wed Weekly News

6. Develop ways of measuring the effectiveness of the communications strategy for FTSU	June 2023	FTSU Guardian/Comms	Bi-monthly meetings held with Comms Jan 2023 – walk round with Comms to sense check awareness of FTSU Guardian and most effective comms method
7 Ensure FTSU information on local induction check list	March 2023	FTSU Guardian/People Directorate	FTSU listed on Induction Checklist for New Starter (DCM716)
8 Further work needed on how we can encourage managers including targeted support through cultural transformation work to see speaking up as something to be embraced and not feared and an opportunity for improvement and greater staff morale.	October 2023	OD/HRD	FTSU information included in the Manager's monthly email FTSU Guardian part of the Cultural Transformation Working Group FTSU Guardian presented at OMG away day – October 2023 FTSU Guardian held Manager Drop-In sessions during October

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	**5 December 2023**	
Director Lead	**Shaun Stacey – Group Chief Delivery Officer**	
Contact Officer/Author	**Ashy Shanker – Deputy Director of Planning and Performance**	
Title of the Report	**NLAG Winter Plan 2023/24**	
Purpose of the Report and Executive Summary (to include recommendations)	The Winter Plan 2023/24 sets out NLAG's approach to maintaining effective delivery of its services, mitigating the impact of additional pressures, and keeping patients safe throughout the winter period. The document provides an update on the context, progress made in NLAG and risks associated with managing patients through our hospitals during Winter 2023/24.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	✓ Divisional SMT ☐ Other: Group Exec Meeting
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)	Part of operational planning	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	In alignment	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

1.0 Introduction

The winter period is usually characterised by significant increases in the volume and acuity of patients presenting to our emergency departments with wider demands placed on capacity and resources across the Trust. There is also the increased risk of significant adverse events, such as Influenza, Covid, Norovirus and other RSVs causing disruption to patient flow in our hospitals. In addition, we have extended bank holiday weekends over the festive period placing more pressure on services.

The Winter Plan is therefore the operational response of the Trust to identify how it aims to deliver sufficient capacity to meet expected demand and in doing so maintain patient safety, sustain delivery of operational standards and ensure operational resilience throughout the most challenging time of the year.

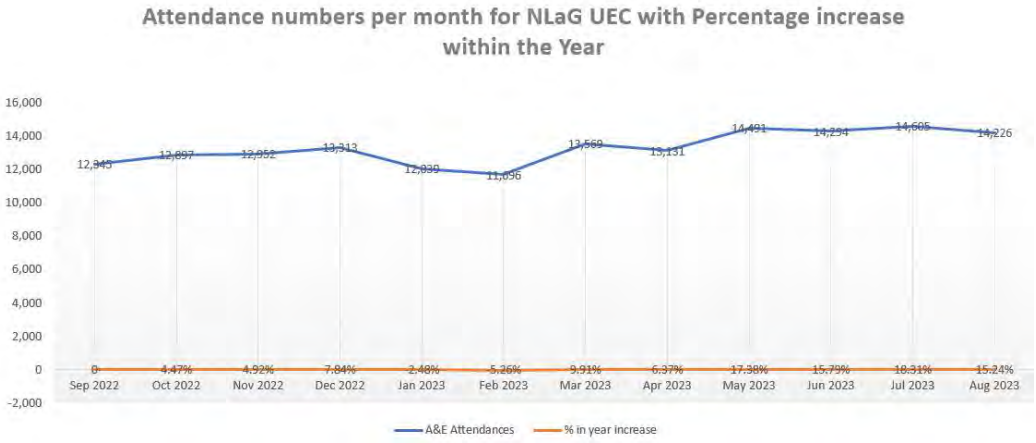
For planning purposes, the winter period is usually defined as the period covering 1st December 2023 to 31st March 2024, with peak pressures anticipated during January and February. However, this period can be relatively fluid extending from October to March depending on various factors including the relatively new impact of any new Covid variants presenting.

The winter of 2022/23 was characterised by a combination of demand pressures and the need for

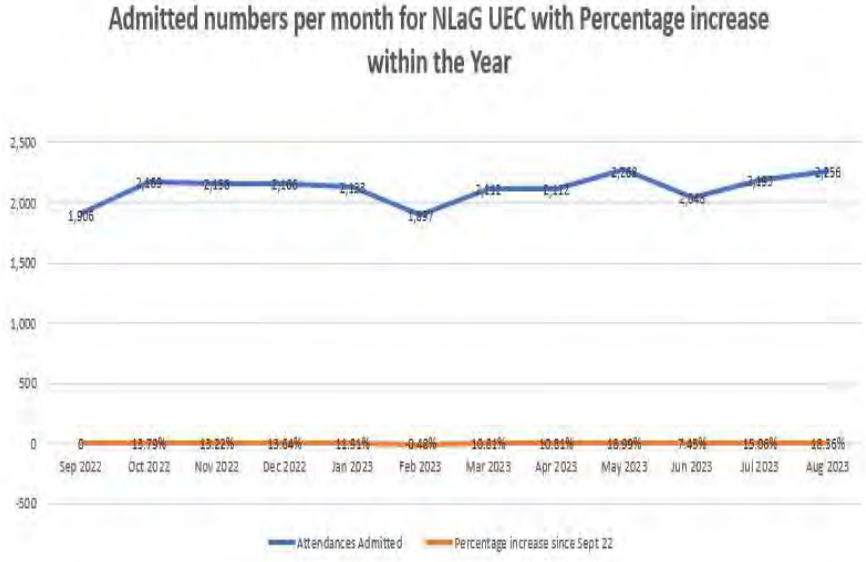
- Maintaining social distancing
- Testing for Covid for patients and staff
- Providing sufficient levels of PPE and fit testing
- Maintaining capacity in the hospital, ‘cohorting’ and isolating Covid asymptomatic and symptomatic patients
- Managing outbreaks of RSV and Covid infections
- Maintaining high levels of infection prevention and control measures – deep cleans, revised clinical pathways, installation of ‘Redirooms’ etc.
- Managing and covering staff sickness
- Maintaining safe levels of staffing
- Maintaining elective activity including cancer treatments/ surgery
- Looking after the wellbeing of staff and patients

All the above priorities remain very relevant for Winter 2023/24 in addition to potential.

- increases in the number, age profile and acuity of patients presenting to A&E


Attendance numbers per month for NLaG UEC with Percentage increase within the Year
16,000
14,000
12,000
10,000
8,000
6,000
4,000
2,000
0
-2,000
12,345
12,897
12,952
13,313
12,639
11,696
13,569
13,131
14,491
14,294
14,605
14,226
0
4.47%
4.92%
7.84%
2.48%
5.26%
9.91%
6.37%
17.38%
15.79%
18.31%
15.24%
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
Mar 2023
Apr 2023
May 2023
Jun 2023
Jul 2023
Aug 2023
A&E Attendances
% in year increase


Attendances Month on month
15,000
14,000
13,000
12,000
11,000
10,000
9,000
8,000
7,000
6,000


Admitted numbers per month for NLaG UEC with Percentage increase within the Year
2,500
2,000
1,500
1,000
500
0
-500
1,906
2,169
2,158
2,166
2,123
1,897
2,112
2,112
2,268
2,043
2,193
2,256
0
13.79%
13.22%
13.64%
11.91%
-0.48%
10.81%
10.81%
18.99%
7.15%
15.06%
18.36%
Sep 2022
Oct 2022
Nov 2022
Dec 2022
Jan 2023
Feb 2023
Mar 2023
Apr 2023
May 2023
Jun 2023
Jul 2023
Aug 2023
Attendances Admitted
Percentage increase since Sept 22

- increase in the number of patients who do not meet the criteria to reside in hospital due to 'exit blocks' such as
    - availability of therapy staff
    - domiciliary care
    - care home beds
    - capacity in home care services

(Exit blocks above are particularly relevant for North Lincolnshire and Lincolnshire patients.)

- risk of multiple infections (Covid, flu, norovirus and other RSVs) and the need for multiple testing
- increase in length of stay of patients due to increase in acuity.
- reduced utilisation of community general and acute bed equivalent e.g., Home First, virtual wards, OPAT etc.
- unanticipated equipment failure MRI,CT etc

The NLAG Winter plan for 2023/24 focuses and prioritises the initiatives, risks and other variables most within the Trust's ability to influence. There are Place level, Northern Lincolnshire wide and ICS level winter planning discussions progressing in line with NHSE/I framework requirements. The resultant system wide plans when agreed, will be overseen, and authorised by the A&E Delivery Board. The NLAG Winter plan plays an integral role in influencing these discussions.

2. Process for 2023/24 Planning

The winter plan aims to achieve a balance between sustaining the delivery against elective care targets such as cancer and RTT, and meeting the demand placed on our urgent and emergency care services. To achieve this, it is essential that standards of quality and safety are always maintained and that the schemes identified within the plan acknowledge current financial pressures by remaining relatively affordable.

The schemes identified in the plan are grouped around key themes.

1. Admission avoidance
2. Reducing length of stay in hospital to GIRFT/model hospital top decile.
3. Maintaining safety and quality of care
4. Optimising available funded capacity
5. Supporting early and safe discharge

In developing the plan, NLAG aims to support wider system priorities around enhancing capacity, reducing delayed transfers of care, implementing streaming approaches in ED and ensuring that adequate flu planning processes are in place, as indicated in the NHS England preparation for winter letter to system leaders in July (Appendix A).

In September 2023, the Northern Lincolnshire system was expected to review the submissions already made earlier in year in relation to expected demand and capacity available in the system. This required the completion and of submission of numeric and

narrative templates to the ICS in September, which is currently being finalised with the national team.

NLAG has provided the projection based on actual demand seen so far and reviewed and agreed the bed capacity planned. This equated to 629 Hospital beds and 65 community based General and Acute beds (total 694). In addition, as required by the Integrated Care Board, we have provided a plan to extend capacity by 54 beds, to be opened only 'in extremis' if funding and staffing was available. It si to be noted that the assumption used in the bed capacity modelling only included a 2.5 percent increase in demand however we have seen a 15% increase in attendances and an 18% increase in admissions. If this continues without a proportional increase in funded bed base, our bed occupancy rates will increase. This could result in a reduction of quality of care offered and staff fatigue and potential burn out.

We currently have a risk posed due to capacity pressures faced in the NLAG Information team caused by PAS migration requirements. This has meant that NLAG currently is not able to report bed capacity accurately and with assurance both internally and externally. Work that has been progressing for the last three months to try and identify capacity in the Information team to assist with this, however progress is slow.

In addition, as per the Emergency care data set requitements we are expected to separate out Type 1 and Type 3 Accident and Emergency attendances. This work is underway however needs to be completed including Goole activity figures to enable accurate reporting of Accident and Emergency data.

In addition, Same day Emergency Care activity will also need to be recorded differently as Type 5 attendance. This has also been delayed due to capacity pressures in our information team.

There is a change to OPEL level reporting required nationally, to be in place by the 6th of December 2023. This will require nine indicators to be electronically monitored, which will determine OPEL status of the hospitals and trust. This work is also progressing.

In addition, Trusts were expected to complete a Board level certification checklist that provided assurance that elective capacity would be protected during Winter (Appendix B).

The internal NLAG Winter action plan (Appendix C) is intended to be dynamic document which is currently being refined by the Divisions and corporate functions. This will be subject to on-going monitoring and change throughout the winter period as anticipated needs and organisational responses change. Where necessary, it will be supplemented, amended, and adapted to respond to any specific challenges that winter brings. It is recognised that there is not separate budget for a Winter plan to be delivered therefore the focus has been mainly on mitigation of risks and delivery of plans using existing resources.

However, should additional/non recurrent funding become available regionally /nationally NLAG will have a prioritised list to consider and submit.

3. Meeting the demands of Winter

There are several measures and initiatives currently in place to maintain patient flow throughout each hospital site and ensuring there is sufficient capacity to meet urgent care demand. This includes

- Extension of Urgent care Services to 24/7
- Extension of Same Day Emergency care to 10:00pm with additional support for diagnostics
- Extension of Single Point of Access service to reduce Cat 3,4, and 5 Ambulance presentations to Emergency Department
- Improvement of Discharge to Assess services to facilitate timely Discharge
- Extension of Home First services
- Improvement of Virtual wards for respiratory and frailty
- Implementation of OPAT services
- Maintaining and managing effective utilisation of community rehabilitation beds (approximately 147 including spot purchased beds in Northern Lincolnshire)
- Implementation the vaccination programme
- Ensuring appropriate levels of staffing
- Maximising isolation facilities to manage the increase in respiratory viruses (RSV)

There will also be a more expansive, rigorous approach to the operational command and control arrangements designed to maintain operational effectiveness throughout winter. These will include a fortified approach to the daily operational calls, ensuring senior input and oversight and fostering a more thorough review of staffing and capacity across all sites.

There is a fortnightly Winter planning (and delivery) meeting, in place since August to oversee and coordinate all activities relating to Winter. All Divisional and Corporate teams are required to attend to facilitate review of progress, identify risks to delivery and take swift corrective action where necessary.

3.1 Managing Patient flow

Ensuring the timely assessment, admission, or discharge of patients from ED and maintaining adequate flow throughout each hospital site remains a significant challenge, especially during the winter period.

Several internal schemes are in place for this winter to support admission avoidance. To provide alternatives to admission throughout winter, Divisions have been asked to provide sufficient senior medical support in ED and assessment areas during the busiest periods. This will enable faster assessment of patients, a potential reduction in admissions and an increase in discharges directly from ED.

To better manage ED demand and accommodate front door streaming we are expanding Urgent Treatment Centre (UTC) hours and strengthening minors streaming facilities. This will help improve performance by allowing more timely assessment of patients and utilising Same Day Emergency Care and the Integrated Acute Assessment Unit better, to maintain optimum length to stay. We are also reengineering the paediatric pathway to take the focus away from ward stay to Same day emergency care.

Adherence to the agreed policies for the transfer of admitted patients will be rigorously monitored by the operations centre to deliver optimal transfer times from ED to SDEC, assessment areas and base wards, with swift and effective escalation where this does not happen.

To maximise capacity, specialties will undertake daily reviews of their elective theatre lists to avoid last minute cancellations and to ensure the early identification of any unused theatre lists. Demand for trauma and emergency cases will be closely monitored throughout winter. Since NLAG is integrated surgical hub for elective recovery in the ICS, with ring fenced elective beds, all efforts will be maintained to continue elective/cancer surgery without any interruptions from urgent care pathways.

In addition, to ensure continued delivery against operational plan targets, NLAG will be running high intensity elective theatre and outpatient sessions, utilising ring-fenced elective hub capacity in the Trust.

All specialties, where appropriate, are also expected 'front load' pathways by switching elective inpatient activity to either day case or additional outpatient activity.

3.2 Inpatient Capacity

Bed occupancy across the Trust is currently reported at 96% in August 2023, however work is being progressed with information colleagues to improve accuracy in bed capacity reporting. The aim is to maintain bed occupancy at 92% in line with national expectations. The constraints of staffing (sickness and vacancies), the Trust's financial position and the need to maintain GIRFT standards for length of stay all contribute towards maintaining a reasonable level of ringfenced beds for elective capacity. Therefore, every effort will be made this winter to ring fence the following ward areas.

- SGH High Observation Beds (HOBS) – Ward 28 – 16 elective and 4 HOBS beds
- Goole – Ward 6 – 15 beds
- DPOW – Ward B7 – 22 beds inclusive of 4 HOBS beds

There is currently a high level of nursing and medical vacancies across the divisions. This position is being mitigated through the significant use of agency and bank staff, however if the vacancy gap cannot be narrowed through other substantive recruitment, there are likely to remain risks around the consistency, quality, and reliability of care throughout winter.

3.3 Staff Vaccination campaign

The staff vaccination campaign is progressing well, led by the Occupational health team who will co-ordinate efforts for delivery.

The delivery model for 2023/24 includes

- Co-administration offer with COVID booster in pop-up hubs that run until the last week of September 2023

- Peer Vaccinators within ward areas and community staff to administer to colleagues
- Sessions run by OH October and November to support other methods of delivery (including for staff over the age of 65)

Details of the Flu vaccination programme is included in Appendix B.

3.4 Non-Ward Based Nursing Staff

As last year, there will be periods during winter where wards and assessment areas come under considerable pressure and significant levels of demand and increased levels of staff absence. This has the potential to impact on the ability of a specific area to maintain safe and effective nurse staffing levels.

Staffing will be managed and escalated as per the NLAG Short-Term Staffing Standard Operating Procedure. If additional support to clinical operational areas during the most severe periods is required, nursing staff that are not usually ward-based may be called upon to provide nursing support in wards and departments.

To ensure this is managed in the most effective and safe way, the Corporate Nursing Team will collaborate closely with the Associate Chief Nurses throughout winter to identify any clinical areas that are struggling to provide safe staffing levels and to risk-assess the potential for non-ward-based nursing staff to provide additional support to ward areas.

4 External Stakeholders

We will continue to work with the ICS structures at Board, Place and Collaboratives level and Local Authorities to align NLAG's winter plan to the system level plans. This will involve submitting any bids for any additional winter allocations, influencing the use of the Better Care Fund and monitoring delivery of initiatives and evaluation of outcomes to ensure best use of limited resources.

Currently there is funding allocated for the implementation of Home first services, Outpatient Parenteral Antimicrobial Therapy (OPAT) and virtual wards (frailty and respiratory) in addition to maintaining rehabilitation beds already commissioned across North and North East Lincolnshire. A total of approx. 150 beds (commissioned and spot purchased) are available in the Northern Lincolnshire community to support flow though winter.

5. Monitoring and Governance

Overall responsibility for the winter plan rests with the Chief Operating Officer. A fortnightly Winter Planning Group attended by all Divisions and functions has been set up in August 2023 initially to engage in planning (Phase 1- July to September) and subsequently oversee implementation (Phase 2 - October to February) of actions.

Phase Two will see this group move into a ‘delivery mode’ that consists of the same membership as Phase One. The group will agree and enact any required deviations to the plan based on the prevailing circumstances.

The Group will report to the Trust Management Board for direction and escalation as required.

The Winter plan will also form part of a system-wide response to winter via the Urgent and Emergency Care Delivery Board and Place and ICS level planning groups that are established to develop overarching plans that set out the resilience arrangements for the peak of winter.

6. Communications and Engagement

NLAG communications team will support in taking any relevant actions forward relating to patient, public and staff engagement. The Trust website, social media channels will also be used to push forward winter preparedness messaging. Messaging for staff will include communicating key schemes within the plan aimed at improving discharges, maintaining flow and reducing hospital pressures during the winter period. This may include improved uptake of community services and changes to processes and services to maintain service delivery. Winter plan communications will also align with wider communications to encourage staff uptake of flu vaccinations and infection control messaging related to hand hygiene and sickness policy.

7. Financial impact of Plan

The Trust is currently facing a challenging financial position and therefore the clear message to all services has been that there is no additional funding set aside to support Winter, other than that already committed though the annual business planning process and funding received from the ICB/national team in response to specific schemes submitted. Additional scrutiny of the winter plan to avoid adding significant further risk to delivery of the financial control total by the year end is done through the Winter Planning Group.

Increasingly, the Planning team in NLAG is requiring Divisions and services to include Winter planning as part of their annual business plans supported by demand and capacity modelling. This will include the need for managing seasonal variations in demand and reducing the dependence on possible external allocation of non-recurrent monies each year that are not conducive to long term sustainability and delivery of robust services.

8. Conclusion and Recommendations

As part of developing and implementing the Winter plan, operational divisions and corporate services have made early provision to put the organisation in the best place possible to minimise the impact of winter on its operational performance and delivery, maintain effective services and keep patients safe throughout. The Executive team is requested to

- note the context, risks, mitigations and progress made in NLAG with regards to winter planning
- acknowledge potential risks to bed occupancy, staffing and quality of care due to managing the unexpected increase in demand
- acknowledge potential risks presented (reputational, operational and quality) due to capacity pressures in the Information team that have affected/continues to affect accurate internal and external reporting of data in relation to
    - Bed occupancy reporting
    - A&E performance reporting (Type 1 and 3 split)
    - SDEC activity reporting as Type 5 ED activity
    - Implementing new national OPEL requirements

Appendix A – separate document attached

Appendix B – separate document attached

Appendix C

Vaccination Plan 2023/2024

Action	Lead	Update	Deadline
Recruit Peer Vaccinators from across the Trust.	PB/POS/ /Divisional Leads	Peer vaccinators working through training programme Peer vaccinator Leads identified for all Divisions POS to retain register of Peer Vaccinators.(recorded on ESR) POS oversee adequate training resource.	October 2023
Provide Peer Vaccinator Support sessions	POS	MS Team meetings to be arranged for Peer vaccinators. TEAMS meeting invites will be circulated to all Peer Vaccinators.	On-going
Content of peer vaccination kit needs to be agreed, collated and sent internally.	POS	No national resource available yet.	September 2023
Order Vaccinations	PH	Ordered	Completed

Action	Lead	Update	Deadline
Order Flu Promotional Kits from NHS Employers.	HM	No resource available nationally.	Completed
In accordance with the CQUIN identify the staff roles for recording purposes. CQUIN states all staff with patient contact clinical and non-clinical.	NB	Reports will be prepared at the end of August to ensure most up to date information. Parameters defined.	ongoing
Review consent form for use by peer-to-peer vaccinators.	POS	NIVS to be used with consent checklist on Hub to update	Completed
Ensure Written Instruction for flu vaccine is in place before Sept 2022.	POS/PH	Instructions prepped pending approval of Pharmacy governance process	September 2023
Ensure reporting requirements are in place for the provision of SITREP information and updates to the Trust	POS/PB/TG	Reporting arrangements are in place.	Monthly
Await confirmation of Flu Vaccination delivery.	POS/PB	September	Completed

NHS England

To:
- ICB:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- NHS acute, community and mental health trust:
  - chairs
  - chief executives
  - chief operating officers
  - medical directors
  - chief nurses/directors of nursing
  - chief people officers
- Primary care networks

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

27 July 2023

Dear Colleagues,

Delivering operational resilience across the NHS this winter

This letter sets out our national approach to 2023/24 winter planning, and the key steps we must take together across all parts of the system to meet the challenges ahead.

In January, we published our delivery plan for recovering Urgent and Emergency Care (UEC) services: an ambitious two-year plan to deliver improvements for patients across the integrated Urgent and Emergency Care (iUEC) pathway. This plan, along with the Primary Care Recovery Plan, Elective Recovery Plan and the broader strategic and operational plans and priorities for the NHS, provides a strong basis to prepare for this winter.

The publication of the UEC Recovery Plan followed an incredibly challenging winter – with high rates of infectious disease, industrial action, and capacity constraints due to challenges discharging patients, especially to social and community care. We know these challenges have continued but want to thank you for the work you have done in the face of this to ensure that there have nonetheless been significant improvements in performance. Thanks

to these improvements, we are in a significantly better place compared to last summer. Compared to last June, A&E performance has improved and Category 2 performance is 14 minutes faster.

This progress and the plan we are today setting out for winter preparedness are key steps in helping us achieve our two key ambitions for UEC recovery of:

- 76% of patients being admitted, transferred, or discharged within four hours by March 2024, with further improvement in 2024/25.
- Ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25.

To help achieve these ambitions, we have ensured that systems have had clarity over finances well before winter to allow them to plan effectively and further roll-out the measures that we know will improve services for patients. We have invested extensively in this, including:

- £1 billion of dedicated funding to support capacity in urgent and emergency services, building on the £500 million used last winter.
- £250 million worth of capital investment to deliver additional capacity.
- £200 million for ambulance services to increase the number of ambulance hours on the road.
- Together with DHSC, an additional £1.6 billion of discharge funding over 2023/24 and 2024/25, building on the £500 million Adult Social Care Discharge Fund.

While we are making good progress towards achieving our overall ambitions, we want to encourage providers to achieve even better performance over the second half of the year. We will therefore be launching an **incentive scheme** for those providers with a Type 1 A&E department to overachieve on their planned performance in return for receiving a share of a £150 million capital fund in 2024/25. We are asking providers to meet two thresholds to secure a share of this money:

- Achieving an average of 80% A&E 4-hour performance over Q4 of 2023/24.
- Completing at least 90% of ambulance handovers within 30 minutes during Q3 and Q4 of 2023/24.

We recognise that these are stretching targets but know that many providers will be able to achieve these to help the NHS as a whole make greater headway towards improving care for patients. Providers should already be putting measures in place which will contribute towards reaching these, including a greater focus on the longest times in department, particularly those spending longer than 12-hours, and wider system flow. We will communicate more details on this shortly, including how we will be working with you to improve data quality.

Turning to our wider planning for winter, we are clear that the challenges are not just in ambulance services or emergency departments, and recovery requires all types of providers to work together to provide joined-up care for patients. ICBs will play a vital role in system leadership but the actions we take need to extend across the wider health and care system including mental health services, services for children and young people, community health services, primary care and the voluntary, community and social enterprise (VCSE) sector.

We are therefore setting out four areas of focus for systems to help prepare for winter:

1. Continue to deliver on the UEC Recovery Plan by **ensuring high-impact interventions are in place**

Together with systems, providers, and clinical and operational experts we have identified 10 evidence-based high-impact interventions. These are focused around reducing waiting times for patients and crowding in A&E departments, improving flow and reducing length of stay in hospital settings. Delivering on these will be key to improving resilience in winter. We have recently written to all systems to ask that they assess their maturity against these areas as part of the universal improvement offer for the UEC Recovery Plan. Systems will then receive dedicated support on the four areas they choose to focus their improvement for winter.

More detail on these areas can be found at Appendix A and on the NHS IMPACT website.

2. **Completing operational and surge planning** to prepare for different winter scenarios

We have already collectively carried out a detailed operational planning round for 2023/24 but we are now asking each system to review their operational plans, including whether the assumptions regarding demand and capacity remain accurate. Although this will cover surge planning for the whole winter, specific plans should be made for the Christmas/New Year/early-January period which we know is often the most challenging time of the entire year.

In addition to this, and recognising the importance of planning for multiple scenarios, we are asking systems to identify how they will mobilise additional capacity across all parts of the NHS should it be required to respond to peaks in demand driven by external factors eg, very high rates of influenza or COVID-19, potential further industrial action.

This planning is essential to ensure winter plans protect and deliver elective and cancer recovery objectives, as well as deliver the primary care access programme, and proactive care for those most at risk of hospital admission (guidance on proactive care will be published shortly).

Next week, we will be issuing each ICB with a template to capture their surge plan and overall winter plan. We will work with those areas that are facing the greatest challenges across the UEC pathway via our tiering programme to support them in completing these returns. If you think you require additional support, please contact england.uec-operations@nhs.net.

All returns should be sent to england.uec-operations@nhs.net by **11 September 2023**.

3. **ICBs should ensure effective system working across all parts of the system**, including acute trusts and community care, elective care, children and young people, mental health, primary, community, intermediate and social care and the VCSE sector.

ICBs will play a vital role in system leadership and co-ordination but it is important that all parts of the system play their role. The NHS England operating framework describes the roles that NHS England, ICBs and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

To help systems plan, we have developed a set of recommended winter roles and responsibilities (**Appendix B**) to ensure clarity on what actions should be undertaken by each part of the system. These will require broad clinical leadership to implement, and systems should be using these to develop their winter planning return, reflecting how these relate to the circumstances within their individual system.

DHSC is also writing to local authorities and the adult social care sector shortly to set out priority actions for improving winter resilience and encouraging cross-system working with the NHS on winter planning.

To assist system working this winter, next week, we will also be publishing an updated specification for System Co-Ordination Centres and an updated Operational Pressures Escalation (OPEL) Framework to ensure we are taking a consistent and co-ordinated approach to managing pressures across all systems.

4. **Supporting our workforce** to deliver over winter

This year colleagues have continued to work incredibly hard in the face of increased demand. We know how much supporting your workforce matters to you, and it is crucial that employers ensure that they take steps to protect and improve the wellbeing of the workforce.

Last winter, we saw flu return at scale. It is vitally important that we protect the public and the health and care workforce against flu and other infectious diseases, and the best way of doing this is to ensure they are vaccinated. Providers should also ensure that they have an

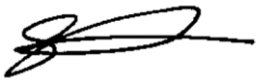
established pathway for identifying patients at-risk of COVID-19 and flu in their care, including those who are immunosuppressed.

Systems and providers should also continue to improve retention and staff attendance through a systematic focus on all elements of the NHS People Promise, as set out in 2023/24 priorities and operational planning guidance and more recently in the NHS Long Term Workforce Plan, and ensure continued supply through maintaining education and training.

We want to thank you and everyone across the NHS for your continued hard work this year, we have again faced some unprecedented challenges but through strong partnership working we have once again risen to these.

The coming months will undoubtably be difficult, but we will continue to support you to ensure that we collectively deliver a high-quality of health service to patients and support our workforce. Thank you again for all your efforts as we work to build a more resilient NHS ahead of winter.

Yours sincerely,



Sarah-Jane Marsh
National Director of Integrated Urgent and Emergency Care and Deputy Chief Operating Officer
NHS England

Sir David Sloman
Chief Operating Officer
NHS England

Julian Kelly
Chief Financial Officer
NHS England

Appendix A: 10 High-Impact Interventions

Action	
1.	**Same Day Emergency Care**: reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2.	**Frailty**: reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3.	**Inpatient flow and length of stay (acute)**: reducing variation in inpatient care (including mental health) and length of stay for key iUEC pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients.
4.	**Community bed productivity and flow**: reducing variation in inpatient care and length of stay, including mental health, by implementing in-hospital efficiencies and bringing forward discharge processes.
5.	**Care transfer hubs**: implementing a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and prevent re-admission to a hospital bed.
6.	**Intermediate care demand and capacity**: supporting the operationalisation of ongoing demand and capacity planning, including through improved use of data to improve access to and quality of intermediate care including community rehab.
7.	**Virtual wards**: standardising and improving care across all virtual ward services to improve the level of care to prevent admission to hospital and help with discharge.
8.	**Urgent Community Response**: increasing volume and consistency of referrals to improve patient care and ease pressure on ambulance services and avoid admission.
9.	**Single point of access**: driving standardisation of urgent integrated care co-ordination which will facilitate whole system management of patients into the right care setting, with the right clinician or team, at the right time. This should include mental health crisis pathways and alternatives to admission, eg home treatment
10.	**Acute Respiratory Infection Hubs**: support consistent roll out of services, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in ED and general practice to support system pressures.

Working together to deliver a resilient winter

System roles and responsibilities

The NHS England operating framework describes the roles that NHS England, integrated care boards (ICBs) and NHS providers should play, working alongside our partners in the wider health and care system. It outlines our collective accountabilities and responsibilities to ensure we deliver a health service that maximises outcomes for patients.

As we continue planning for winter it is important that we are clear on the actions that each part of the NHS system must now take to ensure that we are collectively pulling in the right direction to deliver for patients.

To support this, we have developed a set of recommended winter roles and responsibilities for each part of the system, which are included in this document, largely taken from existing guidance and recovery plans. These build on the core objectives outlined in the winter letter and provide a platform for systems to be clear on how actions are taken in all areas to deliver a resilient winter period.

The roles and responsibilities are designed to be supportive and provide clarity but are by no means exhaustive – each system should use these to develop their winter planning return and consider how these relate to the circumstances within their individual system.

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27 July 2023

Integrated care boards

- Ensure that the system winter operating plan incorporates all the high-impact interventions and actions for the entire health and social care economy. This should include specific operating actions for all system partners across acute, community, mental health, primary care aa well as links with local authority services. Systems should ensure that plans reflect the needs of all age groups, including services for children and young people.
- Facilitate partnership working – ensuring that all system partners are pulling in the same direction to deliver a resilient system this winter, and appropriately manage risk to ensure that it is balanced across the entire system, ensuring all parts of the system are held to account for delivery of their responsibilities.
- Be accountable for the delivery of capacity in line with agreed 2023/24 ICB Operating Plan – including additional capacity identified via the winter planning exercise.
- Ensure that arrangements are in place to lead the system through winter – including:
- maintaining 24/7 oversight of system pressures through the System Co-ordination Centre (SCC)
- implementing the revised SCC specification to ensure appropriate structures, systems and process are in place to maintain operational oversight and delivery
- implementing the revised Operating Pressures Escalation Levels (OPEL) Framework in a consistent manner across all acute sites as the key clinical safety indicator of system pressure
- leading the development of a comprehensive winter operating plan underpinned by a locally agreed operating model.
- Ensure infection prevention and control (IPC) colleagues are involved in winter planning and that they continue to be involved in responding to winter.
- Lead the liaison and engagement with the voluntary, community and social enterprise partners to ensure that they are fully engaged in winter planning and their support maximised.
- Ensure the continued workforce supply through early planning of actions to mitigate any loss of education and training during the periods of greatest winter service pressures.

Lead the delivery of high-impact interventions 5-10

- **Care transfer hubs**: In partnership with local authorities, implement a standard operating procedure and minimum standards for care transfer hubs to reduce variation and maximise access to community rehabilitation and reablement

services and prevent unnecessary re-admission to a hospital bed. Improve the operation of current care transfer hubs from the baseline assessment, including operation throughout the winter holiday period.

- **Intermediate care demand and capacity**: With local authorities, commission sufficient capacity to meet projected demand for step-down care, including both home-based and bed-based care, to facilitate the timely discharge of patients from across acute and community hospitals and services.

  Make effective use of the Better Care Fund, including the Discharge Fund, to support patients to leave hospital with a package of care where needed.

  Ensure that capacity and resource gaps are escalated, and actions progressed; all data is submitted for all commissioned beds to the Community Discharge and Acute Discharge SitReps and the Capacity Tracker.

  Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.

  Embed mechanisms to enable monitoring of the impact of intermediate care interventions on people's functional outcomes and their long-term care needs.

- **Virtual wards**: Be accountable for the delivery of virtual ward capacity and maximising virtual ward use, ensuring 80% occupancy across VWs is maintained over the winter period. Systems should ensure appropriate step-up and down capacity is in place at scale for frailty, respiratory and for heart failure, ensuring capacity is tightly aligned to winter flow priorities. This includes:

  - All step-up virtual wards should be accepting admission alternative referrals from care homes, ambulance trusts, primary care, and urgent community response ahead of winter and should ensure there are clear agreed processes in place between partners.

  - **Urgent Community Response (UCR)**: Ensure full geographical coverage with a minimum of 7 days a week and 08.00-20.00 operating times – going beyond the 9 clinical conditions/needs set out in the national specification to meet all appropriate community-based demand. Ensure, through working with the ambulance service, that plans are in place for most clinically appropriate Cat 3 or 4 calls to be diverted to UCR or community-based falls services.
  - **Advanced clinical support**: You should also ensure that care homes have access to advanced clinical decision-making support outside of UCR operational hours (eg 8pm to 8am) to ensure residents receive treatment and care in the right setting, and to enable clinical risk sharing across the system.
  - **Single point of access**: driving standardisation of urgent integrated care co-ordination which will support whole system management of patients into the right care setting, with the right clinician or team, at the right time. This includes

increasing the number and breadth of services profiled on the directory of services (DoS) and ensure steps are in place to maximise the use of the DoS.

- **Acute respiratory infection (ARI) hubs**: support consistent roll out of services for adults and children and young people, prioritising acute respiratory infection, to provide same day urgent assessment with the benefit of releasing capacity in emergency departments and general practice to support system pressures.
- Through commissioning actions, ensure that **NHS 111** clinical input is prioritised where it will have most impact – in particular, maximising the assessment of NHS 111 Category 3 or 4 ambulance dispositions. Ensure that robust workforce plans are in place for NHS 111 service advisors, health advisors and clinical advisors. This should include using home working opportunities to the full.
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use
- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Acute and specialist NHS trusts

Lead the delivery of high-impact interventions 1-4

1. **Same day emergency care (SDEC)**: Reducing variation in SDEC provision by providing guidance about operating a variety of SDEC services for at least 12 hours per day, 7 days per week.
2. **Frailty**: Reducing variation in acute frailty service provision. Improving recognition of cases that could benefit from specific frailty services and ensuring referrals to avoid admission.
3. **Inpatient flow and length of stay**: Reducing variation in inpatient care and length of stay for key integrated urgent and emergency care (iUEC) pathways/conditions/cohorts by implementing in-hospital efficiencies and bringing forward discharge processes for pathway 0 patients. This includes through:
    a. Delivering improvements in ambulance handover times

    b. Ensure documented internal professional standards are in place for rapid specialty in-reach to urgent and emergency care pathways 24/7 – ensuring that patients requiring admission are moved from the emergency department in line with these standards. Put in place mechanisms to monitor performance against these standards and take action to course correct delivery where required.
4. **Community bed productivity and flow**: Reducing variation in inpatient care and length of stay by maximising therapeutic interventions to reduce deconditioning and bringing forward discharge processes.

    - Ensure that general and acute beds are available and open in line with the agreed 2023/24 ICB Operating Plan – including escalating the number of beds as needed in line with the winter addendum to this plan. This includes monitoring and reducing occupancy in the run up to Christmas.
    - Focus on improving performance against the four-hour standard for type one attendances, to contribute to the overall A&E performance target of 76%.
    - Continue focused efforts on patients attending A&E who spend more than 12 hours in department from arrival to discharge, admission or transfer.
    - Ensure clear arrangements for early referral to care transfer hubs where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance,

operational grip and decision-making and to support intermediate care capacity and demand planning.

- Ensure that sufficient capacity is in place to protect the elective pathway for both adults and children and young people – with clear triggers in place to open additional non-elective capacity in line with the winter addendum to the 2023/24 Operating Plan.
- Ensure actions to improve the primary and secondary care interface set out in the Primary Care Access Recovery Plan are implemented with system wide understanding of pressures across the totality of the UEC pathway including primary care.
- Ensure that robust workforce plans are in place to respond to an increase in demand over the winter period, including planning annual leave to maintain a continuous physician presence throughout the Christmas/New Year period. This should include planning for a possible increase in staff sickness associated with an increase in winter illness, including Covid-19 and influenza.
- Implement flexible mechanisms for staff pooling and utilisation of resources across organisational boundaries, including increasing use of staffing banks to onboard both health and care workers to the right part of the pathway utilising ‘mutual aid’ arrangements where needed and supplemented by digital solutions.
- Ensure that a robust plan is in place for the vaccination of staff, volunteers and patients against influenza and that plans are in place to rapidly respond to any other vaccination programme recommended by the Joint Committee on Vaccination and Immunisation (JCVI)

Primary care

Ensure plans are in place to maintain access to primary care services between 18 December 2023 and 8 January 2024, including ensuring Bank Holiday cover in line with primary care national contracts is in place, so that patients can access services in primary care settings over the Christmas and New Year period.

- Ensure tools are in place to understand demand, activity and capacity in primary care, eg operational pressures escalation levels (OPEL) reporting. This should be shared across the system to give a comprehensive view of primary care pressures and where support may be required that could alleviate pressure on primary care and on the UEC pathway.
- Through working with the ICB and other system providers, ensure additional capacity is in place to respond to a surge in demand for primary care services – including through the development and provision of hot hubs and/ or acute respiratory infection hubs.
- Ensure proactive identification and management of people with complex needs and long-term conditions, so care is optimised ahead of winter and that people are supported to better manage their health, to reduce demand on primary and secondary care.
- Work with the ICB to develop system plans and communication strategies to maximise the role of general practice and community pharmacy.
- Lead delivery of actions from the Primary Care Recovery Plan that will support winter pressures, particularly:
- Support the delivery of key actions from the **Primary Care Recovery Plan** that will support winter pressures, including over the Christmas/New Year Period by improving access to general practice – particularly:
- Increasing support for self-directed care
- Expanding community pharmacy services
- Implementing modern general practice by:
- engaging and nominating their practices and PCNs to join the national general practice improvement programme
- supporting practices to move to cloud-based digital telephony and to access the right digital tools
- improving online patient journeys, including practice websites
- understanding general practice transformation maturity and support needs, via completion of the support level framework to enable ongoing local support to continue improvement:
- to make online channels easy to use

- to enhance navigation and triage processes
- to improve the experience of access
- to understand and better match demand and capacity.

Increasing capacity with larger multidisciplinary teams, including over the Christmas period

Improving the primary-secondary care interface.

Children and young people (CYP) services

Winter plans should reflect the needs of the local children and young people's population, with actions in place to manage pressures in paediatric services.

- **High-impact interventions for children and young people**: ICBs should ensure commissioning arrangements are in place to support scaling of age-appropriate virtual ward models and ARI hubs; building on pilots and plans and targeting areas of greatest needs to effectively manage winter pressures and increases in respiratory infections.
- **Whole-system planning**: embed whole-system approaches to winter planning for paediatric services, linking to paediatric critical care surge planning and Level 2 bed provision expansion, led by operational delivery networks (ODNs) with paediatric ARI hubs and virtual ward development. Disaggregate datasets should be available at ICB level to permit monitoring of CYP data, pressures across paediatric services, as well as the wider system and patient pathway, including primary care, acute and mental health services, immunisation, and school attendance.
- **Paediatric critical care surge planning**: ICBs and ODNs should work in partnership to co-ordinate, implement and oversee robust winter and surge planning, including mitigations to manage the impact of surges in paediatric respiratory infections on CYP services. This should include mutual aid arrangements at regional and national level, particularly for Level 3 paediatric intensive care unit (PICU) bed provision and for children on long term ventilation.
- **Mutual aid**: ensure local winter plans include mutual aid considerations across paediatric and adult teams, between providers within the system, and across systems.
- **Protecting elective capacity for children and young people**: ensure preservation of the standard clinical pathway for CYP elective surgery, critically ill children, emergency, general and specialist services and continue to reduce disparity in elective recovery between adults and CYP. Ensuring close monitoring of paediatric surgery cancellations.
- **Vaccination uptake**: ensure that a robust plan is in place to maximise uptake of childhood and flu vaccinations as part of winter preparedness.
- **Supporting self-care and management of minor illness**: ensure targeted communication and paediatric advice is available to parents/carers. Ensure collaborative approaches with VCSE partners, embedding preventative approaches to support parents/carers in management of minor illness and navigating NHS services, particularly across areas with high attendances and communities that experience the greatest health inequalities.

Community trusts and integrated care providers

Lead and support the delivery of high-impact interventions 4-6

- **Community bed productivity and flow**: reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes. This includes:
  - ensuring actions from daily ward and board rounds have been implemented and are being recorded or escalated in the day
  - discharge planning takes place early on in admission and in conversation with the person and/or next of kin
  - screening, assessment and rehabilitation plans are in place and communicated to the person and/or their next of kin
  - protocols for mobilisation of the individual are in place
  - workforce planning to ensure rehabilitation needs are met with minimum delays.
- Ensure clear arrangements for early referral to **care transfer hubs** where patients are likely to require step-down care following hospital discharge. Align processes and protocols with standard operating procedures for care transfer hubs to reduce variation, minimise discharge delays, maximise access to community rehabilitation and reablement and optimise 7-day working. Provide timely data where needed by care transfer hubs to support governance, operational grip and decision-making and to support intermediate care capacity and demand planning.
- Ensure focus on **admission avoidance**, ensuring 24h access to palliative care services and enhanced join-up between primary, community and social care services through enhanced care in care homes.
- **Data sharing and submission**: Reducing variation in inpatient care and length of stay by implementing in-hospital efficiencies and bringing forward discharge processes.
  - Submit data for all commissioned community beds to the Community Discharge SitRep.
  - Ensure data sharing arrangements are in place to enable rehabilitation/recovery plans to be shared by partners providing services and to streamline pathways and reduce duplication.
- Ensure there are joint executive leadership and system agreements in place across partner organisations, to ensure shared decision making and governance arrangements.
- Ensure multi-professional teamworking and a partnership approach to discharge, and multi-agency working with local authority partners and the

independent and voluntary sector to review availability of resource, provide access to reablement/pathway services for ongoing recovery support at home, and ensure timely discharge from intermediate care for a person's ongoing and longer-term needs.

- Implement flexible mechanisms for staff pooling and use of resources across organisational boundaries, including increasing use of staffing banks to onboard health and care workers and deployment of therapy capacity to the right part of the pathway using 'mutual aid' arrangements where needed and supported by digital solutions.
- Implement solutions to release therapist time and increase rehabilitation capacity, including through use of digital solutions, admin capacity, streamlining referral processes and utilising support workers to undertake tasks where appropriate.
- Implement data and operational dashboards, including daily oversight of capacity and demand and blocks in the pathway including:
    - demand for therapy workforce to deliver rehabilitation assessment and interventions
    - working with acute hospitals to proactively plan for demand, support timely discharge and enable flexible resource utilisation plans across partners and organisations
    - working with systems to undertake the self-assessment exercise as part of the system maturity evaluation and progress agreed actions to maximise delivery of services through winter.

Ambulance trusts

- Ensure a greater number of deployed hours on the road over winter in line with agreed recruitment and resourcing plans.
- Increase the clinical assessment of calls in every emergency operations centre to deliver the navigation and validation of Cat 2 calls, as well as increasing clinical input to Cat 3 and 4 calls.
- Ensure efficient electronic processes are in place for the transfer of patients who do not need a face-to-face response to services more appropriate for their needs, including urgent community response, urgent treatment centres and SDEC. Note the responsibility for other parts of the system to maximise the number of cat 3 and 4 calls responded to by UCR and falls services.
- Establish sufficient call handling capacity and finalise arrangements for the use of the ‘Intelligent Routing Platform’ in times of surge.
- Ensure mental health professionals are embedded in all emergency operation centres ahead of winter.
- Use the ambulance auxiliary service when needed.

Mental health provider pathways

Lead and support the delivery of high-impact interventions 3, 4 and 9 across mental health provider pathways

- Ensure plans are in place so that individuals know how to access mental health services with access to effective assessment and help in a timely manner and that crisis alternatives are in place to help reduce reliance on A&E (recognising that A&E is still an appropriate way of seeking help and people presenting with mental health issues also may have urgent physical health care needs). This should include making reasonable adjustments to pathways and therapeutic interventions for people with a learning disability and autistic people who seek mental health support.

- Where individuals do seek help for mental health issues via A&E, ensure processes are in place for assessment and onward support, including adjustments to meet the needs of autistic people and people with a learning disability. Ensure there are clear escalation processes for A&E where there is considerable delay in receiving specialist support.

- Mental health, learning disability and autism services should ensure maximum uptake of vaccinations for their populations, both inpatient and community. This is vital given the high incidence of COPD and other co-existing long-term conditions such as diabetes which can compromise response to flu and Covid-19.

- Ensure tools are in place to understand demand, activity, workforce and capacity in mental health provider pathways. This should be shared across the system to give a comprehensive view of mental health pressures and where support may be required that could alleviate pressure on both mental health and UEC pathways.

- Ensure access to emergency housing funds to enable discharge of patients with no fixed abode (NFA) to ensure that they can be supported with follow up crisis / community care and support.

- Lead delivery of actions from the NHS Long Term Plan and Delivery Plan for Recovering Urgent and Emergency Care Services that support winter pressures, particularly:

- Strengthen ambulance response to mental health by deploying multidisciplinary professionals to support 999 mental health demand and preparing for the rollout of mental health response vehicles.
- Optimising flow through mental health inpatient settings through system-wide focus on reducing delayed discharges and avoidably long length of stay in mental health inpatient settings. Work collaboratively with social care and other system partners who play a key role in timely discharge.
- Continuing to raise profile of all-age 24/7 urgent mental health helplines and other complementary crisis support services – including those for people with a learning disability and autistic people, such as intensive support teams, ensuring delivery of

NHS 111 ‘select mental health option’ and working towards crisis text line implementation.

- Supporting children and young people with mental health needs in acute paediatric settings by adopting the new integration framework for systems to support children and young people with mental health needs within acute paediatric settings, and to take up NHS England (Workforce, Training and Education directorate) commissioned CYP crisis telephone training to support crisis mental healthcare staff.

- Maximise the uptake of training on learning disability and autism appropriate to their role, to ensure preparedness to be able to meet the needs of autistic people and people with a learning disability.

Local authorities and social care

Local authorities should continue to work with ICBs to ensure an integrated approach across health and social care.

This includes:

- commissioning intermediate care services that help keep people well at home, prevent avoidable hospital admissions and support timely and effective hospital discharge.
- areas keeping under review their Better Care Fund (BCF) capacity and demand plans for intermediate care, in line with the BCF Policy Framework and planning requirements, considering trends in demand.
- improving data flows where the BCF capacity and demand plans showed limited data or insights available to support local areas' ability to accurately forecast demand for these services throughout the year.
- supporting NHS winter surge planning, including considering contingency arrangements for a significant flu or COVID-19 wave.
- deploying this year's Discharge Fund in ways that have greatest impact in patient safety and experience and in reducing delayed discharges, both to improve outcomes following hospital admission and help prevent avoidable A&E and ambulance delays for patients who need emergency care, alongside planning how to deploy next year's discharge funding.
- systematically embedding good practice in the use of care transfer hubs to manage discharges for patients with more complex needs, focusing on nine priority areas that will be set out as part of the upcoming support offer for the UEC Recovery Plan.
- ensuring systematic involvement of social care and community health providers in planning discharge services and in improving the operation of care transfer hubs.

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

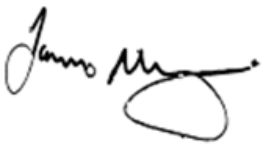
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Agenda item: NLG(23) 195

Name of the Meeting	**NLaG Joint Development Board**	
Date of the Meeting	**27th September 2023**	
Director Lead	**Shaun Stacey – Chief Operating Officer**	
Contact Officer/Author	**Ab Abdi – Deputy Chief Operating Officer**	
Title of the Report	**Elective capacity – Board Assurance Checklist**	
Purpose of the Report and Executive Summary (to include recommendations)	As part of the national elective recovery programme, all acute NHS Trusts received a letter from Sir Jim Mackey and Professor Tim Briggs on 04 August 2023, entitled Protecting and Expanding Elective Capacity. It requests that Trusts complete a Board Assurance checklist and secure sign-off by the Trust Board against several requirements, including validation, outpatients and additional support requirements. The completed checklist will be signed by the Group Chair and Group Chief Executive and submitted to NHS England via our Regional Team.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	✓ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Finance & Performance
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)	Already part of operational planning	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	In alignment	
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

PROTECTING AND EXPANDING ELECTIVE CAPACITY -
BOARD ASSURANCE SELF-CERTIFICATION

1. BACKGROUND

As part of the national elective recovery programme, all acute NHS Trusts received a letter from Sir Jim Mackey and Professor Tim Briggs on 04 August 2023, entitled Protecting and Expanding Elective Capacity. A copy of the letter is attached at **Appendix I**.

It requests that Trusts complete a Board Assurance checklist and secure sign-off by the Trust Board against a number of requirements, including validation, outpatients and additional support requirements.

The completed checklist will be signed by the Group Chair and Group Chief Executive and submitted to NHS England via our Regional Team.

2. ANALYSIS

The self-certification can be seen in **Appendix II**. All supporting documents are also included in **Appendices III-VIII**

The self-certification has also been RAG rated across 11 areas:

- **Green** (on track to deliver) – 6 areas
- **Amber** (off track to deliver but recoverable to deliver)– 5 areas
- **Red** (off track to deliver and unlikely to recover) – 0 areas

3. CONCLUSION

In conclusion, the Trust is in a favourable position to deliver the requirements contained within the letter and further work will be undertaken to ensure the amber elements of the checklist are brought back in line.

4. RECOMMENDATIONS

The Board is requested to note the contents of the paper and approve the attached self-certification assessment for sign off by the Group Chair and Group Chief Executive Officer.

The Board is also asked to approve the current requests for additional support and consider where any further external support is required.

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the 'call to arms', colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

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This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

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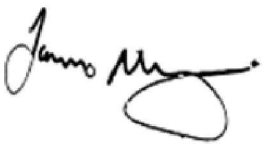
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	**Assured?**
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
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data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

PROTECTING AND EXPANDING ELECTIVE CAPACITY

APPENDIX A: SELF-CERTIFICATION

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking Trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: Northern Lincolnshire and Goole NHS Foundation Trust

The chair and CEO are asked to confirm that the board:

Assurance area	Assurance	Trust Board or Committee	Lead	RAG
1. Validation				
The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation	The Trust has had a robust validation regime in place prior to covid. During covid validation of clock stops was limited to priority and high-risk specialties only, due to other workload priorities. However, this has since recommenced, and we are now at 100% validation of clock stops. The Trust has over 30 different validation reports which are monitored and managed on a daily / weekly basis by Patient Services. LUNA data shows 99.3% data quality consistently - 0.7% is to do with system recording not data quality. The LUNA information will be included in standard reports to Planned Care Improvement and Productivity (PCIP) with effect from September 2023 and will be included in the Operational Management Group (OMG) and Finance and Performance (F&P) papers.	PCIP F&P	Associate Director, Patient Services	

	Clock Stop validation monitoring report can be found in **Appendix III** Supporting Patients on Multiple Pathways slide deck can be found in **Appendix IV**			
b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation	We commenced validating new outpatients at 12 weeks+ (with no appointment booked) in May 2023. As at the end of July 2023: • May and June 2023 are complete - 4,180 patients contacted and all actioned leading to a percentage of removals of 11% • July 2023 - 3,144 patients contacted, 733 responses 7% discharge rate to date – still a work in progress We now have a monthly rolling programme to contact every patient that tips into 12 weeks with no first appointment booked. The Trust has a digital solution in place for validation, digital letters and text reminders. We are looking to use the same functionality to validate our follow-up waiting list and introduce a digital patient-initiated follow-up (PIFU) service.	PCIP F&P	Associate Director, Patient Services	
c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients	The Trust undertakes local assurance of application of RTT rules by: • An up-to-date Access Policy (last updated February 2023) which is based on the national elective access policy which is renewed biannually and signed off by Trust Management Group, and the Primary / Secondary Care Interface Group to ensure systemwide compliance • No staff are given access to waiting list data or the PAS unless they have been fully trained and passed an RTT competency test. If 85% compliance not met, staff are retested until competency met. • Annual refresher of RTT competency is mandatory for all staff accessing waiting list data • For the last 3 months the % compliance has been at 98%, 99%, 98% • We undertake clock stop validation on a daily basis of 100% clock stops in month and have an error rate of circa 13%. From the validation we target lessons learned with trends and individual staff • We track trends such as repetitive occurrence on a log. Lessons learned are picked up with individual users or identified trends are included in retraining • We hold month Validation Best Practice meetings, who assess trends and develop guidelines and training resources • The Trust Access Policy stipulates the importance and mechanisms for communicating with patients – we provide regular updates to patients via social media. Waiting times for first appointment and diagnostics are provided on the Trust website. Patient Knows Best (PKB) is the Trust patient portal and is used to shared outpatient and discharge summaries with patients. All appointments and	PCIP F&P	Associate Director, Patient Services	

	admission letters are sent digitally to patients along with text reminders and messaging.			
d. has received a report on the clinical risk of patients sitting in the non-RTT cohorts and has built the necessary clinical capacity into operational plans	In line with national guidance the Trust adopted Risk Stratification for inpatients and diagnostics. In addition, the Trust also developed its own Risk Stratification matrix for outpatients including RTT non-admitted and those patients on an outpatient follow-up waiting list. A monthly summary report is routinely submitted to the Trust Quality Governance Group (QGG) and discussed monthly at PCIP meeting. This report provides a summary of risk stratification across all waiting lists including non-RTT. Within high-risk specialties, ie Ophthalmology, we have in place Failsafe Officers. Patients who are identified as high priority who are not treated within the timescale are escalate automatically to senior management and clinical members of the Divisions. A copy of the Risk Stratification report (August 2023) can be seen in **Appendix V** – non RTT Risk Stratification for planned and outpatient follow-up can be seen on pages 2-3. The 2023/2024 activity plans contain outpatient transformation trajectories set to achieve a 25% reduction in follow-up activity. The waiting list position in some specialties is greater than the capacity available meaning outpatient transformation is a key priority. We are using the GIRFT recommendations to support delivery of the outpatient transformation. Please see **Appendix VII** for the GIRFT outpatient plans Work is needed across the health system to ensure we have effective shared care arrangements in place.	QGG PCIP F&P	Divisional Medical Directors	
2. First appointments				
The board: a. has signed off the Trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023	As at 21 August 2023 the following table shows all patients currently waiting 38 weeks and over:	PCIP F&P	Deputy Chief Operating Officer – Planned Care Deputy Director of Planning and Performance	

	Routine Referrals overdue and un-appointed (38 weeks and over) = 198 The following areas all raised issues with capacity: • Paediatrics x34 (longest wait 60w) • Comm Paeds x66 (longest wait 61w) • Gynae x70 (longest wait 51w) Need MyoSure capacity **Specialty** 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 55 57 60 61 **Total** Clinical neurophysiology 1 — 1 Community paeds 10 10 5 4 11 8 4 3 1 1 1 2 2 1 1 1 1 66 Ent 1 1 2 General medicine 1 1 Gynaecology 12 8 7 9 6 7 5 6 3 2 1 4 70 Oral surgery 6 3 6 2 2 1 1 1 1 23 Paediatrics 1 1 5 2 13 4 3 1 1 1 1 1 34 Trauma and Orthopaedics 1 1 **Total** 30 24 18 20 22 29 14 13 2 6 4 2 2 6 1 1 1 1 1 1 198 We anticipate all patients identified in this cohort will be booked a first OPA before 31 October 2023 as a result of: • The Trust are contacting the patients individually by telephone to confirm all patients still require a first appointment – all patients have previously been written to • All available capacity up to the end of October is being checked to ensure it is booked (we usually only book 6 weeks in advance) • There are twice weekly meetings in place to ensure all patients at 38 weeks and over are dated and capacity fully maximised • Desktop reviews taking place across gynaecology and paediatrics to release more capacity for new patients • Community paediatric patients (circa 80) will potentially move to the audiology waiting list and not be counted on RTT pathways • Funding secured to set up additional clinics for ADHD and Endocrine paediatrics • Colposcopy and hysteroscopy are key pressure points in gynaecology capacity – funding plan being worked up to create additional capacity via internal consultants or insourcing model.			
b. has signed off the Trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is	All avenues including utilisation of the independent sector have been considered as part of operational planning process for 2023/24. The NLG operational plan has been developed and submitted to the ICS in accordance with national timescales.	F&P Trust Management Board (TMB)	Deputy Director of Planning and Performance	

available via the IS Co-ordination inbox england.iscoordination@nhs.net				
3. Outpatient follow-ups				
The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan	The 2023/2024 Operational Plan outlined the trajectory to deliver outpatient follow-up activity at 88% of the 2019/2020 activity baseline. In Q1 of the year, NLAG has not delivered on the trajectory. Performance is reported on monthly as part of the Performance Review and Improvement (PRIM) meetings and escalations made to the F&P Committee. Please refer to the transformation plan (roadmap) for 2023/2024 in **Appendix VI and** GIRFT OP plans in **Appendix VII**	PRIM PCIP F&P Trust Management Board (TMB)	Divisional Medical Directors Associate Chief Operating Officer Associate Director, Patient Services (Outpatient Transformation Lead)	
b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the Trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty	The PIFU target is set internally at 5% and currently performance is at 3.52%. Highest performing specialties are community paediatrics at 12.90%, Breast Surgery is 10.83% and Gastro at 11.54%. GIRFT plans outline opportunities to go 'Further Faster' on the implementation of PIFU. PIFU applies to cancer pathways as PSFU (personalised stratified follow up) for all stated tumour types and is encompassed in the work of the Living with and Beyond Cancer transformation programme (post treatment).	Outpatients Transformation Programme (OPTP) Board PCIP F&P	Associate Director, Patient Services (Outpatient Transformation Lead)	
c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying Trust access policies to clinically review patients who miss multiple consecutive appointments	The Trust has a digital letter and text reminder service in place. Since its introduction the DNA rate has reduced by 4.5% to ~6-6.5%, the Trust target is 6%. The digital solution enables patients to confirm, rebook and cancel their appointment digitally and the text reminder service reminds patients at 7 and 2 days before their appointment, with options to cancel or rebook. Furthermore, a piece of work has been completed to identify patients that consecutively DNA or cancel. This has identified a need to engage differently with those patients from more deprived areas. We are working with local ICB to target these patients as part of a wider piece of work, led by the ICB Northern Lincolnshire PLACE	OPTP PCIP F&P	Associate Director, Patient Services (Outpatient Transformation Lead)	

d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet minimum levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking data (via the Model Health System and data packs) to identify further areas for opportunity	As per the Elective Recovery Outpatient Collection (EROC) return, the Trust reported in June 2023 a rate of 36.5% against a target of 16%. Job plans reflect identified time for responding to A&G, and response times have improved. Please see **Appendix VIII** for the outpatient dashboard from the OPTP highlight report	OPTP PCIP F&P	Associate Director, Patient Services (Outpatient Transformation Lead)	
e. has identified transformation priorities for models such as group outpatient follow-up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity	Virtual consultations are continuing at 20-25%, a systemwide outpatient transformation plan is in progress (**Appendix VI**), and we have completed full assessment of the GIRFT recommendations and have developed action plans for delivery of identified gaps. Please see **Appendix VIII** for the outpatient dashboard from the OPTP highlight report and **Appendix VII** or the GIRFT OP plans. A plan to validate outpatient follow-ups was supported by the Executive Team in August 2023	OPTP PCIP F&P	Divisional Medical Directors Associate Chief Operating Officer Associate Director, Patient Services (Outpatient Transformation Lead)	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	The Trust Board is asked to support: Internally: • a plan to validate outpatient follow-ups through a means of both clinical and patient validation – please refer to **Appendix IX** for the proposal. • the delivery of consistent business analyst / intelligence support to develop and maintain planning and performance systems in NLG, in the context of detailed reporting requirements in place following establishment of the ICS.			

Sign off

Trust lead (name, job title and email address):	Shaun Stacey, Chief Operating Officer, NLG shaun.stacey@nhs.net
Signed off by chair and chief executive (names, job titles and date signed off):	Jonathan Lofthouse, Group Chief Executive Officer jonathan.lofthouse4@nhs.net (NLAG) jonathan.lofthouse@nhs.net (HUTH) Sean Lyons, Group Chair sean.lyons@nhs.net

APPENDIX III
NLG Clock Stop Validation

	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23
No of Non-Admitted Stops Submitted	8,063	6,590	7,195	5,626	6,627	7,103	6,864
No of Non-Admitted Stops Validated	4,894	6,558	7,161	5,612	6,610	7,077	6,845
Percentage Validated	60.70%	99.51%	99.53%	99.75%	99.74%	99.63%	99.72%

Referral To Treatment Clock Stop Validation Performance Report

Trend From When Data Collection Started (January 2023)

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Clock Stop Validation by Submission Month

Financial Year	Percentage of All Clock Stops Validated	Percentage of Admitted Clock Stops Validated	Percentage of Non Admitted Clock Stops Validated	Number of Admitted Stops Validated	Number of Non Admitted Stops Validated	Total Number of Stops Validated	Number of Clock Stop Errors Identified	Percentage of Clock Stop Errors Identified
2022/23	**68.8%**	**2.5%**	**85.2%**	**134**	**18,613**	**20,993**	**2,246**	**10.7%**
Jan 2022/23	50.4%	1.9%	60.7%	32	4,894	5,379	453	8.4%
Feb 2022/23	79.4%	2.6%	99.5%	44	6,558	7,379	777	10.5%
Mar 2022/23	78.7%	2.9%	99.5%	58	7,161	8,235	1,016	12.3%
2023/24	**75.8%**	**2.6%**	**96.1%**	**228**	**30,813**	**35,668**	**4,627**	**13.0%**
Apr 2023/24	78.0%	2.5%	99.8%	40	5,612	6,503	851	13.1%
May 2023/24	79.8%	3.6%	99.7%	63	6,610	7,678	1,005	13.1%
Jun 2023/24	78.9%	2.9%	99.6%	56	7,077	8,207	1,074	13.1%
Jul 2023/24	79.3%	2.3%	99.7%	41	6,845	7,935	1,049	13.2%
Aug 2023/24	61.6%	1.6%	79.9%	28	4,669	5,345	648	12.1%
Total	**73.0%**	**2.5%**	**91.7%**	**362**	**49,426**	**56,661**	**6,873**	**12.1%**

APPENDIX IV
Supporting Patients on Multiple Pathways slide deck

APPENDIX V
Risk Stratification report (August 2023)

APPENDIX VI
Outpatient Transformation Programme Road Map

APPENDIX VII
GIRFT outpatient plans

APPENDIX VIII
Outpatient Transformation Programme – highlight report including dashboard (August 2023)

APPENDIX IX
Patient validation proposal

Supporting Patients on Multiple Pathways

WLMDS analysis to highlight patients on multiple pathways
NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST - PLAN

- DRAFT -

Summary of key findings for NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

- 0 combinations of duplicate pathways identified in the WLMDS data. Additional detail is set out in slide 6.

- 4,498 currently on waiting list are on multiple RTT pathways, with 26.3% of those multiple pathways being across Ear Nose and Throat Service, Ophthalmology Service, Gynaecology Service. Additional detail is set out in slides 7-11.

- 176 of these multi pathway patients have been waiting in excess of 52 weeks for at least one of their pathways. Additional detail is set out in slide 7.

- 33.5% of patients on two pathways have their second pathway with another provider. Additional detail is set out in slide 11.

- 33% of patients on an RTT pathway were validated in 12 weeks prior to 06/07/2023. As per national guidance all patients over 12 weeks should be validated to ensure they are not on multiple pathways incorrectly and that they are happy to remain on the waiting list.

Actions for NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

Stage	Actions	Due
1. **Address Duplicate Pathways / Data Quality**	**Undertake work to confirm and remove duplicates, including:** • **For NORTHERN LINCS there were 0 combinations of duplicate pseudo NHS number & patient pathway ID, 0 combinations of complete duplicate records, and 0 combinations of ASI duplicates** • As good practice NLAG continue to follow robust DQ and Validation routines to manage duplicate records • Weekly validation of all waiting lists. Daily validation of patients at 40w+. • Continue to utilise existing LUNA reporting to address duplicate RTT pathways • Daily duplicate pathway report actioned	End August 2023 Complete
2. **Assure local application of RTT rules**	**Undertake local assurance of application of RTT rules** • No staff are given access to waiting list data or the PAS unless they have been fully trained and passed an RTT competency test. If 85% compliance not met, staff are retested until competency met. • Annual refresher of RTT competency is mandatory for all staff accessing waiting list data • For the last 3 months the % compliance has been at 98%, 99%, 98% • Clock stop validation is undertaken on a daily basis. 100% clock stops are validated within the corresponding month, the current error rate for wrong clock stops is c13%. The validation provides opportunity to learn • Trends such as repetitive occurrences are tracked and logged to feed into further learning. Lessons learned are picked up with individual users or identified trends are included in re-training, dedicated workshops • Monthly Validation Best Practice meetings are held to assess trends and develop guidelines and training resources • All patients on at RTT pathway at 12ww with no booked appointment are validated on a rolling monthly programme, between 9-11% of patients are being removed on a monthly basis, as a result. • Current practice will continue, no further actions identified.	End Q2 (Sept) 2023 Complete

Actions for NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

Stage		Actions	Due

3.	**Review opportunities for co-ordination of care for those on multiple pathways**	**Initiate local clinical engagement to support collaboration between clinical teams overseeing common overlapping pathways highlighted within the pack, including**
		• Identify sources of multiple pathways (e.g. GP, consultant to consultant) to explore opportunities to reduce flow of multiple pathways being created at referral
		  • 236 multiple pathways have been reviewed, providing an opportunity to merge 15
		  • On referral receipt checks take place for other existing pathways and opportunities to merge or treat together
		  • The weekly PTL meeting reviews patients on Waiting List for multiple procedures and explores opportunities to undertake surgery at the same time
		• Clinical engagement to support referral pathway co-ordination and proactively manage ongoing levels of demand, e.g. collaboration with other providers with whom common pathways may be developed; establishment of MDTs to enable better oversight and joined up, co-ordinated care in a timely manner;
		  • Clinical Networks are in place across the ICB in 4 specialties, these explore opportunities for developing common pathways and opportunities for collaboration
		  • The Humber Acute Services Programme provides opportunity to develop common pathways across HUTH and NLAG. Joint MDT's are being introduced as part of this work.
		• System level analysis to understand the patterns of our high intensity users, to identify and address potential health inequalities.
		  • Some analysis as commenced on missed appointments, work is being progressed with system partners to address this as part of a wider health inequalities programme, led by the North Lincolnshire Place.
			End Q2

4.	**Apply board level oversight**	**Trust Boards to assure actions to address duplicate and multiple pathways**
		• Commission reporting on duplicates and multiple pathways via safety committee
		  • Reporting on duplicates is part of a DQ Dashboard, which is reported monthly to the Planned Care Improvement and Productivity Committee
		• Identify named point of contact to lead local co-ordination at trust-level
		  • Named Lead is Associate Director – Patient Services
		• Based on findings and agreed actions, sign off a declaration with PTL projections
		  • Duplicates is reported as 0 for NLAG (slide 2 refers)
			End Q2

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Operating Officers Directorate

Patient Services Department

Risk Stratification Monthly Summary For PCIP

Reference:	
Version:	1.0
This version issued:	09th August 2023
Result of last review:	n/a
Date approved by owner (if applicable):	n/a
Date approved:	n/a
Approving body:	n/a
Date for review:	n/a
Owner:	Jackie France, Associate Director, Patient Services
Document type:	Standard Operating Procedure
Number of pages:	14 (including front sheet)
Contact:	Kerry Higgins

Planned Care Risk Stratification Inpatient and Outpatient.

RTT Patients waiting in excess of 52weeks for treatment, includes Admitted and Non-Admitted

Risk Stratified

Spec	Total
Anaesthetics	107
Clinical neurophysiology	1
Colorectal surgery	8
Community paediatrics	7
Endocrinology	4
Ent	103
Gastroenterology	62
General surgery	6
Gynaecology	146
Ophthalmology	2
Oral surgery	50
Paediatrics	18
Respiratory medicine	25
Trauma & Orthopaedics	230
Upper gastrointestinal surgery	4
Urology	16
Total	**789**
Total %	**96%**

Not Risk Stratified

Spec	Total
Anaesthetics	3
Colorectal surgery	2
Ent	6
Gastroenterology	1
Gynaecology	10
Ophthalmology	4
Oral surgery	1
Trauma & Orthopaedics	2
Trauma and Orthopaedics	1
Urology	1
Total	**31**
Total %	**4%**

- As of the 09th August 2023 4% of patients are not risk stratified.

Patients on an Outpatient Follow Up Waiting List (excludes RTT)

With and without risk stratification, includes:

- **patients with a booked appointment and those not yet booked**
- **no due date**
- **not yet due**
- **overdue**

Risk Stratified

Spec	Total
Anaesthetics (190)	18
Breast Surgery (103)	3681
Cardiology (320)	4371
Clinical Haematology (303)	377
Clinical Neurophysiology (401)	2
Colorectal Surgery (104)	2399
Community Paediatrics (290)	2573
Critical Care Medicine (192)	3
Dermatology (330)	7
Diabetic Medicine (307)	2431
Endocrinology (302)	1561
ENT (120)	4268
Gastroenterology (301)	5913
General Medicine (300)	416
General Surgery (100)	374
Geriatric Medicine (430)	1774
Gynaecology (502)	4656
Medical Oncology (370)	2386
Obstetrics (501)	2174
Ophthalmology (130)	6368
Oral Surgery (140)	738
Orthoptics (655)	2566
Paediatric Diabetic Medicine (263)	241
Paediatric Epilepsy (223)	476
Paediatrics (420)	6520
Respiratory Medicine (340)	3421
Rheumatology (410)	5937
Transient Ischaemic Attack (329)	44
Trauma & Orthopaedics (110)	3850
Upper Gastrointestinal Surgery (106)	584
Urology (101)	7355
Total	**77484**
Total %	**84%**

Not Risk Stratified

Spec	Total
Anaesthetics (190)	101
Breast Surgery (103)	73
Cardiology (320)	746
Clinical Haematology (303)	19
Clinical Neurophysiology (401)	1
Colorectal Surgery (104)	330
Community Paediatrics (290)	98
Critical Care Medicine (192)	6
Diabetic Medicine (307)	14
Endocrinology (302)	56
ENT (120)	271
Gastroenterology (301)	112
General Medicine (300)	149
General Surgery (100)	168
Geriatric Medicine (430)	467
Gynaecology (502)	295
Medical Oncology (370)	21
Obstetrics (501)	347
Ophthalmology (130)	9314
Oral Surgery (140)	80
Orthoptics (655)	194
Paediatric Diabetic Medicine (263)	4
Paediatric Epilepsy (223)	23
Paediatrics (420)	620
Post-COVID-19 Syndrome Service	1
Respiratory Medicine (340)	234
Rheumatology (410)	155
Trauma & Orthopaedics (110)	395
Upper Gastrointestinal Surgery (106)	97
Urology (101)	414
Total	**14805**
Total %	**16%**

- Due to the continual movement of patients in the system, it would not be expected to ever hit a 100% risk stratification status. On average there is approximately 29k patients being worked through the system on a monthly basis

Patients on an Outpatient Follow Up Waiting List who are overdue their follow up appointment (excludes RTT and those with no due date)

With and without risk stratification, includes:

- **patients with a booked appointment and those not yet booked**

Risk Stratified

Spec	Total
Anaesthetics (190)	13
Breast Surgery (103)	142
Cardiology (320)	2259
Clinical Haematology (303)	42
Clinical Neurophysiology (401)	2
Colorectal Surgery (104)	546
Community Paediatrics (290)	1368
Critical Care Medicine (192)	3
Diabetic Medicine (307)	1795
Endocrinology (302)	794
ENT (120)	2344
Gastroenterology (301)	3636
General Medicine (300)	173
General Surgery (100)	120
Geriatric Medicine (430)	567
Gynaecology (502)	2066
Medical Oncology (370)	605
Obstetrics (501)	280
Ophthalmology (130)	2127
Oral Surgery (140)	507
Orthoptics (655)	1105
Paediatric Diabetic Medicine (263)	68
Paediatric Epilepsy (223)	187
Paediatrics (420)	2843
Respiratory Medicine (340)	1775
Rheumatology (410)	2676
Transient Ischaemic Attack (329)	12
Trauma & Orthopaedics (110)	315
Upper Gastrointestinal Surgery (106)	145
Urology (101)	2649
Total	**31164**
Total %	**88%**

Not Risk Stratified

Spec	Total
Anaesthetics (190)	6
Breast Surgery (103)	3
Cardiology (320)	366
Clinical Haematology (303)	3
Colorectal Surgery (104)	79
Community Paediatrics (290)	83
Critical Care Medicine (192)	6
Diabetic Medicine (307)	11
Endocrinology (302)	47
ENT (120)	117
Gastroenterology (301)	86
General Medicine (300)	59
General Surgery (100)	49
Geriatric Medicine (430)	198
Gynaecology (502)	62
Medical Oncology (370)	1
Obstetrics (501)	18
Ophthalmology (130)	2505
Oral Surgery (140)	44
Orthoptics (655)	28
Paediatric Epilepsy (223)	4
Paediatrics (420)	258
Post-COVID-19 Syndrome Service	1
Respiratory Medicine (340)	143
Rheumatology (410)	140
Trauma & Orthopaedics (110)	15
Upper Gastrointestinal Surgery (106)	25
Urology (101)	56
Total	**4413**
Total %	**12%**

New and Review Out-Patient Waiting Lists

Total Numbers of Risk Stratification Red and Amber Categories (including no due date, not yet due and overdue)

Specialty	Category Amber	Category RED	Total
	See within 3M	See within 6W	
Accident & Emergency (180)	1		1
Anaesthetics (190)	4	4	8
Breast Surgery (103)	150	206	356
Cardiology (320)	2305	380	2685
Clinical Haematology (303)	133	58	191
Clinical Neurophysiology (401)	3	6	9
Colorectal Surgery (104)	846	805	1651
Community Paediatrics (290)	436	53	489
Critical Care Medicine (192)	1	2	3
Dermatology (330)	5	1	6
Diabetic Medicine (307)	456	245	701
Endocrinology (302)	551	103	654
ENT (120)	2232	1677	3909
Gastroenterology (301)	3098	941	4039
General Medicine (300)	165	32	197
General Surgery (100)	271	277	548
Geriatric Medicine (430)	562	61	623
Gynaecology (502)	2726	1170	3896
Medical Oncology (370)	848	472	1320
Obstetrics (501)	311	365	676
Ophthalmology (130)	1839	797	2636
Oral Surgery (140)	327	209	536
Orthoptics (655)	898	626	1524
Paediatric Diabetic Medicine (263)	223	15	238
Paediatric Epilepsy (223)	141	8	149
Paediatrics (420)	2082	337	2419
Respiratory Medicine (340)	1512	643	2155
Rheumatology (410)	1323	385	1708
Transient Ischaemic Attack (329)	34	60	94
Trauma & Orthopaedics (110)	2763	833	3596
Upper Gastrointestinal Surgery (106)	244	301	545
Urology (101)	3041	1380	4421
Total	**29531**	**12452**	**41983**
Total %	**70%**	**30%**	

- A full breakdown can be provided of all the risk stratification categories if needed.
- The in-house tracking system (COBRA) has been developed to track and escalate all Red patients that are not seen/do not have an appointment date booked within the timeframe

New and Review Out-Patient Waiting Lists

Total Numbers of Risk Stratification Red and Amber Categories (only includes overdue and no due date)

Specialty	Category Amber	Category RED	Total
	See within 3M	See within 6W	
Anaesthetics (190)	3	3	6
Breast Surgery (103)	28	52	80
Cardiology (320)	1235	240	1475
Clinical Haematology (303)	8	11	19
Clinical Neurophysiology (401)	2	6	8
Colorectal Surgery (104)	237	295	532
Community Paediatrics (290)	388	46	434
Critical Care Medicine (192)	1	2	3
Diabetic Medicine (307)	358	218	576
Endocrinology (302)	326	54	380
ENT (120)	1176	1177	2353
Gastroenterology (301)	1741	683	2424
General Medicine (300)	57	17	74
General Surgery (100)	91	109	200
Geriatric Medicine (430)	182	28	210
Gynaecology (502)	1127	570	1697
Medical Oncology (370)	167	187	354
Obstetrics (501)	8	168	176
Ophthalmology (130)	826	409	1235
Oral Surgery (140)	191	157	348
Orthoptics (655)	455	350	805
Paediatric Diabetic Medicine (263)	55	10	65
Paediatric Epilepsy (223)	65	3	68
Paediatrics (420)	1213	238	1451
Respiratory Medicine (340)	883	426	1309
Rheumatology (410)	617	165	782
Transient Ischaemic Attack (329)	6	20	26
Trauma & Orthopaedics (110)	156	104	260
Upper Gastrointestinal Surgery (106)	79	107	186
Urology (101)	1210	850	2060
Total	**12891**	**6705**	**19596**
Total %	**66%**	**34%**	

New Outpatient Waiting List – Patient Waiting for 1st Appointment.

Total Number of Risk Stratification Red and Amber Categories - Where the Risk Stratification due date has expired (only includes overdue and not yet due)

Specialty	Category Amber	Category RED	Total
	See within 3M	See within 6W	
Accident & Emergency (180)	1		1
Breast Surgery (103)	19	84	103
Cardiology (320)	670		670
Clinical Neurophysiology (401)	3		3
Colorectal Surgery (104)	90	61	151
Community Paediatrics (290)	8		8
Diabetic Medicine (307)	25		25
Endocrinology (302)	147	1	148
ENT (120)	114	14	128
Gastroenterology (301)	346	6	352
General Medicine (300)	4		4
General Surgery (100)	38		38
Geriatric Medicine (430)	20		20
Gynaecology (502)	336	60	396
Medical Oncology (370)	77		77
Ophthalmology (130)	155		155
Oral Surgery (140)	58	10	68
Orthoptics (655)	27		27
Paediatric Epilepsy (223)	6		6
Paediatrics (420)	63		63
Respiratory Medicine (340)	237	12	249
Rheumatology (410)	17		17
Transient Ischaemic Attack (329)	8		8
Trauma & Orthopaedics (110)	61	1	62
Upper Gastrointestinal Surgery (106)	19	41	60
Urology (101)	128	9	137
Total	**2677**	**299**	**2976**
Total %	**90%**	**10%**	

Review Outpatient Waiting List – Patient Waiting for Follow-up Appointment.

Total Numbers of Risk Stratification Red and Amber Categories (including no due date, not yet due and overdue)

Specialty	Category Amber	Category RED	Total
	See within 3M	See within 6W	
Anaesthetics (190)	4	4	8
Breast Surgery (103)	131	122	253
Cardiology (320)	1635	380	2015
Clinical Haematology (303)	133	58	191
Clinical Neurophysiology (401)		6	6
Colorectal Surgery (104)	756	744	1500
Community Paediatrics (290)	428	53	481
Critical Care Medicine (192)	1	2	3
Dermatology (330)	5	1	6
Diabetic Medicine (307)	431	245	676
Endocrinology (302)	404	102	506
ENT (120)	2118	1663	3781
Gastroenterology (301)	2752	935	3687
General Medicine (300)	161	32	193
General Surgery (100)	233	277	510
Geriatric Medicine (430)	542	61	603
Gynaecology (502)	2390	1110	3500
Medical Oncology (370)	771	472	1243
Obstetrics (501)	311	365	676
Ophthalmology (130)	1684	797	2481
Oral Surgery (140)	269	199	468
Orthoptics (655)	871	626	1497
Paediatric Diabetic Medicine (263)	223	15	238
Paediatric Epilepsy (223)	135	8	143
Paediatrics (420)	2019	337	2356
Respiratory Medicine (340)	1275	631	1906
Rheumatology (410)	1306	385	1691
Transient Ischaemic Attack (329)	26	60	86
Trauma & Orthopaedics (110)	2702	832	3534
Upper Gastrointestinal Surgery (106)	225	260	485
Urology (101)	2913	1371	4284
Total	**26854**	**12153**	**39007**
Total %	**67%**	**33%**	

Review Outpatient Waiting List – Patient Waiting for Follow-up Appointment.

Total Numbers of Risk Stratification Red and Amber Categories (only includes overdue and no due date)

Specialty	Category Amber	Category RED	Total
	See within 3M	See within 6W	
Anaesthetics (190)	3	3	6
Breast Surgery (103)	28	46	74
Cardiology (320)	874	240	1114
Clinical Haematology (303)	8	11	19
Clinical Neurophysiology (401)		6	6
Colorectal Surgery (104)	222	293	515
Community Paediatrics (290)	381	46	427
Critical Care Medicine (192)	1	2	3
Diabetic Medicine (307)	348	218	566
Endocrinology (302)	227	54	281
ENT (120)	1145	1177	2322
Gastroenterology (301)	1575	680	2255
General Medicine (300)	55	17	72
General Surgery (100)	79	109	188
Geriatric Medicine (430)	174	28	202
Gynaecology (502)	987	553	1540
Medical Oncology (370)	151	187	338
Obstetrics (501)	8	168	176
Ophthalmology (130)	799	409	1208
Oral Surgery (140)	175	155	330
Orthoptics (655)	448	350	798
Paediatric Diabetic Medicine (263)	55	10	65
Paediatric Epilepsy (223)	61	3	64
Paediatrics (420)	1183	238	1421
Respiratory Medicine (340)	784	426	1210
Rheumatology (410)	617	165	782
Transient Ischaemic Attack (329)	6	20	26
Trauma & Orthopaedics (110)	139	103	242
Upper Gastrointestinal Surgery (106)	74	106	180
Urology (101)	1195	849	2044
Total	**26854**	**12153**	**39007**
Total %	**67%**	**33%**	

Patients on the OPS follow-up waiting list with No Due Date – Split by Specialty

Risk Stratified

Spec	Total
Cardiology (320)	1
Colorectal Surgery (104)	12
ENT (120)	5
General Surgery (100)	1
Gynaecology (502)	25
Ophthalmology (130)	66
Oral Surgery (140)	11
Trauma & Orthopaedics (110)	50
Upper Gastrointestinal Surgery (106)	4
Urology (101)	17
Total	**192**
Total %	**3%**

Not Risk Stratified

Spec	Total
Accident & Emergency (180)	1
Anaesthetics (190)	114
Breast Surgery (103)	152
Cardiology (320)	97
Clinical Haematology (303)	4
Colorectal Surgery (104)	746
Community Paediatrics (290)	6
Endocrinology (302)	3
ENT (120)	709
Gastroenterology (301)	12
General Medicine (300)	12
General Surgery (100)	572
Geriatric Medicine (430)	19
Gynaecology (502)	887
Medical Oncology (370)	7
Obstetrics (501)	276
Ophthalmology (130)	1195
Oral Surgery (140)	395
Orthoptics (655)	139
Paediatric Diabetic Medicine (263)	3
Paediatric Epilepsy (223)	1
Paediatrics (420)	239
Respiratory Medicine (340)	32
Rheumatology (410)	15
Transient Ischaemic Attack (329)	2
Trauma & Orthopaedics (110)	372
Upper Gastrointestinal Surgery (106)	234
Urology (101)	1006
Total	**7250**
Total %	**97%**

Patients on the OPS follow-up waiting list with No Due Date (inc booked/unbooked) – Split by Division.

Risk Stratified

Spec	Total
Medicine	1
Surgery & Critical Care	166
Women & Children's	25
Total	**192**

Not Risk Stratified

Spec	Total
Medicine	204
Surgery & Critical Care	5482
Women & Children's	1564
Total	**7250**

Patients on the OPS follow-up waiting list with No Due Date – and no appointment booked.

Risk Stratified

Spec	Total
Cardiology (320)	1
Colorectal Surgery (104)	12
ENT (120)	3
Gynaecology (502)	20
Ophthalmology (130)	42
Oral Surgery (140)	11
Trauma & Orthopaedics (110)	38
Upper Gastrointestinal Surgery (106)	4
Urology (101)	10
Total	**141**
Total %	**3%**

Not Risk Stratified

Spec	Total
Anaesthetics (190)	26
Breast Surgery (103)	74
Cardiology (320)	91
Clinical Haematology (303)	3
Colorectal Surgery (104)	665
Endocrinology (302)	2
ENT (120)	555
Gastroenterology (301)	12
General Medicine (300)	10
General Surgery (100)	470
Geriatric Medicine (430)	15
Gynaecology (502)	793
Medical Oncology (370)	1
Obstetrics (501)	41
Ophthalmology (130)	858
Oral Surgery (140)	382
Orthoptics (655)	78
Paediatric Epilepsy (223)	1
Paediatrics (420)	156
Respiratory Medicine (340)	22
Rheumatology (410)	5
Transient Ischaemic Attack (329)	2
Trauma & Orthopaedics (110)	70
Upper Gastrointestinal Surgery (106)	217
Urology (101)	737
Total	**5286**
Total %	**97%**

Although the number of patients with no due date recorded for their next Out-Patient appointment appears to be quite high at 5427, 4202 of these patients will not require a due date as they are on an inpatient waiting list, waiting for surgery. The breakdown for all patients with no due date is included in the table below. There are a number across the different categories who do not require a follow-up. Patients who do required follow-up dates are validated or flagged to the Divisions to track down follow-up dates.

Patients on the OPS follow up waiting list with No Due Date – Split by last attendance outcome category.

Last Attendance Outcome	Waiting List Category	Comment	Total
Closed Episode – reopened		Should have due date or appt booked – validation exercise	16
New Planned Referral – not yet seen		No able to add due date for new planned refs - validation exercise	179
No Outcome		Attendances require cashing up	382
Outcome 4 – no rebook days		Data Quality issue – rebook days left blank – should have due date	7
Outcome 5 – add to IP waiting list	Current WLE – no TCI	No due date expected	2352
	Current WLE – Old TCI	Should be admitted or removed from WL - validation exercise	43
	Current WLE TCI in future/today	No due date expected	1029
Outcome 5 - add to IP waiting list	No Current WLE – WLE removed	Why removed? f/up needed - validation exercise	14
	No Current WLE – No previous admission	Awaiting WLE to be added – no due date expected	269
	No Current WLE – previous elective/emergency admission	? due date needed or discharge from cons – validation exercise	916
Outcome 7/8 – Admitted as an Emergency/Non Emergency		No due expected - at time of attendance pt admitted and only 1 outcome can be entered. Due date would be entered from discharge summary if f/up required – validation exercise	7
Outcome 9 – No PAS Action		No due date functionality for new planned refs - validation exercise	47
Referred to Another Consultant, Original Episode still open		No due expected - at time of attendance pt admitted and only 1 outcome can be entered. Due date would be entered from discharge summary if f/up required – validation exercise	5

In-Patient Elective Waiting List

7591 patients in total – 100% Risk Stratified
Number and % risk stratified and not risk stratified

Spec	Total
Cardiology	149
Colorectal surgery	698
Ent	689
Gastroenterology	364
General surgery	607
Gynaecology	778
Ophthalmology	612
Oral surgery	625
Respiratory medicine	11
Trauma & Orthopaedics	1951
Upper gastrointestinal surgery	225
Urology	798
Total	**7591**
Total %	**100%**

Inpatient Planned Waiting List

Number and % risk stratified and not risk stratified

Planned IP - With Risk Stratification

Spec	Total
Cardiology	72
Colorectal surgery	1598
Gastroenterology	631
General surgery	63
Gynaecology	1
Ophthalmology	502
Oral surgery	16
Upper gastrointestinal surgery	405
Urology	911
Total	**4199**
Total %	**95%**

No Risk Stratification

Spec	Total
Colorectal surgery	138
Gastroenterology	39
General surgery	10
Upper gastrointestinal surgery	12
Total	**199**
Total %	**5%**

Inpatient Elective Waiting List

Where the Risk Stratification P2, P3, P4 - due date expired

Spec	Cat 2 - Deferred to 4wk	Cat 2a – Diag Only Defer 2wk	Cat 3 - Delayed to 3m	Cat 4 - Delayed for +3m	Total
Breast surgery	9		20	1	30
Cardiology	3		4	2	9
Colorectal surgery	49	38	121	29	237
Ent	31		13	399	443
Gastroenterology	41	6	7		54
General surgery	42		188	65	295
Gynaecology	93		283	2	378
Ophthalmology	10		47	130	187
Oral surgery	26		91	194	311
Respiratory medicine	3		1		4
Trauma & Orthopaedics	126		202	975	1303
Upper gastrointestinal surgery	29	7	12	63	111
Urology	169	7	155	5	336
Total	**631**	**58**	**1144**	**1865**	**3698**
Total %	**17.06%**	**1.56%**	**30.93%**	**50.43%**	

Inpatient Planned Waiting List

Where the Risk Stratification due date has expired

Planned IP - With Risk Stratification P2, P3, P4 - due date expired

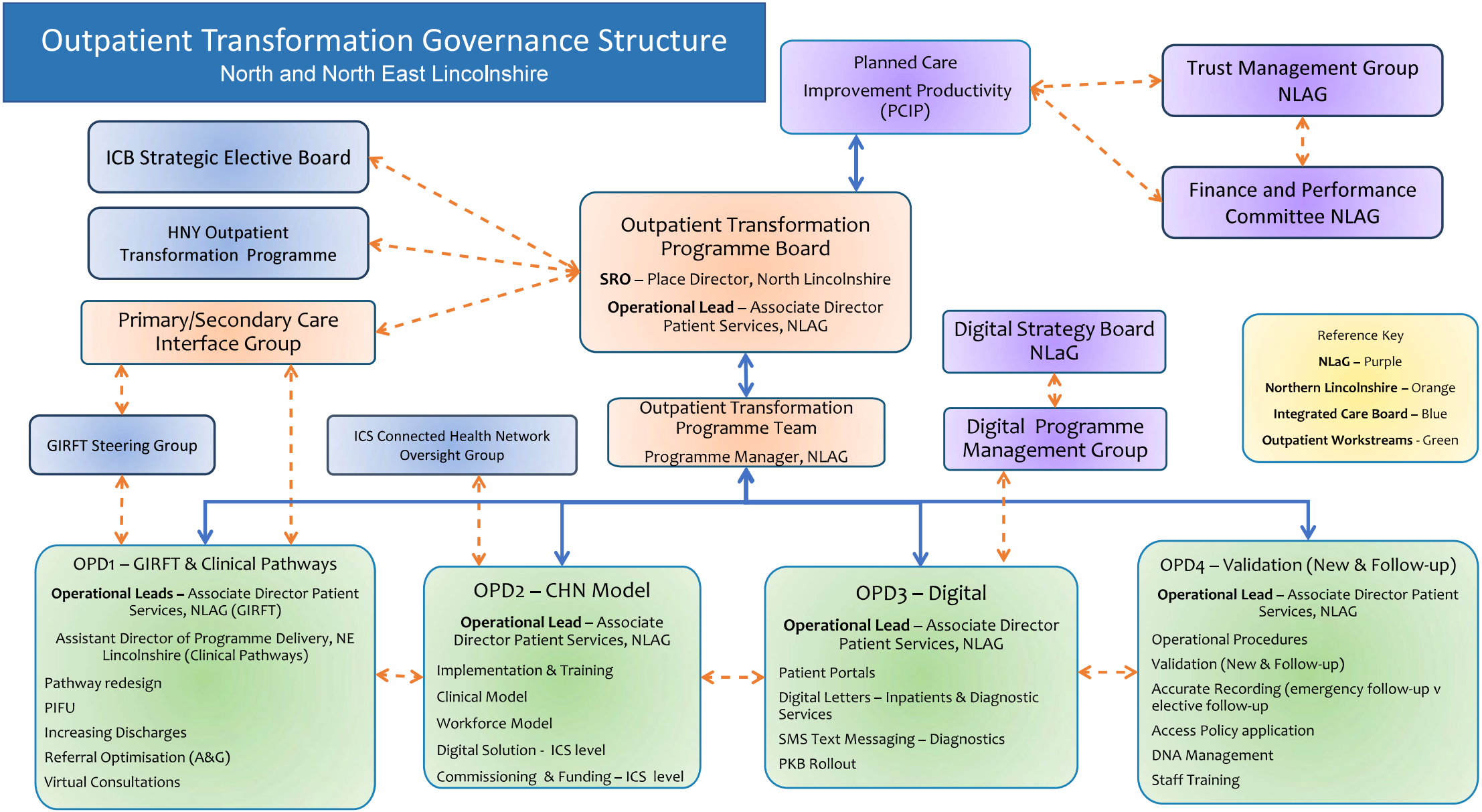
Spec	Cat 2 - Deferred to 4wk	Cat 2a – Diag Only Defer 2wk	Cat 3 - Delayed to 3m	Cat 4 - Delayed for +3m	Total
Cardiology	2		6	23	31
Colorectal surgery		5	66	1263	1334
Gastroenterology			21	453	474
General surgery			2	46	48
Ophthalmology	322				322
Oral surgery	4			5	9
Upper gastrointestinal surgery			15	340	355
Urology	18	2	22	430	472
Total	**346**	**77**	**132**	**2560**	**3045**
Total %	**11.36%**	**2.52%**	**4.33%**	**84.07%**	

CONCLUSION

- We will never achieve 100% risk stratification, due to the constant movement of patients on pathways
- We have a robust recording and reporting framework in place
- At this point there is no further development work to support risk stratification
- Risk stratification has transferred to business as usual and is reported as part of the Planned Care Performance Framework to Finance and Performance Committee
- The patients with no due date recorded will need some focus once they have been validated

RECOMMENDATIONS

The group are asked to note the contents of the report and the sustained position for risk stratification across the specialties


Outpatient Transformation Governance Structure
North and North East Lincolnshire
Planned Care Improvement Productivity (PCIP)
Trust Management Group NLAG
Finance and Performance Committee NLAG
ICB Strategic Elective Board
HNY Outpatient Transformation Programme
Primary/Secondary Care Interface Group
Outpatient Transformation Programme Board
SRO – Place Director, North Lincolnshire
Operational Lead – Associate Director Patient Services, NLAG
Digital Strategy Board NLaG
Digital Programme Management Group
Reference Key
NLaG – Purple
Northern Lincolnshire – Orange
Integrated Care Board – Blue
Outpatient Workstreams - Green
GIRFT Steering Group
ICS Connected Health Network Oversight Group
Outpatient Transformation Programme Team
Programme Manager, NLAG
OPD1 – GIRFT & Clinical Pathways
Operational Leads – Associate Director Patient Services, NLAG (GIRFT)
Assistant Director of Programme Delivery, NE Lincolnshire (Clinical Pathways)
Pathway redesign
PIFU
Increasing Discharges
Referral Optimisation (A&G)
Virtual Consultations
OPD2 – CHN Model
Operational Lead – Associate Director Patient Services, NLAG
Implementation & Training
Clinical Model
Workforce Model
Digital Solution - ICS level
Commissioning & Funding – ICS level
OPD3 – Digital
Operational Lead – Associate Director Patient Services, NLAG
Patient Portals
Digital Letters – Inpatients & Diagnostic Services
SMS Text Messaging – Diagnostics
PKB Rollout
OPD4 – Validation (New & Follow-up)
Operational Lead – Associate Director Patient Services, NLAG
Operational Procedures
Validation (New & Follow-up)
Accurate Recording (emergency follow-up v elective follow-up
Access Policy application
DNA Management
Staff Training

Northern Lincolnshire Outpatient Transformation Programme 2023/24

OUR VISION

To provide timely and equitable care in the right place, at the right time, by the right person and ensuring patients have more control and ownership of their health care.

PROGRAMME AIMS	AMBITIONS	OUTCOMES	AREAS OF FOCUS

We aim to:
• Support elective recovery by transforming outpatient services and adopting and embedding new ways of working to reduce follow-ups by 25% and repurpose capacity to support delivery of the elective recovery programme
• Build on and increase system wide working across both primary and secondary care to deliver transformed models of care
• Achieve the national objectives as outlined in the Operational Plans, NHS Long Term Plan and any other relevant national strategies or guidance
• Ensure health and digital inequalities are minimised and ensure equity of access for all when implementing new ways of working
	We will:
	• Reduce the number of follow-up appointments where clinically appropriate by redesigned pathways and new models of care
	• Evaluate specialities against GIRFT clinically-led outpatient guidance, identify gaps and develop robust action plans to meet GIRFT recommendations and streamline pathways between primary and secondary care
	• Increase the rate of discharge and the number of patients on a Patient Initiated Follow Up (PIFU), aiming for a minimum of 5% of all OP attendances to be on a PIFU pathway by March 2024
	• Reduce demand through the increase of the Advice & Guidance requests from primary care to a minimum of 16/100 outpatient appointments. Secondary care to ensure timely high quality responses to Advice & Guidance requests. Assess opportunities for implementing Advice & Guidance to reduce internal referrals
	• Roll out the Connected Health Network cardiology model to the remaining Primary Care Networks in Northern Lincolnshire (10 in total). Establish CHN as Business as Usual to ensure long-term sustainability.
	• Encourage patient self-care through the continued implementation of the Patient portals;
	  • Implement PKB across all specialities; phase 1 outpatient letters and discharge summaries
	  • Initiate and implement phase 3 of the Digital Patient Letters project for diagnostic, Lung Health Check and therapy services
	• Waiting lists are effectively managed to ensure patients are clinically appropriate and prioritised based on waiting times.
	• To deliver against the National waiting times
		This will deliver:
		• Reduction in the number of follow ups by a minimum of 25% against 2019/20 baseline activity by March 2024
		• Increase the number of appointments undertaken virtually by one third of activity by March 2024
		• Increased the rate of patient discharge
		• Increased the number of patients on a PIFU pathway; providing the ability to instigate their own care
		• A reduction and prevention of an increase in any backlogs of patients waiting to access care
		• Maximise the use of Advice & Guidance and One-stop clinics to reduce referral demand in Secondary care
		• Patients will be treated within 65 weeks by March 2024
			Reducing Demand (internal and external referrals)
			Increase use of A&G and explore the use for internal referrals
			Effective Triage of external and internal referrals
			Education to internal Drs on referral guidelines
			Use of One Stop Clinics, Direct Access and Straight to Test
			
			Alternative Models
			PIFU, CHN, Shared Care, Remote Consultations – Latest clinical appropriate date for follow-up LCAD
			
			Improving Discharge
			Review New to Follow-up ratios, maximise opportunities through GIRFT
			Application of access policy
			
			Data & Activity
			Validation (New & Follow-up)
			Accurate Recording (emergency follow-up v elective follow-up)
			Access Policy application
			DNA Management
			Staff Training

Programme
Highlight Report April

Northern Lincolnshire Outpatient Transformation Programme 2023/24

PROGRAMME OBJECTIVES

- Reduce outpatient follow up activity by a minimum of 25% against 2019/20 base line activity levels and going further where possible.
- Reduce overdue follow up backlog, and prevent further increases.
- Waiting lists are effectively managed to ensure patients are clinically appropriate and prioritised based on waiting times

DELIVERY	OPD1	OPD 2	OPD 3	OPD 4
QUARTER 1 (PROGRESS TO DATE)	**GIRFT** To initiate development of action plans and identify gaps within specified specialties, assessments completed for 12 of the 14 identified. Action plans in place for 3. **A&G** Increase A&G requests to 10% of 1st OP attendances (currently 8.15%) **PIFU** To achieve 3% in PIFUs by end of Q1 (currently 2.35%) **Virtual Consultations** To achieve 25% target by the end of Q1 (currently 23.93%) **Pathways** Complete 22/23 pathways outstanding Identify specialities and new pathways from GIRFT OP improvement (Top 3 specialities as agreed at PSCIG) **DNAs** To reduce DNA Rate to 6% (currently 6.34%)	**CHN** Agreement on recurrent funding stream Continue existing pilots **CHN S1** Implementation completed for existing S1 PCNs Sign off RTT process for CHN Obtain finance approval for CHN prescribing	**Digital Letters** Complete Endoscopy implementation for Digital Letters and SMS reminders Conduct Patient Satisfaction Survey for digital communications Provide support to OPD4 on ad hoc basis **PKB** Complete PID and plan for 23/24 – subject to funding available **Wayfinder** To work with the Wayfinder programme to allow all patients to access the Portal through the NHS App by September 2023	**Validation (New & Follow-up)** Determine scope of specialities - wider analysis around opportunities Work with HCC PEP supplier to support digitising validation requests Collaborate with other workstreams to support optimisation/management of referrals and increase productivity across the system Review FA:FU ratio The development and agreement of HNY wide clinical guidance (considering local nuances) for each specialty – inclusion/exclusion criteria
QUARTER2	**GIRFT** To evaluate gaps against guidance, and agree actions with speciality. Complete final 2 assessments and finalise action plans for remaining specialities **A&G** Increase A&G requests to 12% of 1st OP attendances **PIFU** To achieve 4% in PIFUs by end of Q2 **Virtual Consultations** To achieve a 29% target by the end of Q4 **Pathways** Create and implement pathways from top 3 specialties / Support GIRFT and Outpatient improvements locally and across the ICB **DNAs** To reduce DNA Rate to 5.5%	**CHN Cardiology** Complete roll out to remaining PCNs in Northern Lincolnshire Transition PCNs to Business as Usual **CHN Other Specialties** Continue existing pilots Evaluation of pilots which began in 2022/23 **CHN New Specialties** Commence pilots (e.g. Colorectal, Paediatrics, Urology) **CHN S1** Implementation completion for new PCNs and Freshney Pelham PCN (EMIS) Commence RTT recording Support development of RTT reporting Commence prescribing	**Digital Letters** Implement LHC with digital letters and SMS reminders Go live end of Q2 with Radiology Provide support to OPD4 on ad hoc basis **PKB** Implement OP summary letters, Discharge summary letters. Drive forward plan for roll out of Pre-assessment **Wayfinder** To work with the Wayfinder programme to allow all patients to access the Portal through the NHS App by September 2023	**Validation (New & Follow-up)** Technical – agree a set of validation routines Administrative – model up a validation process to routinely contact all patients due /overdue their follow up appointment. Clinical - Work with clinical networks to determine inclusion and exclusion criteria for validation ie., high risk pathways, those greater than 50% overdue, lowest risk Explore and agree the implementation approach – including the exploration of an ICB wide approach to validation

Northern Lincolnshire Outpatient Transformation Programme 2023/24

PROGRAMME ROADMAP

The proposed target timeline is subject to the programme interdependencies of each project

DELIVERY	OPD1	OPD 2	OPD 3	OPD 4
QUARTER 3	**GIRFT** To deliver the action plans agreed with specialities **A&G** Increase A&G requests to 14% of 1st OP attendances **PIFU** To achieve 5% in PIFUs by end of Q3 **Virtual Consultations** To achieve a 33% target by the end of Q3 **Pathways** Create and implement pathways from top 3 specialties / Support GIRFT and Outpatient improvements locally and across the ICB **DNAs** To reduce DNA Rate to 5%	**CHN Cardiology** Operating as Business as Usual **CHN S1** System operating as Business as Usual **CHN Other specialities** Commence financial and planning work on moving to BAU for 2024/25 where efficacy proven	**Digital Letters** Plan and implement Community & Therapies and Audiology Provide support to OPD4 on ad hoc basis **PKB** Implement pre-assessment / work up plan for improving watchful wait support documentation (lifestyle / generic, specialty specific) **Wayfinder** To work with the Wayfinder programme to further develop functionalities through the NHS App	**Validation (New & Follow-up)** Development of detailed SOP's, ie booking SOP, managing clinic outcomes, missed appointments (priorities to be determined) Agreeing standard templates and documentation Process mapping
QUARTER4	**GIRFT** To support implementation of the action plans within identified specialities **A&G** Increase A&G requests to 16% of 1st OP attendances **PIFU** To achieve 5+% in PIFUs by end of Q4 **Virtual Consultations** To achieve the 35% target by the end of Q4 **Pathways** Create and implement pathways from top 3 specialties / Support GIRFT and Outpatient improvements locally and across the ICB **DNAs** To maintain DNA Rate of 5% and reduce further	**CHN Other specialities** Complete financial and planning work on moving to BAU for 2024/25 where efficacy proven **CHN New specialties** Evaluation of pilots commenced in Q2	**Digital Letters** Plan and implement Medical Physics and Cardiology Provide support to OPD4 on ad hoc basis **PKB** Implement watchful wait support documentation where applicable. Identify ICB funding for continued licencing . **Wayfinder** To work with the Wayfinder programme to further develop functionalities through the NHS App	**Validation (New & Follow-up)** Reporting and embedding as BAU Deliver the functionality for the Trust to send a waiting list validation message / questionnaire to all patients to confirm they wish to take up their appointment at 12 / 18 / 26 & 52 weeks via HCC Scope opportunity to expand to view total waiting time for surgical treatments by including average inpatient wait (currently published via My Planned Care)

OUTPATIENT GIRFT ACTION PLAN

Gynae

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Nicki Chatterton / Sonia Last		Jul-23			1	
The workstream will be completed and considered a success when: The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG							
Trust: Northern Lincolnshire and Goole NHS Foundation Trust			**Region: HNY**	**Submission Month:** **Last updated:**			
Actions: **12**	**Actions completed:**	**Actions off track:**	**Number not accepted:**				

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Secondary Care Triage: Are all new referrals into secondary care clinically triaged to ensure patients are seen in the right place and identify where it is appropriate to: • refer patient for diagnostics prior to 1st appt • return referral to GP with specialist advice - in line with local agreements e.g. for conservative treatments to be explored • Redirect (i.e. physio) or return inappropriate referrals • Triage to correct clinic (face to face or remote)	May updates: CLs to scope DA/BAU for diagnostics (ultrasound) around routine referrals. Review referral guidance and specific conditions in the Directorate of Services to ensure diagnostics are requested prior to 1st apt.		MA/SQ		Potential work with Diagnostics to achieve scans prior to first appt. SQ noted that most pts would need examinations on 1st appt - potential to add pt to PIFU for follow-up and diagnostics, results fed back through VC. Potential for A&G opportunity pre-referral		
2	Validation of all outpatients waiting (esp non RTT & follow ups): Is the entire list reviewed regularly by an appropriate clinician?	May updates: NC to hold discussions at Ops meetings to encourage Increase recording of diagnosis to enable patient condition specific validation. Increase PIFU/Discharge where possible. F-up lists are currently being validated to identify pts suitable for PIFU/Discharge.		NC		potential to allocate time within job plan for CLs and Admin to review more often Meetings are being scheduled to discuss further		
3	Validation of all outpatients waiting (esp non RTT & follow ups): Discharge / PIFU - are patients called to see if suitable for discharge without follow up or suitable for PIFU?	As part of plan for 23/24 May updates: F-up lists are currently being validated to identify pts suitable for PIFU/Discharge.		Clinical Team				
4	Validation of all outpatients waiting (esp non RTT & follow ups): If appointment is required are remote appointments offered first?	Review specific conditions where a remote apt may be offered on first/follow-up apts. NC to discuss at ops meeting to task Clinical team with criteria development		NC/ Clinical Team				
5	Do you have one-stop clinics in place for the following patient conditions? (Overall)	May Update (for all): CLs to scope DA/BAU for diagnostics around routine referrals. Review referral guidance and specific conditions in the Directorate of Services to ensure diagnostics are requested prior to 1st apt. NC to work with diagnostics to increase capacity for routine conditions identified		NC/ Clinical Team				
6	Do you have one-stop clinics in place for the following patient conditions? Prolapse and stress urinary incontinence	Scope to include technology to reduce need for F2F physio (physio can follow-up with remote apts) to standardise process		NC/ Clinical Team		Currently provide pts with leaflets, no physio available in clinics - would need to refer directly to physio if required		
7	Do you have one-stop clinics in place for the following patient conditions? Lower abdominal and pelvic pain Recurrent Miscarriage	Working with PC to ensure diagnostics are complete prior to SC apts		NC/ Clinical Team		Lover ab and pelvic pain covered in Endometriosis Clinic		
8	Do you have one-stop clinics in place for the following patient conditions? Vulval conditions	Pathway to be developed with PC		NC/ Clinical Team/ JG				
9	If one in place, does your one stop clinic have the following staffing? Nurse Specialists	May update: Service available in DPoW. Due to be transitioned from Wardbase to SDEC - capacity will increase to resolve issues by Oct 23		NC	Oct-23	For oncology/endometriosis. Colp only available on SGH site due to resources		

10	Patient-Initiated Follow Ups (PIFU) - is PIFU offered in the following pathways once treatment efficacy is established and on-going follow up is clinically required? Secondary amenorrhoea - following blood sample analysis PCOS - chronic/stable Menopause - following consultation including treatment/guidance	Standardised pathway required - review existing process and work with JG to strengthen pathway		NC/ JG / Clinical Team				
11	Patient-Initiated Follow Ups (PIFU) - is PIFU offered in the following pathways once treatment efficacy is established and on-going follow up is clinically required? Recurrent miscarriage - following successful treatment Fibroids (medically managed patients) - following successful treatment Chronic pelvic pain - following successful treatment	In process of developing clinical guidelines/criteria to implement PIFU		NC/ JG / Clinical Team				
12	Remote Consulations: Where all necessary diagnostics/reports are available and patient doesn't need a physical examination, - do all conditions (exceptions below) have an initial remote (video/telephone) appointment? • 2WW referrals • all vulval conditions • post-menopausal bleeding • abnormal vaginal bleeding • post coital bleeding	Identify conditions where VCs can be implemented		NC/ Clinical Team		Opportunities to discuss pathways with PC - CJS to speak with DJ/DB to support forward movement (to discuss 28w faster diagnosis pathways) May Update: Conditions to be included on clinical validation as part of CL team review		

Gynaecology

The questions below are taken from the GIRFT Outpatients guidance and aims to benchmark your service with the GIRFT recommendations.

Please answer the questions below and insert any comments as required.

If you can please return your completed form to Kerry Roy by 15th February 2023 it would be appreciated.

Trust	Northern Lincolnshire & Goole
Form completed by	

1 Secondary Care Triage	**Yes/No**	**Comments**	**Next Steps**	**Owner**
Are all new referrals into secondary care clinically triaged to ensure patients are seen in the right place and identify where it is appropriate to: • refer patient for diagnostics prior to 1st appt • return referral to GP with specialist advice - in line with local agreements e.g. for conservative treatments to be explored • Redirect (i.e. physio) or return inappropriate referrals • Triage to correct clinic (face to face or remote)	Yes	Admin currently pre-assess/triage referrals, return inappropriate and allocate patients to consultant for clinical review where appropriate. In some instances, consultants may refer to colleague for specialist appointments. Currently no prior diagnostics before 1st appt, where scans occur in primary care, not all are transferred through to secondary. Pre-referral - specialist advice can be provided	Potential work with Diagnostics to achieve scans prior to first appt. SQ noted that most pts would need examinations on 1st appt - potential to add pt to PIFU for follow-up and diagnostics, results fed back through VC. Potential for A&G opportunity pre-referral **May updates:** CLs to scope DA/BAU for diagnostics (ultrasound) around routine referrals. Review referral guidance and specific conditions in the Directorate of Services to ensure diagnostics are requested prior to 1st apt	MA/SQ
Conduct clerical validation prior to clinical assessment to ensure the right information is provided, eliminate duplication and ensure the patient still wishes to be seen	No	NC - needs more work around patient exp & clinical mgt.	SAT team transferring into PS effective from May 1st 23 - CH developing project to support this	N/a

Clinical action
Agree clinical criteria and SOP for triage

2 Validation of all outpatients waiting (esp non RTT & follow ups)	**Yes/No**	**Comments**	**Next Steps**	**Owner**
Is the entire list reviewed regularly by an appropriate clinician?	No	Clinicians review when follow-up is due - alerted by admin.	potential to allocate time within job plan for CLs and Admin to review more often Meetings are being scheduled to discuss further **May updates:** NC to hold discussions at Ops meetings to encourage Increase recording of diagnosis to enable patient condition specific validation. Increase PIFU/Discharge where possible. F-up lists are currently being validated to identify pts suitable for PIFU/Discharge.	NC
Are patients waiting more than 12 weeks for first appointment contacted (admin) to ask if they still have symptoms and want to be seen?	Yes	Implemented from April 23. All patients on the waiting list at 12w+ with no appt booked are routinely contacted to confirm their requirements		
Discharge / PIFU - are patients called to see if suitable for discharge without follow up or suitable for PIFU?	No		As part of plan for 23/24 **May updates:** F-up lists are currently being validated to identify pts suitable for PIFU/Discharge.	Clinical Team

If appointment is required are remote appointments offered first?	No	Not applicable for first appointment.	**May updates:** Review specific conditions where a remote apt may be offered on first/follow-up apts. NC to discuss at ops meeting to task Clinical team with criteria development	NC/ Clinical team

3	**One stop shop and efficient diagnostics**	**Yes/No**	**Comments**	**Next Steps**	**Owner**
	Do you have one-stop clinics in place for the following patient conditions?	No	Only one-stop offered is 2ww Cancer pts	May updates:	**May Update (for all):** CLs to scope DA/BAU for diagnostics around routine referrals. Review referral guidance and specific conditions in the Directorate of Services to ensure diagnostics are requested prior to 1st apt. CL/NC
	Abnormal uterine bleeding	No	Hysteroscopy? If they have already had a scan Scan is provided on the day prior to clinic, only 3 ultrasounds slots available to cover 6 consultant apts	Opportunity to match ultrasound capacity with consultant clinic capacity	
	Long-standing non-urgent gynaecological problems	No			
	Prolapse and stress urinary incontinence	No	Currently provide pts with leaflets, no physio available in clinics - would need to refer directly to physio if required	Scope/Discuss to include technology to reduce need for F2F physio (physio can follow-up with remote apts) to standardise process	NC/Clinical Teams
	Suspected ovarian cyst	No	Require blood test (C125) and scan prior to appt		
	Lower abdominal and pelvic pain	No	Endometriosis clinic	Working with PC to ensure diagnostics are complete prior to SC apts	
	Heavy periods or bleeding between periods in pre-menopausal women	No	Currently offered to Post-menopause. Hysteroscopy? If they have already had a scan Scan is provided on the day prior to clinic, only 3 ultrasounds slots available to cover 6 consultant apts	Opportunity to match ultrasound capacity with consultant clinic capacity	
	Lost or misplaced coils	No	Demand relatively low. Once scan is complete from PC they are referred to minor ops clinic referrals at times		
	Recurrent miscarriage	No	no referral should be done prior to 3 miscarriages	Work with PC to be developed to ensure no referrals are made prior to 3	
	Vulval conditions	No	Minor ops for biopsy/colposcopy	Pathway to be developed with PC	

4	**Are the following diagnostics/treatments available in one stop cli**	**Yes/No**	**Comments**	**Next Steps**	**Owner**
	Ultrasound	No		**See line 17**	
	Hysteroscopy	Yes	For Post-MP/ Heavy menstrual bleeding Clinics Scan is provided on the day prior to clinic, only 3 ultrasounds slots available to cover 6 consultant apts	Opportunity to match ultrasound capacity with consultant clinic capacity **See line 17**	
	Biopsy	Yes			
	Pessary fitting	Yes			
	Pelvic floor exercise advice	Yes	Leaflet given to pts - referral to physio if required	**See line 20**	

5	**If one in place, does your one stop clinic have the following staffing?**	**Yes/No**	**Comments**	**Next Steps**	**Owner**
	consultant	Yes			
	nurse specialists	Yes	For oncology/endometriosis	Colp only available on SGH site due to resources **May update:** Service available in DPoW. Due to be transitioned from Wardbase to SDEC - capacity will increase to resolve issues by Oct 23	NC
	Sonographer	No	Scan is provided on the day prior to clinic, only 3 ultrasounds slots available to cover 6 consultant apts	Opportunity to match ultrasound capacity with consultant clinic capacity **See line 17**	
	Physiotherapist	No			

6 **Patient-Initiated Follow Ups (PIFU) -** is PIFU offered in the following pathways once treatment efficacy is established and on-going follow up is clinically required? **NOTE -** PIFU should not be used in place of suitable clinical discharge *(italics = suggested PIFU timeframe from GIRFT)*	**Yes/No**	**If no, what is the reason why e.g patient routinely discharged; PIFU not yet mobilised etc**	**If no, do you agree with suggested PIFU timeframe in GIRFT recommendations**	**At end of PIFU timeframe - straight to discharge or clinical review for next steps?**	**Next Steps**	**Owner**
Endometriosis - mild - following successful treatment *(PIFU 6m)*	Yes			In endometriosis specialist clinic if pts don't opt for surgery, we put them on PIFU or discharge.		
Endometriosis - severe - following successful treatment *(PIFU 12m)*	Yes			In endometriosis specialist clinic if pts don't opt for surgery, we put them on PIFU or discharge.		
Secondary amenorrhoea - following blood sample analysis *(PIFU 6m)*	No	Standardised pathway required			Standardised pathway required - review existing process and work with JG to strengthen pathway	JG/Clinical team
PCOS - chronic/stable *(PIFU 6m)*	No	Standardised pathway required			Standardised pathway required - review existing process and work with JG to strengthen pathway	JG/Clinical team
Heavy or irregular menstrual bleeding - following successful treatment *(PIFU 6m)*	No	Tend to discharge- Option for Merina PIFU			In process of developing clinical guidelines/criteria to implement PIFU	NC/Clinical Team
Chronic pelvic pain - following successful treatment *(PIFU 6m)*	No	Tend to discharge.			In process of developing clinical guidelines/criteria to implement PIFU	NC/Clinical Team
Fibroids (medically managed patients) - following successful treatmen	No	Potential to PIFU following medical treatment			In process of developing clinical guidelines/criteria to implement PIFU	NC/Clinical Team
Recurrent miscarriage - following successful treatment *(PIFU 6m)*	No	Potential for PIFU? Option for early scan			In process of developing clinical guidelines/criteria to implement PIFU	NC/Clinical Team
Menopause - following consultation including treatment/guidance *(PIFU 6m)*	No	Potential for PIFU? No specialist clinic currently			In process of developing clinical guidelines/criteria to implement PIFU Pathway also in development to reduce need for SC apts	NC/Clinical Team/JG
Bulking agents - following successful treatment *(PIFU 6m)*	Yes	Follow-up is a 6m PIFU on patients choice				

Management action:
Ensure patient information available including how to re-access the service
Admin systems to be set up to facilitate PIFU & ensure patients are not lost in system
Processes in place to flag patients coming to the end of PIFU timescale for clinician attention and discharge

Clinician action:
Agree clinical criteria for PIFU and shared decision making, including discharge process in a SOP
Action discharge for patients coming to the end of PIFU pathway

7 **Additional PIFU questions**	**Yes/No**	**Comments**	**Next Steps**	**Owner**
Are you doing PIFU in other areas not mentioned above? If yes, please reflect this in the comments.	Yes	TBC Gynae Cancer, Stage 1a low grade Endo Cancer, regional discussions ongoing for higher grades scope	To confirm higher grade Endo once agreement has been obtained	
Are there any specific conditions you are interested in doing PIFU in? Please comment	Yes	Where clinically appropriate		

7 **Remote Consultations**	**Yes/No**	**Comments**	**Next Steps**	**Owner**
Where all necessary diagnostics/reports are available and patient doesn't need a physical examination, - do all conditions (exceptions below) have an initial remote (video/telephone) appointment? • 2WW referrals • all vulval conditions • post-menopausal bleeding • abnormal vaginal bleeding • post coital bleeding	No	Possible opportunity when cases do not require physical appts	Potential to identify conditions where VCs can be implemented Opportunities to discuss pathways with PC - CJS to speak with DJ/DB to support forward movement (to discuss 28w faster diagnosis pathways) **May Update:** Conditions to be included on clinical validation as part of CL team review	

Management action:
Set up IT and PAS system for remote consultations
Ensure clinician and admin teams have received appropriate training

Clinician action:
Agree SOP for conducting remote consultations, including clinical safety approach, safeguarding and prescribing

8 **Discharge from secondary care** Please confirm that the following are discharged as outlined below:	**Yes/No**	**Comments**	**Next Steps**	**Owner**
Conditions where conservative treatment is recommended and diagnostics do not indicate need for treatment - following negative investigations and review. No PIFU	Yes			
Urinary incontinence (uncomplicated) - following successful conservative management by physio or continence nurse specialist. No PIFU	Yes			
Pelvic floor prolapse (uncomplicated) - following successful conservative management by physio or continence nurse specialist. No PIFU	Yes	Though in pessary cases require changing every 4-6months - PIFU/discharge not possible	Build PIFU pathway into any that require follow-ups	

Surgically treated conditions (minor, complication-free) - PIFU after successful treatment for 3-6m then discharge if no clinical concerns	Yes	PIFU not usually offered unless follow-up needed (Pelvic floor repair?)	Build PIFU pathway into any that require follow-ups	
Surgically treated conditions (complex, complication-free) - PIFU after successful treatment for 6-12m then discharge if no clinical concerns	Yes	PIFU not usually offered unless follow-up needed (Pelvic floor repair?)	Build PIFU pathway into any that require follow-ups	
Medically treated conditions - PIFU after successful treatment 6-12 months then discharge	Yes		Build PIFU pathway into any that require follow-ups	

OUTPATIENT GIRFT ACTION PLAN

Cardiology

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Simon Thackary AMD/Carol Joyce		Jul-23	1			3

The workstream will be completed and considered a success when: The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG				
Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: 5	Actions completed: 1	Actions off track:	Number not accepted: 1	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Triage of Referrals: Are referrals clinically triaged to ensure the patient is on the right pathway and all appropriate diagnostics have been carried out prior to OPFA?	Job plans to be developed as Speciality - essentially merging NLaG & HuTH		CJ/ST	Oct-23	18/7/23: CoW model has currently been signed off in principle. Job plans yet to be agreed		
		Process of referrals to be reviewed following disolvement of contract with Medefer.		CJ	Oct-23	26/6/23: AA has drafted Cardiology Outpatients Action Plan including 11-day audit completed in June 23 to identify source of internal referrals - this will support GIRFT and achievement of 25% reduction in F-ups 18/7/23: CoW model has currently been signed off in principle. Job plans yet to be agreed		
		Transition internal referrals from paper to Digital Solution		HD Digital Lead	Yet to be agreed	18/7/23: Ongoing discussions to identify digital solutions suitable. CJ to speak with DL to confirm route		
2	PIFU: Is PIFU in place for the following pathways? 1. Heart failure - As heart failure is a long-term condition, these patients should be placed on a continuous PIFU pathway so they can access the heart failure MDT for ongoing help and support. 2. Arrhythmia - many patients with arrhythmias, especially atrial fibrillation may be managed through PIFU.	Additional education and support to be provided to clinicians to encourage and embed the use of PIFU		RH/ST	Jul-23	26/6/23: CJ to re-share PIFU slide deck in business meetings to further support encouragement 18/7/23: Ongoing - Validation work being undertaken at HuTH. CJ enforced PIFU at clinical level, shared information packs Action complete	Y	
3	Structured Follow-Up: Is 'Structured Follow Up' in place for the following pathways: Patients with asymptomatic valve disease may be followed up in physiologist or nurse led clinics in line with ESC/EACTS guidelines.	Physiology-led Valve clinic currently going through governance route - approval to be notified once achieved		CJ	Jul-24	18/7/23: SOPs have been agreed, training still in discussions. Clinic agreed in principle - ongoing		
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OUTPATIENT GIRFT ACTION PLAN

Diabetes

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Phil McGlone/Chris Zafara		Jul-23				

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: 4	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Secondary care triage of referrals: Do you have an agreed clinical criteria and SOP in place for triage and identify where it is appropriate to : • return to GP with specialist advice (in line with any local agreements) • refer for pathology prior to OPFA e.g. HbA1c, ACR, eGFR, lipids • redirect referrals to more appropriate services • triage to correct specialist clinic	S6 model and DOS to be reviewed and discussed with clinicians to ensure criteria is met		CZ		No SOP in place - SGH follow agreed intergated model (Super 6) and agreed DOS in place at DPOW 15/8/23: Query - should there be a SOP?		
2	Specialist Advice: Is time protected/allocated in senior clinical decision makers job plans to undertake specialist advice, triage of referrals etc.	Confirm once Job Plan 23/24 is signed off		PM				
3	One Stop Shops: Are one stop multidisciplinary foot clinics available?	MDFT Clinic to be merged at one location		CZ/PM				
		SGH Biweekly plans to move to weekly clinics capturing all NLAG patients		CZ/PM				
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OUTPATIENT GIRFT ACTION PLAN

Endocrine

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Chris Zafara		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: 7	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Where appropriate, are remote FU consultations nurse-led?	Explore opportunity to gain nurse resource to provide service		CZ				
2	Is pre-clinic testing undertaken to avoid delay to decisions for new or FU appts?	Rescope capacity vs waiting times to implement		CZ		This would be covered if Nurse resource is obtained		
3	One stop / virtual clinics	A&G figures to be reviewed to identify viable conditions for virtual/one stops clinics to be implemented		CZ				
4	Validation of outpatients waiting (especially non RTT, follow ups)	Activity performed on adhoc basis - Job planning to be updated to include Validation		CZ				
5	Patient Initiated follow up (PIFU) - Osteoporosis 3-5years on treatment	Pathway/process to be developed with support from OPD Team to implement PIFU pathway		CZ/JG				
6	Patient Initiated follow up (PIFU)	Review other identified conditions to further opportunities for PIFU (eg. Addisons Disease, Pituitary disease, inherited endo tumour syndromes)		CZ/JG				
7	Patients requiring surgical care - Testosterone deficiency - discharged from endocrinology when first review of testosterone levels and safety bloods acceptable. Primary care undertake annual screens of safety bloods including PSA, haemoglobin and serum testosterone levels for patients in high risk groups. Re-referred when testosterone levels and/or safety bloods out of range	Dr Pothina currently reviewing pathway		NP/CZ		15/8/23: due to annual leave, this action has been delayed		
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OUTPATIENT GIRFT ACTION PLAN

Gastro

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Simone Woods		Jul-23	3			4

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: **10**	**Actions completed:** **3**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Managing Demand: Is direct open access to best practice fibrosis assessment available to primary care?	Monitor to see if current pathway works - is further education needed		SW		Dr Sarwar stated this is available but potentially not fully adhered to in primary care Jul.23 - pathway works and is implemented, though it has been identified that staffing		
2	Specialist Advice: Is there protected time in senior clinical decision-maker job plans or diaries for Specialist Advice and triage of referrals, to enable potential signposting to diagnostics and one-stop appointments	Implementation of Consultant of the Week to allocate protected time to alternating consultants. To be reviewed in 3 months		SW	Aug-23	No longer Medefer - Medinet are replacing for in-reach rather than outreach Implementation of Consultant of the Week to allocate protected time to alternating consultants. To be reviewed in 3 months -	Y	
3	Remote Consultations: Coeliac disease - follow up via telephone with GP or dietician	Follow ups are currently undertaken by clinicians - ICS pathway currently in development		SW/JG		OPT working on Coeliac Pathway, currently still within secondary care	Y	
4	Remote Consultations: Alcohol related liver disease - FU following fibro scan to stage alcohol related liver disease and check for cirrhosis (patients to have blood test prior to appointment)	Dr Raza leads on pathway. Discussions to be held aroud merging pathways and moving fibroscan into CDC		SW/JG	Mar-24	Jul.23 - pathway works and is implemented, though it has been identified that staffing resource is an issue. - discussions for merger and		
6	Follow Up arrangements: IBS (complex) - patients referred back to GP for care following diagnosis and advice for ongoing management	Development of pathway and education needed prior to implementation.		SW/JG		Not currently in place - IBS patients not currently followed up by GPs as not part of the current IBS pathway. IBS is also being picked up as part of the CDC (community diagnostic centre) discussions, but this will be in terms of diagnostic surveillance, rather than follow up, as there are currently no plans for clinics to be held in the CDCs		
7	Follow Up arrangements: Coeliac disease - annual review via telephone (with accompanying blood test) delivered by GP or dietician	Currently being developed as part of the Coeliac pathway - Surveillance ideally done by dietician, so not directly transferred to the GP. Pathway implemented June 23 - to be monitored to ensure this action is managed		SW/JG	Aug-23	Jul.23 - pathway being monitored - no issues identified		

8	Follow Up arrangements: Barrett's oesophagus - routine endoscopic surveillance and advice for ongoing management. Access to helpline or follow up if alarm symptoms	Finalise pathway and implement		SW/JG	Aug-23	Pathway in development - Mr Kallam/ Dr Sarwar providing support. Ongoing discussions as to where the responsibility in SC lies in terms of having a tailored WL for these surveillance patients to be put on. Jul.23 - Finalise pathway and implement, agreed with NME to surveil the patients, need to sign		
9	Follow Up arrangements: Compensated cirrhosis - 6 monthly ultrasound and bloods. PIFU via helpline	PIFU to be included as part of the pathway. CNS have received education around PIFU - monitor implementation		SW	Jul-23	Jul.23 - CNS have shown great improvement around PIFU usage - completed	Y	
10	Patient Validation: Is the entire list reviewed regularly by an appropriate clinician to ensure patients are on the right pathway and whether they still need/wish to be seen?	Discuss with consultants around recording diagnosis for pts to identify applicable pathways for patients		AL	Oct-23	Jul.23 - Validation exercise has been completed, WLs have been reduced by circa 3k due to locum support. Continue to		

OUTPATIENT GIRFT ACTION PLAN

Geriatrics

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Lynsey Chessman		Jul-23				

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: 5	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	PIFU: Are older patients with stable conditions and patients with mild or moderate frailty who are engaged in their care considered for/offered PIFU?	Review national data to identify which conditions are able to use PIFU						
2	Efficient diagnostics and one-stop clinics: As a system, is there a model of care in place across primary, secondary and community care that uses the Electronic Frailty Index to identify appropriate patients and based on population need?	Research model usage within P/S/C and ensure effectively implemented				Extent of use of model currently limited knowledge		
3	Efficient diagnostics and one-stop clinics: Is there a mechanism in place to co-ordinate appointments across specialties such as respiratory, gastro, cardiology, neurology, MH of OP and renal?	Review/Amend scripts to prompt identification of other appointments to enable co-ordination				When mutually agreeing apts, time frames are now provided to patient		
4	Efficient diagnostics and one-stop clinics: Are one stop outpatient clinics in place for initial assessments?	Identify conditions where one-stop clinics would be suitable - then to develop						
5	Remote Consultations: Are remote consultations considered if the patients does not need a physical examination?	Identify conditions where Remote Cons would be suitable - then to develop				CNS provide remote clinics where non-physical apts are available		
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OUTPATIENT GIRFT ACTION PLAN

Respiratory

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Phil McGlone		Jul-23	1			

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: Last updated:
Actions: 4	Actions completed: 1	Actions off track:	Number not accepted:	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Specialist Advice: Is there pathway/referral guidance available for primary care that is reviewed and updated according to latest guidance?	ERS currently used - pathway to be reviewed/restructured against latest guidance						
2	Efficient diagnostics and one-stop clinics: Is there a process for organising diagnostics either ahead of or at the same time as an OP appointment?	Spirometry to be re-implemented at new OPAs which would reduce requirement for follow-ups		Yasso/ DB/ Pathways Oversight Group	Jul-23	In development 12/Jul/23 - following analysis, all GPs can undertake Spirometry - no requirement needed for re-implementation. All referral requests can be rejected if clinically suitable	Y	
3		Pathway for diagnostics to be developed						
4	Workforce: Is there sufficient staffing in place to ensure OP clinics are maximised?	Staffing resource to be reviewed						
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OUTPATIENT GIRFT ACTION PLAN

Rheumatology

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Chris Zafara		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust	Region: HNY	Submission Month: Last updated:

Actions: 9	Actions completed:	Actions off track:	Number not accepted:

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	**Secondary care triage of referrals: I**s clinical triage of all referrals undertaken to ensure the patient is being seen in the right place, by the right clinical team	Further work around time allocation and job planning - PM/CZ to confirm once reviewed						
2	**Secondary care triage of referrals:** Do you have local agreements for clinical criteria for referral / triage?	Opportunity to reduce referrals with strengthening pathways in shared-care aspects. DOS to be reviewed to ensure criteria is aligned						
3	**Pathways:** Early inflammatory arthritis	Pathway **I**n development						
4	**Pathways:** Axial spondyloarthritis	Pathway to be Developed						
5	**Pathways:** Giant cell arteritis	Reviewing through internal GIRFT work				15/8/23: Conversations already started with radiology and ophthalmology to determine the resources required to facilitate this service.		
6	**Pathways:** Osteoporosis	Pathway to be Developed						
7	**Pathways:** Do you have any one stop shops in place?	Aspiration to develop.						
8	**PIFU: I**s PIFU offered to: IA patients where disease duration >2y and optimal disease control established/remission and have a good understanding of their condition and the ability to initiate contact where required? PIFU should be <2y with scheduled appointment at end of PIFU period for review	Work ongoing with PC to develop shared care approach to support PIFU						
9	**PIFU:** Are service wide PIFU protocols in place?	HNY Draft Protocol in development and to be reviewed						

OUTPATIENT GIRFT ACTION PLAN

ENT

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Vicki Quinn		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: August 2023 Last updated: 16/08/23
Actions: 6	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Triage of referrals waiting for 1st OP appt. Are clinical criteria and SOPs in place to support admin triage so that only referrals needing clinical review are referred to the clinicians?	GP education in primary care regarding red flag referral symptoms		J Maung V Quinn	Dec-23	All referrals clinically triaged by Consultant on call. Referrals returned to GP where in appropriate referral into the Service. 16/08/23: Waiting for training for all cons in electronic triage no paper triage has ceased		
2	Presentations that can be discharged to alternative services Are patients with recurrent vertigo/balance disorders recommended treatment and discharged to rehab or GP?	Develop Balance Service in NLAG - Balance expert clinician provides other services in NLAG currently.		J Maung V Quinn		Patients assessed and recommended treatment given, referred to Balance Centre in Hull if indicated. 16/08/23: Balance clinic at HUTH is oversubscribed so try to manage service at NLG but some patients require more input		
3	One Stop Clinics Is a one-stop neck lump clinic in place? If yes, does it include: concurrent ultrasound scan list with neck lump/thyroid clinic, specialised head and neck ultrasonographer's verbal report during clinic allows immediate discharge if benign	Head & Neck Lump only To be expanded to include thyroid US.		J Maung V Quinn		16/08/23: Funding requested for portable US to undertake 1 stop - H&N and thyroid lumps already in place but uptake low - to be reviewed		
4	One Stop Clinics Is a one-stop nasal airway/rhinosinusitis clinic in place?	To develop specialist rhinology clinic once new Consultant appointed.		J Maung V Quinn		16/08/23: Awaiting appointment of new Cons		
5	ENT will be the pilot specialty for overdue follow-up backlog letter			V Quinn		16/08/23: Vicki Quinn to provide further detail		
6	OP Community model	To revisit previous proposal		J Maung V Quinn		16/08/23: Vicki Quinn to provide further detail once discussed with Mr Maung		

OUTPATIENT GIRFT ACTION PLAN

Ophthalmology

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Tom Foulds		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: August 2023 Last updated: 16/08/23
Actions: 4	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Validation of Outpatient waiting lists Are patients risk-stratified by subspecialty?	To review once Lorenzo/PAS is in place	Patients will be risk stratified	TF	Jan 24	NLaG do not have digital functionality currently - awaiting Lorenzo/PAS implementation to obtain this All providers have a written failsafe policy in place 15/8/23: Consultants run general clinics; however, do have sub-specialty interests. Patients also have a diagnosis code recorded which does support sub-specialisation. NLaG do not have digital functionality currently - awaiting PAS implementation to obtain this	Partial	
2	Validation of Outpatient waiting lists Do you use consistent grading nomenclature (1-4) on all cataract surgery patients?	To be built in Ophthalmology EPR within 23/24	Patients will be graded once built into EPR	TF	Q2/3 - 24/25	Do not have digital functionality to do this. 15/8/23: requires MediSight procurement (2024/25 business planning)	N	
3	Validation of Outpatient waiting lists Do you have an urgent eye care/CUES risk stratification tool for referral and triage?	Scope to identify tool and review efficacy for implementation		KN	TBC	There is a process in place as BAU - no tool currently documented 15/8/23: No CUES/urgent eye care risk stratification at HUTH/NLAG though developments are happening internally and under review by Associate Specialist and considered as part of emergency eye care HCCP review	Partial	
4	One stop pathways Do suspect adnexal skin tumours have a biopsy on the day of initial clinic appointment?	Recruit sub-spec consultant in 23/24		TF	N/A	No sub-speciality available 15/8/23: Not delivered across HNY and not deemed appropriate with limited sub-specialty workforce currently.	N	

OUTPATIENT GIRFT ACTION PLAN

Oral & Max Fax

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions			
GIRFT	Vicki Quinn		Jul-23	1			

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: August 2023 Last updated: 16/08/23
Actions: 4	**Actions completed:** 1	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Secondary Care Triage Do you have clear referral guidelines in place for Temporomandibular Disorder (TMD)?	Amend and update guidelines where appropriate		PB / Clinical Team		We are in the midst of reviewing our description of service and in amongst this will be our referral guidelines, TMD bite raising appliances do not have lab facilities		
2	Patient Validation Are patients waiting more than 12 weeks for first appointment contacted to ask if they still have symptoms and want to be seen?	Scope to use HCC Digital Letters for 12w for FA contact.		KH/GW		Some patients might not have symptoms. Currently around 30 week wait, SLA in place. Usually urgency and Cancer pts 15/8/23: This is complete – all specialties are included in the New OPS validation, and all patients are being contacted that are unbooked at 12w+, this has been in place since May and is now BAU managed in Patient Services.	Y	
3	Discharge by default following Dentoalveolar Surgery Do you have local follow up protocols agreed?	Amend and update protocols where appropriate, following review		PB / Clinical Team		16/08/23: Vicki Quinn to provide further detail		
4	Discharge by default following Dentoalveolar Surgery Have you undertaken a local audit of follow up rates and ensured protocols are being followed ?	Local audit to be undertaken with Ceri Mckintosh once reviews of guidelines/protocols have been finalised		CM		16/08/23: Vicki Quinn to provide further detail		

OUTPATIENT GIRFT ACTION PLAN

Orthopaedics

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Vicki Quinn		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: August 2023 Last updated: 16/08/23
Actions: 3	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Consent by telephone appointment Is consent for treatment progressed by telephone for patients who have: • previously had a F2F appointment with the operating team at which the procedure was discussed? • the patient has had a good quality shared decision making conversation making treatment, care and support options explicit (including 'do nothing') and providing evidence based information on outcomes benefits and risks associated with these	this is being discussed jointly with HuTH		SA/ Tom Symes		16/08/23: Vicki Quinn to discuss with Mr Alavala and feedback		
2	Discharge and Patient-Initiated Follow Ups (PIFU) Are hip & knee arthroplasty patients discharged by default following a single post surgical follow up between 6w & 3m? Only use PIFU when it is clinically indicated	agree uniform pathway		SA		not uniform practice for all consultants. 16/08/23: Vicki Quinn to discuss with Mr Alavala and feedback		
3	Discharge after first attendances Has the organisation and system reviewed it's performance against percentage of patients discharged at first orthopaedic consultation metric. If greater than 20% review system delivery with focus on making best use of MSK practitioners in primary and community care to support referral	referral criteria, work with primary care and MSK		CL/AGM		MSK services have been strengthened. Still awaiting performance figures to identify any specific conditions 16/08/23: Vicki Quinn to review MSK provision on South Bank		

OUTPATIENT GIRFT ACTION PLAN

Urology

Workstream	Lead	SRO	Reporting Period	RAG Rating – Actions
GIRFT	Vicky Marshall		Jul-23	

The workstream will be completed and considered a success when:
The actions within the GIRFT Report have all been implemented or it has been agreed that there is a valid reason why are not required within NLG

Trust: Northern Lincolnshire and Goole NHS Foundation Trust			Region: HNY	Submission Month: August 2023 Last updated: 16/08/23
Actions: 2	**Actions completed:**	**Actions off track:**	**Number not accepted:**	

Latest progress update and key areas to note:
Dates and RAG to be confirmed

Ref	GIRFT concept	Action	Measurable	Lead	Timeline	Update on progress / status	Complete (Y/N)	RAG
1	Do you have one stop shop Urology clinics?	Recurrent UTI pathway being developed.		IK/VM		LUTS complete as true one stop. Prostate in place but currently two stop due to diagnostic capacity, moving forward working on reducing to one stop. 16/08/23: new rota aligned to be cons led clinics - pathways need to be developed and to be discussed at next business meeting in September		
		Prostate to be re-developed to provide one stop		IK/VM		16/08/23: Currently still a 2 stop due to lack of MRI capacity - working with Radiology to review capacity		

PROGRAMME HIGHLIGHT REPORT

Programme	**Outpatients Transformation**	**RAG status key:**	**Minor/no concerns**	**Some concerns**	**Critical concerns**
SRO:	**Alex Seale**				
Transformation Lead: **Programme Manager:**	**Jackie France**				

Programme objectives:	**Overall RAG status:**	**Critical Concerns**		
The ambitions of the Northern Lincolnshire Outpatient Transformation Programme is to transform the way outpatients is delivered with the aim to: • *Reduce the number of follow-up appointments where clinically appropriate by redesigned pathways and new models of care* • *Evaluate specialities against GIRFT clinically led outpatient guidance, identify gaps and develop robust action plans to meet GIRFT recommendations and streamline pathways between primary and secondary care* • *Increase the rate of discharge and the number of patients on a Patient Initiated Follow Up (PIFU), aiming for a minimum of 5% of all OP attendances to be on a PIFU pathway by March 2024* • *Reduce demand through the increase of the Advice & Guidance requests from primary care to a minimum of 16/100 outpatient appointments. Secondary care to ensure timely high-quality responses to Advice & Guidance requests. Assess opportunities for implementing Advice & Guidance to reduce internal referrals* • *Roll out the Connected Health Network cardiology model to the remaining Primary Care Networks in Northern Lincolnshire (10 in total). Establish CHN as Business as Usual to ensure long-term sustainability.* • *Encourage patient self-care through the continued implementation of the Patient portals.* • *Implement PKB across all specialities; phase 1 outpatient letters and discharge summaries* • *Initiate and implement phase 3 of the Digital Patient Letters project for diagnostic, Lung Health Check and therapy services* • *Waiting lists are effectively managed to ensure patients are clinically appropriate and prioritised based on waiting times.* • *To deliver against the National waiting times*	**Reporting period:**	30th June – 28th July 2023		
	Report completed by:	Kerry Roy/Jackie France		
	Key Metrics:	**PIFU:**	**3.25%**	↑
		Outpatient Backlog:	**35,694**	↑
		A&G:	**10.01%**	↑
		A&G Response Times:		
		48hrs	**38.01%**	↑
		96hrs	**47.6%**	↑
		DNA Rate:	**6.35%**	↓
		Virtual Consultations	**21.88%**	↑
	Quality Impact Assessment (Yes/No):	Yes		

PROGRAMME HIGHLIGHT REPORT

Programme Development	
Key achievements (this reporting period)	**Key tasks/activities (next reporting period)**
• Further development on PIDS and Plans to align with 23/24 OPT Objectives and GIRFT • Support work commenced for the assessment of attend anywhere in preparation for the contract ending in March 24 and the need to look for an alternative solution due to no further funding being available **Cardiology Action Plan** • NLaG Cardiology Outpatient action plan created and agreed with colleagues at NLaG and HUTH. Plan is aimed at supporting the 25% reduction in follow ups.	• Final Drafts of Project Initiation Documents and Plans presented ready for approval at Board • Complete Trust Board Assurance Report for sign off by end of Sept, in response to Protecting and expanding elective capacity letter • Proposal on OP Follow-up Validation to be presented at Execs and TMB for approval. • Plan to be presented in response to Multiple Pathway Validation National Request **Cardiology Action Plan** • NLaG Cardiology Outpatient action plan implementation and commencement of actioning

OPD1 - GIRFT	
Key achievements (this reporting period)	**Key tasks/activities (next reporting period)**
PIFU • July's PIFU rate has increased slightly to 3.25% • Meeting for a demo of the PIFU Module supplied by Health Care Comms 27th July. **DNA** • July has seen a slight decrease in the DNA rate to 6.35% **Advice and Guidance** • Assurances given to NEL & NL practices (via e-RS User Group & PSCIG) that plans are now in place for BAU A&G responses. Practices encouraged to utilise A&G if ceased due to increased response times (demonstrated by decrease in performance). • Further discussion regarding utilising A&G for expediting patients. Meeting to be scheduled to further explore. **Pathway Redesign** • Communications drafted for mobilisation for Ultrasound Shoulder Guided Injection into both N & NE Lincs Primary Care. • Identified priority specialities to be addressed in 23/24 • Specialty Leads / Business Managers have commenced reviews and updates to their Directorate of Services (DoSs) as part of GIRFT, to continue throughout August. • Drafted timeline for MSK procurement for Northern Lincolnshire	**PIFU** • PM developing recommendations for specialities as part of GIRFT work. **DNA** • Data pack to be used to support deep dive analysis – postponed until September 23 **Advice & Guidance** • Organise meeting for NLAGs clinical leads, place and Primary Care leads for clinically led discussion re expedite patients. • Determine clinical appetite to develop A&G FAQs via PSCIG **Pathway Redesign** • Develop replacement shared care process for consideration - medicines and post-surgical procedures. Delayed from June - requires Lorenzo in place until new model can be implemented • Further meeting required for expedites and A&G – identify process for new patients. • Continue review of DoSs and update as advised by Specialty leads/Business Managers • Review infertility documentation against the DoS and referral criteria. North/North East Lincs pathways for infertility require aligning across North Lincolnshire. Family Services to update.

PROGRAMME HIGHLIGHT REPORT

• Met with Community Podiatry to discuss self-referral pathways – further work to identify systems and process. • Met with Audiology to discuss self-referral pathways - plan to develop in Q1 24/25 **GIRFT** • Common themes analysis in development by PM • GIRFT Action Plans shared with specialities to support planning. • Commence establishment of governance through GIRFT steering group	• Review OPT plans to ensure pathways match requirements of plan and GIRFT (from July) • Agree with WebV and dietetics discharges on long term supplement – ward nutrition pathway time period to be established and identify requirement for Community Dietetics. • Draft self-referral template for Podiatry. **GIRFT** • Meetings with specialities to further develop action plans, ensuring that allocated actions are covered by governance. • GIRFT updates and monitoring to be agreed

OPD2 - Connected Health Network Model (CHN)	
Key achievements (this reporting period)	**Key tasks/activities (next reporting period)**
• Meeting 4th July to discuss the documented proposed prescribing process with senior finance colleagues from primary and secondary care. Proposal was agreed in principle. NLaG finance are now awaiting confirmation of the agreement in writing from commissioners. Once received prescribing can be enabled on the new CHN S1 unit with relevant support and training provided. • There was strong support for the CHN model at the local Health and Care Partnership leadership meeting in July and CHN finance paper to be presented in August meeting. • Meridian PCN have received very positive patient feedback on the CHN rheumatology pilot. 60% feel the CHN service is better than a traditional OP appointment, 30% think it is the same. • Dr Shekhawat attended the rheumatology weekly meeting 26th July 2023 to discuss a possible pilot in North Lincs South PCN. Strong support from all clinicians at the meeting and the medicine directorate, for the pilot. • Dr Malik agreed monthly CHN session in job plan for diabetes/endocrinology CHN clinics in North Lincs • Consultation Summary Messaging has been successfully installed in the new CHN S1 unit and is now operational. Meetings with the existing EMIS practices currently using CHN S1 to confirm the process. All parties are satisfied with the solution Meeting on 25th July with information colleagues to progress development of reporting from the CHN S1 unit. There is now a live report (in test phase), available within Power BI community reports for CHN.	• CHN finance paper is due to be presented by Laura Whitton at the next local Health and Care Partnership leadership meeting on 10th August. • Cardiology Clinical Lead to undertake time and motion study on circa 25 Cons2Cons Cardiology Referrals. • Continue development of information BI reports to support management of CHN on new module. Outcome reports and data quality reports are due to be added in the next month. • Present RTT paper at Medicine Governance group on 23rd August. • Carry out evaluation of CHN. • Following support from Rheumatology meeting, NLaG to identify a Consultant to partner Dr Satpal. Aim for October'23 start date subject to funding. • Develop paper for submission to TMB on CHN evaluation, option appraisal and proposed plan for future roll-out

PROGRAMME HIGHLIGHT REPORT

OPD3 – Digital Solutions

Key achievements (this reporting period)	Key tasks/activities (next reporting period)
Digital Letters – Contracting and Business Case • Confirm no funding is available to take forward Diagnostic SMS reminders. **Digital Letters – Phase 2** • First batch of remaining Urology leaflets received and currently being configured. • Infertility eligibility questionnaire requirements confirmed, now building in eForms. • Patient Survey configuration work completed. **Digital Letters – Phase 3** • Completion of PID/Project Plan - established no system support until PAS go live. • Meetings taken place with Diagnostics systems team to review Northwick Park configuration documents. • Meeting taken place with Radiology senior management to advise work and support required for digital letters project. • Radiology prep commenced following Northwick Park meeting – Soliton system prep. **Other** • Review of 'Essential Information' sheet completed, currently being redesigned. • Electronic Fit notes – Project Initiation Request form completed and submitted to Digital Solutions Delivery Group for decision **Patient Knows Best** • Went live with Cardiology patients with OP Summaries and Discharge Summaries • Posters delivered to Outpatient Areas on all sites • No issues reported by end July • Programme Support Officer PEP out to advert • Drafted Deliverables and Outcome report for NHSE funding • Data Protection Impact Assessment updated **Project ORCHA** • Reworded Elective Care Toolkit to the Waiting Well and Beyond Toolkit • Agreed apps within the new Toolkit • New ORCHA Campaign Page now live - Waiting Well and Beyond • Completed ORCHA Comms Campaign Toolkit • Attended NLAG Patient Experience Group • Feedback on NLAG letter wording finalised • Final wording and approach for inclusion in Patient Letters at NLAG and HUTH agreed	**Digital Letters – Phase 2** • Bowel screening specific leaflet to be configured for inclusion digitally • Configuration of first batch of outstanding Urology leaflets completed and in digital comms • Testing of Infertility Eligibility questionnaire once build work completed • Patient Survey build to be completed by HCC **Digital Letters – Phase 3** • HCC external BI support proposal / plan to be received and assessed • Radiology Ultrasound letter reviewing and sectioning meeting arranged 1st August • Radiology CT letter reviewing and sectioning meeting arranged 16th August • Soliton letter sectioning work to commence • Radiology Nuclear Medicine initial discussions planned **Other** • 'Essential Information' sheet updated and submitted to HCC for digital inclusion • Electronic fit notes – discussion to be arranged with Project Manager, Web V, Systems Development Team and potentially HCC if approved at DSDG • Pre and post appointment questionnaires across all specialties continue to be compiled for next phase of Wayfinder project **Patient Knows Best** • Full roll out of OP Summaries and Discharge Letters – August 8th • Communication on Intranet Web Page with all users • Share business Cards in all OP clinics • Sign up patients - onboarding • Draft SOP for sensitive content **Project ORCHA** • Share Comms Campaign Toolkit with Trusts • Commence Clinical Engagement via email • Attend MDT/Business Meetings for secondary care awareness/training on ORCHA Pro/QR • Go live with PKB Links in the Library section • Get Letter wording live across both Trusts • Compile Lesson Learnt Report • Schedule handover of outstanding activities (August is Project Managers last month due to 6-month Fixed Term Contract)

PROGRAMME HIGHLIGHT REPORT

• Decision made to discontinue poster and notecard workstream due to lack of funding • Generated QR Code Sheet for Secondary Care Referrals • Created a Waiting Well Toolkit folder for Pro Account users • Collated list of clinicians and other staff to engage across four pathways in two trusts **Project Wayfinder** • Phase 2 Governance review including DPIA review on 17th July • Background work for patient questionnaires has commenced **Patient Portals** • Project discussions for allocation of funding to support developments to patient portal, including clarification around potential duplication costings in licensing. • Project governance identified • First round of recruitment commenced • Development has commenced on the Patient Engagement Portal Work Plan, for spending the £153k Allocated to NLAG	• Create PKB Links and liaise with PKB Specialty Teams to upload them • Generate Links and QR Codes for Secondary Care Referrals (Pro Accounts) once ECT is agreed **Project Wayfinder** • Background work for patient questionnaires to continue • Closure report to be completed for Phase 1 and sign off to be gained **Patient Portals** • Project discussions ongoing for clarification around potential duplication costings in licensing. • Establish Project Governance in form of Highlight report monthly to N3i/NHSE • Recruitment round to be repeated following confirmation of 12month funding for post • Work plan to be drafted for confirmed Patient Engagement Portal funding including recruitment plans

OPD4 – Validation (New & Follow Up)	
Key achievements (this reporting period)	**Key tasks/activities (next reporting period)**
• Establish Validation reporting with Project manager **Validation of New Out-Patients – 12 weeks + (with no appointment booked)** • 4,180 patients contacted • Responses received so far – 1817 via Envoy, 5 via email, 120 via phone, 1169 responses received from Trust initiated calls • Percentage of cancellations from responses to date – 9% **OPS Follow Up Validation** • Initial meet with ENT completed, agreed as pilot specialty • Process drafted • Exclusions being discussed within ENT Specialty at clinical level • Initial meet with Paediatrics completed • Meeting required with Patient Services Team AGM and Family Services Division AGM to discuss clinical engagement and exclusions	• Updates on activities next month now reporting has been agreed **Validation of New Out-Patients – 12 weeks + (with no appointment booked)** • Rolling monthly programme in place

PROGRAMME HIGHLIGHT REPORT

Progress against key deliverables			
Deliverable	**Agreed delivery date**	**On/off track**	**Comment**
Virtual Consultations	March 2024	**Off Track**	VCs have decreased to 20.18% and we have under delivered the local ICS target of 25% and lower than Trust target of 32%. This will continue to decrease as we continue to reduce our follow-up activity
Outpatient Activity reduction by 25% compared to 19/20 baseline data **Reduction in Follow-up Waiting List to enable reduced activity**	March 2024	**Off Track**	NLAG is the only Trust in HNY to deliver on the reduction in OP activity target (operational plan) (June data - Planned reduction - 16,769 – Actual Reduction -15,151) M4 Outpatient follow up backlog has increased to 35,694, circa 1.2k patients on M3 23 and 5k pts higher than July 22 Data packs in development to support deliverables
OPD 1 – Clinical pathway re-design	March 2024	**On Track**	GIRFT pathway work is in development
OPD1 – PIFU	March 2024	**Within Plan**	No target set for PIFU in the 23/24 Operational Plan, although Trust internal target remains at 5% There has been an increase to 3.25% in M4. We remain comparable to other Trusts in HNY and HNY are comparable to other ICB's Top 3 are Comm Paeds at 12.90%, Breast Surgery is 10.83%, Gastro at 11.54%. Bottom 3 are 0.29% Cardiology, 0.56% Gen Surgery and 0.67% for Gen Medicine
OPD 1 – Referral Optimisation (A&G/Specialist Advice)	March 2024	**Within Plan**	No target set for Referral Optimisation in the 23/24 Operational Plan, although Trust internal target remains at 16%. In line with national reporting we are ahead of target as this reports all referrals managed via a RAS A&G requests have increased to 10.01% Response times for 48 and 96hrs have increased to 31.09% and 41.74%
OPD 2 – CHN Model –North East Lincolnshire	March 2023	**On Track**	5 out of 5 NEL PCNs established
OPD 2 – CHN Model – North Lincolnshire	October 2022	**Off Track**	3 out of 4 NL PCNs established, West PCN delayed - subject to funding
OPD 2 – CHN Model – East Riding	June 2022	**On Track**	1 out of 1 East Riding
OPD3 – Digital Patient Letters – Phase 3	March 2024	**On Track**	PEP funding has been confirmed to finance digital resource –awaiting on external support offer to be agreed from HCC
OPD 3 – PKB Trust wide roll out	March 24	**On Track**	PKB Roll-out Phase 1 completed, Phase 2 scheduled for 8th August

PROGRAMME HIGHLIGHT REPORT

Risks and Issues		
Risk/Issue	**Description**	**Mitigation strategy**
Risk		
Programme - Clinical Capacity	There is a risk that primary and secondary care clinical staff do not have capacity to engage with changing practice in how outpatient services are delivered. This may result in the organisation being unable to deliver the National and system targets	Engage flexibly to maximise opportunities with clinical colleagues. IP and system flow significantly high and non-essential meetings cancelled
CHN	There is a risk to governance regarding reporting and oversight of patients as RTT rules are not fully applied to patients under the CHN model of care. Intensive support team have identified CHN patients must be monitored under RTT rules as CHN is an interface service.	Project Manager presenting governance paper and mapping process at Medicine Governance Group 23rd August. The new Sys1 CHN unit provides oversight of patients within CHN. The information services reporting from this module is currently being developed. Freshney Pelham PCN has not yet migrated on to SyS1 unit. However, dual data entry of all CHN pts continues on PAS until agreed otherwise
Digital Workstream	There is a risk of delays to digital workstreams due to capacity within the digital services teams and the Patient Services Training Team due to the ongoing work to support the implementation of the new PAS	Development team to pause any additional work during Feb and March. Will complete ongoing work for phase 2 of digital letters project. PKB on hold
25% Reduction in Out-Patient Follow-up Activity	The data reporting to identify the ask is still in development. Initial investigation suggests this is above 25% in some specialties. There will need to be radical change to reduce activity within the remaining timeframe	Reporting has been escalated. Options to look at specialty wide patient validation to help reduce follow-up waiting lists by March whilst working in parallel on the transformation change to sustain reduction and reducing the activity
Issues		
Connected Health Network	Current contracting arrangements do not cover the model being developed	Regional teams unable to support with future commissioning and this is being picked up at system level. DDOF has instigated contracting discussions.
Connected Health Network (CHN)	There is no commissioning agreement for funding of the CHN model of care now the pump prime NHSE funding expires in 2022/23, due to no provision for carry over. This funding provides for circa 450 clinics and supports further roll-out of the model.	CHN identified as a key enabler as part of ICS elective recovery strategy. Model and approach syncs with recently published GIRFT clinically led OP Transformation guidance. Financing models are being developed with commissioners and contracting experts.
PIFU Targets	At month 4 the internal PIFU target of 5% is not being achieved as planned, there has been a gradual month on month increase of PIFU activity	Clinical leads fully engaged with speciality leads to encourage the use of PIFU in pathways where clinically appropriate. PM to develop Specialty packs to support usage increase
PM Resource	The programme has had limited Programme Management support since April, which has impacted progress and focus in some areas.	Some temporary PM resource has been provided to the Programme, but as of the end of July this has ceased. Leaving the programme without a dedicated Progamme Manager

PROGRAMME HIGHLIGHT REPORT

Escalations		
Escalation	**Description**	**Agreed next Steps**
Pathways	The legacy data for Barrett's patients was reported as completed in June with no issues. However in July an incident has been raised and it is now apparent that there are 1676 patients are still awaiting clinical validation.	A new legacy completion date of the 30th September has been provided.

Benefits realisation: key measures/KPIs – see embedded dashboard	
2022-23 Outpatient Transformation Das	**In July 2023, the overdue follow up backlog stands at 35,694 – an increase of circa 1,221 pts comparative with previous month (June 23) and circa 5k pts higher than July 2022.** **The DNA rate for July 2023 has decreased to 6.85% from 6.49%**

RAG status explained

Amber – Medium risk

Colour	Delivery Risk	Description			Action
RED	High Risk	• Delays in milestone and/or reduced capacity/capability present significant risk to delivery. • Related KPIs/benefits off track	AND	• No clear plans for remedial action to recover the position *OR* • Mitigating actions not impacting on performance	Escalation required to Executive Owner and Delivery Group immediately.
AMBER	Medium Risk	• Delays in milestone and/or reduced capacity/capability present significant risk to delivery. • Related KPIs/benefits off track	AND	• Plans in place for remedial actions to recover progress	Delivery Group should be notified using a Highlight Report or equivalent. Depending on significance, Executive Owner should be notified of concerns.
GREEN	Low Risk	• No delays or constraints impacting on milestone delivery. • Related KPIs achieving target.			No action required.

Northern Lincolnshire and Goole NHS Foundation Trust

Chief Operations Directorate
Patient Services Department

Trust-wide
Patient Validation - Outpatient Follow-up

Reference:	
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Author / Contact:	Jackie France, Associate Director, Patient Services

Background

The Operating Planning Guidance for 2023/24 requires Trusts to deliver a 25% reduction in their Out-Patient (non- procedure) activity, against the 2019/20 baseline. The impact of this is that from April 2024 Trusts will only be paid for 75% of their Outpatient (non-procedure) follow-up activity.

To compensate for this, operational plans have already converted 25% of follow-up activity into new activity, unless we can reduce the number of patients requiring a routine follow-up appointment, follow-up waiting lists will continue to increase. At the present time, we have a number of specialties where patients are overdue their appointment due date by 60+weeks and a potential for clinical harm.

It is recognised that some specialties have already undertaken significant transformational work to reduce their follow-ups, which includes; reducing new:follow-up ratios in line with national averages, introducing patient initiated follow-up (PIFU), introducing new models of care (Connected Health Network), adopting GIFRT recommendations. However, the stark reality is that to deliver 25%, radical change is required within the next 6-8 months.

PIFU was implemented around 2 years ago and is an established process within NLAG, there is a robust governance process in place which tracks all patients added to a PIFU pathway, with a flagged date for review. Patients are provided with a leaflet at the point they are put on a PIFU patient, this describing what PIFU is, the process and details for contacting the service to initiate an appointment. Patients who initiate an appointment are referred to the service to triage and appoint as appropriate. Although we have been encouraging the use of this, adoption has been slow, with the Trust reporting 3.25% of patients on a PIFU as at the end of July 2023., against a target of 5%.

An an acute Provider, we need to achieve a position whereby the follow up waiting list reflects only those patients who need acute follow up care, it is critical that we take action to address this.

Proposal

To achieve a rapid reduction in a short space of time requires us to adopt a tactical approach to deliver the short term objective whilst in parallel delivering transformation change which allows us to sustain a manageable follow-up list.

It is therefore proposed that we focus attention on 2 key aims for the remainder of this year;

- To adopt PIFU at an accelerated rate across all specialties – this provides a “safe” alternative to routine follow-up as it still enables a review of the patient to take place, but this is managed outwith the normal follow-up clinic. Whilst the patient is managed on a PIFU they are not classed as “waiting for a follow-up appointment” and therefore are not counted in the same way *(Appendix C provides a guide to using PIFU in outpatient follow-up management)*
- To validate all patients (with pre-identified exclusions) on the follow-up waiting list, though a contact letter giving the patient a variety of options. As per the national definition “*validation must include contact with the patient or carer but can be via text, eForm, software application used to conduct an online conversation(chatbox). Where these are not available or where patients’ needs indicate, a letter or a phone call to the patient to assess their wishes can be used”*

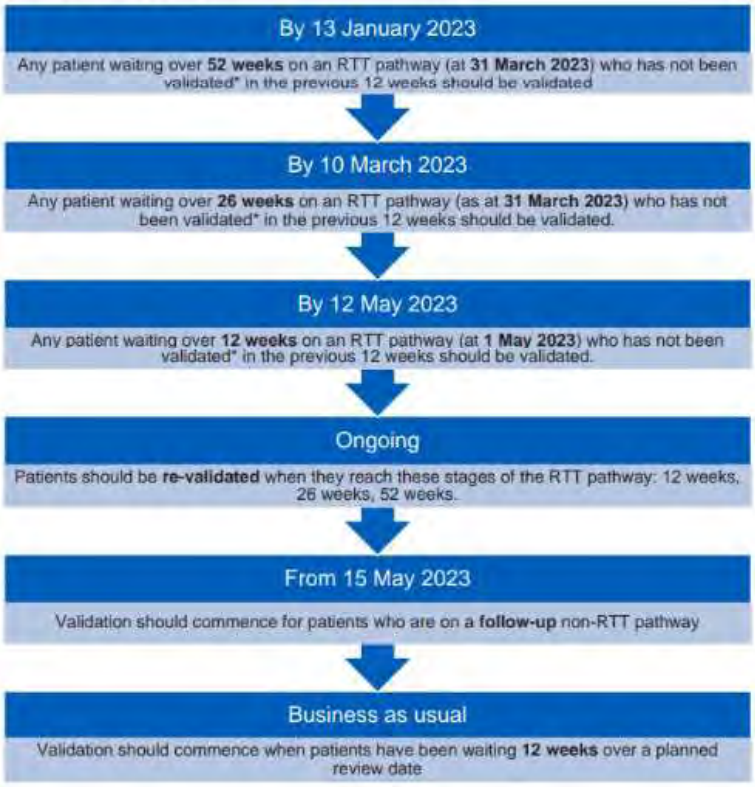
It is accepted that there will be some patients who do not qualify for PIFU or validation, however, the purpose of this exercise is to ensure those patients that are on the waiting list for follow-up require continued specialised input in an acute setting

In December 2022 the national team published guidance to providers on validating their waiting lists *(B2121ii validation toolkit and guidance – Appendix A refers*). There is an expectation for Providers to have commenced validation for patients who are on a follow up non-RTT pathway from May 2023. Although we have continued to validate follow-up lists as part of our routine work, due to the volume, this is having minimal impact

Validation is well established as one of the key elements of the national elective recovery plan. NLAG, along with other Providers have seen positive results from validating their admitted RTT lists and new patients waiting over 12wks for their appointment. NLAG has seen circa 10% of patients coming off the new waiting list as having been treated elsewhere or no longer requiring an appointment with a specialist.

*Validation must include contact with the patient or carer but can be via text, eForm, software application used to conduct an online conversation (chatbot). Where these are not available or where patients' needs indicate, a letter or a phone call to the patient to assess their wishes can be used.

Figure 3: Timings for validation



APPROACH FOR VALIDATION

The following criteria will be adopted for all specialties;

- All patients who have been added to the follow-up waiting list longer than 3 months of the validation start date, with no appointment booked.
- By the end of September 2023 - each specialty in association with their business manager to;
    - identify the patients/pathways they wish to be excluded and the criteria to be used to identify the patients on the waiting list; ie., patients with a particular diagnosis code, or specific clinic codes, planned diagnostics
    - agree any changes to the set of options to be included in the patient letter (a copy of the letter to be sent can be found at Appendix B)

- On a rolling programme between October – February – all patients will be contacted via a text message, requesting them to login to a portal and choose one of the options provided
- Patients who do not respond within 48hrs will be sent a reminder
- Patients who do not respond within the following 48hrs or who have opted out of digital letters will be posted a letter requesting them to contact the hospital with their chosen option
- Patients who do not respond to the posted letter within 14 days will be contacted by phone on 3 separate occasions.
- All attempts will be made to contact the patient, including a full demographic check with the GP
- In the event that we are unable to contact a patient, the patient will be sent a letter, cc to the GP, advising them that we have been unable to contact and if we don't hear from them by (3 weeks hence) we will discharge to the care of the GP.
- The Patient Services contact centre will act as the point of contact for all patients.
- The Patient Services team will manage the above process and update the PAS to reflect any changes to the patients follow-up status
- On request, specialties can be provided with a list of patients and the options they have chosen, prior to any action being taken on the patient record
- Contacts within each specialty/division will be established for patient queries/concerns.

ENT have opted to be the first pilot specialty, we have identified their criteria for exclusion and are currently finalising the process, the plan is to commence validation from late September.

Impact

Of doing Nothing

- If we continue to in our current state and activity continues as predicted in operational plans we will be operating at a loss as we are not paid for follow-up activity over and above 75%
- If we convert follow-up activity to new and don't tackle the follow-up waiting list we will continue to see a rapid increase in the number of patients overdue their follow-up appointment.
- Although we operate a risk stratification process, we are currently creating a backlog of patients overdue and all exceeding their risk stratification status. In some specialties there are patients who are 60+weeks overdue their follow-up appointment. This is a significant risk for the Trust in terms of clinical harm and is was a significant contributor to the Section 31 notice served by the CQC in 2019.

Benefits

- It gives confidence in relation to accuracy of waiting lists, that all patients on a waiting list need to be there, and it ensures the most efficient use of staff time and resources
- Filtering of patients through digital validation support, allows clinicians to focus on those patients who require further investigation
- Shared responsibility with the patient, patients overdue their follow-up could be experiencing symptoms, but will be waiting for us to contact them. PIFU gives some responsibility to the patient to make contact with us.
- PIFU has been in place for 2 years plus, during that time, we have seen between 1-3% of patients make contact with us before their review date
- Reduces potential of clinical harm
- Ability to operate within our financial envelope

Consequences and Risks

There will be a cost associated with contacting each patient.
Cost of Digital message 10p per patient
Cost of posted letter 54p (if required)

There will be cost to patient services of 2 x B2 staff for 10 months to manage the process and the outcomes £ £45,725. It is accepted that due to the current financial position, this cost will need to be absorbed.

It is recognised that the Information Team is within a freeze period for new reports, due to the implementing Lorenzo go live and the Data Warehouse, however, their input is a critical requirement for this work to go ahead.

There is a risk that the migration to Lorenzo PAS occurs within this period which could have a serious impact on the measuring the outcome, as data is migrated from the current PAS over to Lorenzo.

In Conclusion (following discussion at OMG)

- There are a variety of ways to manage out-patient follows, patient validation is one way of tacking these in a suite of options including PIFU, desktop reviews, clinical validation.

- Following a detailed discussion at OMG (Operational Management Group) with active Divisional Medical Director engagement, it was agreed that:

- It was unacceptable to do nothing and maintain and ever-increasing cohort of overdue patients waiting a long time without any intervention for the trust to manage risk.

- The first principle is to implement zero tolerance to follow ups, unless there is a clinical reason for the patient to be seen.

- This process will be monitored closely at specialty level to enable the opportunity for DMDs/clinical leads to manage areas of concern with their clinical colleagues.

- Desktop reviews of patient records do not attract payment. However, Divisions can undertake them if the net impact is of value. i.e in one session 50 patients are desktop reviewed and a considerable number discharged or transferred to PIFU. Divisions need to demonstrate activity, clinical and financial benefits to the respective ACOO and DFM before this is implemented.

- DMDs, working with their Clinical leads will identify any specific cohorts suitable for PIFU without the need for desktop reviews.

Next Steps

Shared at OMG for support and agreement
Submitted to TMB for approval.
Shared at MAC/HCC – for information, rather than consultation.
Shared at Primary/Secondary Care Interface Group for support and agreement

Appendix A

National Validation Toolkit and Guidance – December 2022

B2121ii-validation-to
olkit-and-guidance-de

Appendix B

Copy of validation letter (there is some flexibility to make the letter more specialty specific)

Ref: **Patients NHS number**

Acute Trust Name
Team/Directorate
Address 1
Address 2
Address 3
Postcode
Telephone
Email address
Date

Recipient's name

Address 1
Address 2
Address 3
Postcode
Private and Confidential

Dear [**Patients Name]**

Our records show that you are currently waiting for an outpatient follow up appointment with Northern Lincolnshire and Goole NHS Foundation Trust,

Firstly, we acknowledge it has been some time since you were placed on the *[specialty name]* waiting list and we would like to apologise sincerely for any delays. You will likely be aware of the pressure which the COVID-19 pandemic has placed on NHS services, and we are still recovering from this.

One regrettable impact of this is that patients are experiencing additional delays in the time it would ordinarily take to be seen. We are working to recover as quickly and as safely as we can, but it is also important that we understand our patients' position and are able to direct our resources appropriately.

We know things can change over time, so we are writing to confirm whether your situation has changed since being placed on the follow-up waiting list and ask you to confirm whether you still need an appointment, by completing the below questionnaire.

For patients who identify themselves to us as still requiring an appointment (option 3), you will remain on our outpatient follow-up waiting list and will be contacted as soon as we are able to offer you an appointment date.

Please note you may be contacted again separately if you are on a different waiting list with another department within Northern Lincolnshire and Goole NHS Foundation Trust.

We look forward to hearing from you.

Yours sincerely

Chief Medical Officer

Please select one of the following options:

1. You are happy for you/your child to be discharged back to the care of your GP. Should your symptoms reoccur, your GP is able to make a re-referral back into the service at any time.
2. You/your child wish to remain on the waiting list but are happy to be placed on a patient-initiated follow-up and you will contact the hospital when you need an appointment, rather than be sent a routine appointment. *(a link to a PIFU leaflet will be provided with the letter, explaining the process and details for contacting the hospital, should the patient wish to initiate an appointment)*
3. You/your child still require a further appointment and wish to remain on the waiting list.
4. You/your child's symptoms are more severe, and you wish to be seen sooner.

Appendix C

MAC-HCC PIFU Presentation_July23 v

Presentation to Medical Advisory Committee/Hospital Consultant Committee at the July 2023 meeting

Appendix D

Case Studies

UHP - Open Appointment Validati

University Hospitals, Plymouth – successful pilot in Orthopaedics, looking to implement in Urology next, then progress to all specialties

https://future.nhs.uk/gf2.ti/f/796802/162207685.1/PDF/-/Validation%20-%20Review%20of%20Non-RTT%20Follow%20Up%20-%20FAQ%20v1.0.pdf

https://future.nhs.uk/OutpatientTransformation/view?objectId=153700837

Case studies - 25% fup reduction - May 2

Although there is lots of presentations of Trust who have undertaken validation on follow-up patients, there is limited evidence in the form of case studies that can be shared.

Both numerical and colour keys are to be used in the RAG rating. If target dates are changed this must be shown using ~~strikethrough~~ so that the original date is still visible.

RAG Status Key:	5	Complete	4	On Track	3	Some Delay – expected to be completed as planned	2	Significant Delay – unlikely to be completed as planned	1	Not yet commenced

NLAG Winter Action Plan 2021/2022

NLAG Winter Action Plan 2023/2024 - Shortlist

To reduce the impact of adverse weather, increased infections, staff sickness and other variables may have on patient care.

1. This document sets out a prioritised set of actions/initiatives that NLAG need to complete to manage the seasonal challenges presented by Winter 2023/24.
2. This plan must include seasonal requirements only and not BAU shortfalls in service capacity.
3. The owner of the action/initiative is responsible for timely delivery, in addition to providing updates on progress and risks to implementation.
4. Updates need to be emailed to gary.burroughs1@nhs.net at least a day before the meeting to enable value-adding conversations at the meeting.
5. Actions / initiatives need to be costed at a high level initially for planning purposes and if prioritised, detailed costing and project plans / Gannt charts need to be provided as assurance to the Winter Planning Group.
6. The group will meet fortnightly to plan and oversee delivery of the Winter Plan from July 2023 to February 2024. As required the frequency of meetings will increased/decreased.
7. Attendance to the meeting will be recorded for audit and Governance purposes.

No	Priority	Service area / initiative	Description	Actions	Winter enhancement (£) requested	Risk to delivery	Progress Updates	Time Scale	Start Date	Costs/Funding	Source of Funding	Risk if not delivered	Expected date - completion	Status on progress	Owner
	Based on -Patient Safety -Clinical Outcomes -Patient Flow											3 High, 2 Medium, 1 Low			
1.0	High	**Community & Therapies**	North Lincolnshire Home Care Service >85% occupancy	Continue to provide a NL Home Care service to assist with patient flow and accelerate discharge for pathway 1 patients and promotion of these pathways as part of daily ops	Yes - Funding agreed with NL PLACE	Risk for non delivery would mean further delayed discharges and the ability to avoid hospital admissions would not be met	Homecare service for NL in place up to 15 x patients on P1 * Agreement from NL PLACE for non recurrent additional funds to support winter Additional funding would mean temporary staffing extension to support further discharges during winter	Commenced	Oct-23	£35k - funding agreed	ICS Winter funding/BCF additional funding	2	In Place	In Progress	Claire Shipley
2.0	High	**Community & Therapies**	North Lincolnshire Virtual Ward >85% occupancy	Further development of the virtual ward model moving into a push model and step up from community to support hospital admission avoidance and promotion of these pathways as part of daily ops	No	Risk for non delivery would mean further delayed discharges and the ability to avoid hospital admissions would not be met	Virtual ward for frailty & ARI in place, further actions to support winter include: * Move to a push model for acute patients * Develop and commence step up model from community to support with hospital avoidance * Monitoring of utilisation and ensuring all wards discuss at board rounds	Oct-23	Oct-23	In Place	ICS	2	In place and increasing capacity Nov 2023	In Progress	Claire Shipley
3.0	High	**Community & Therapies**	Northern Lincolnshire Extension of OPAT Service >85% occupancy	Further develop NL OPAT Service & promotion of these pathways as part of daily ops	No	Risk for non delivery would mean further delayed discharges and ability to avoid hospital admissions would not be met	OPAT Service model for NL to accomadate 10 patients, actions to develop the model include: * OPAT Nursing team established, 7 days per week * SOP further development to support new service model * Agreed NL Location for OP model	Sep-23	Sep-23	In Place	ICS	2	Nov-23	In Progress	Claire Shipley
4.0	High	**Community & Therapies**	NL 2 Urgent Care Response & SPA Developments	Continue to develiver the 2 UCR Model across North Lincolnshire and work with the ambulance service to transfer calls to avoid hospital admission	No	Risk for non delivery would mean ability to avoid hospital admissions would not be met	Working with both ambulance services and primary care/care homes regarding access to SPA	Sep-23	Sep-23	In Place	ICS	2	In Place	In Progress	Claire Shipley
5.0	High	**Family Services**	Development of Maternity Triage Model	Implement a fully operational maternity triage service across the whole of the maternity service in NLAG, that utilises a nationally recognised Triage Model.	Yes - ICS Funding - discussions underway	Risk for non delivery would mean further delayed discharges and the ability to avoid hospital admissions would not be met	* implementation of a telephone triage single point of access which follows the BSOTS model * Antenatal Day Units (ADU) and community teams in reduced phone calls by 20hrs per week on average releasing time to care back to frontline teams * full implementation of the BSOTS model which following the above telephone triage of a patient, if it is deemed they need to be assessed face to face. This extensive service redesign, including changes to staff roles and the physical footprint of our wards and areas, although fundamentally the service will be doing the same amount of work but in a different way. Go live is planned for Monday 16th October 2023	Oct-23	Oct-23	In Place	ICS	2	9th Oct 2023	In Progress	Claire Shipley
6.0	High	**Family Services**	Gynaecology integrated pathway implementation (IAAU/wards)	Development across SGH & DPOW sites of integrated pathways for gynaecology services including SDEC/IAAU	No	Pathway work commenced however dependant on IAAU/SDEC building work completion to initiate moves	* Working group established * Pathway work underway working through demand model * Workforce model to support pathway development * All pathway and workforce development work to be finalised ready for IAAU opening	TBC	TBC	Nil	N/A	2	Dec 23/Jan 24 DPOW May 23 SGH	In Progress	Claire Shipley
7.0	High	**Family Services**	Development of Paediatric hospital at home model for NL & NEL	To implement the model at SGH as already established in Grimsby	No	Inpatient on patient flow through ED, PAU and in-patient ward	Job descriptions awaiting approval or permission to advertise with indictative banding. Recruit the nursing staff into post Training to be delivered as required Promote the service to primary care, ED etc... Ensure all equipment and stores available	Oct-23	Oct-23	In Place	N/A as agreed with the approval of the business case	2	01/12/2023	In progress	Claire Shipley
8.0	High	**Family Services**	Paediatric middle grade for SGH & DPOW to support ED assessment during winter demand	Funding to support additional middle grade to support ED paediatric assessment	Yes - submitted through Business planning but not approved	Impact flow in ED regarding response times of paediatrics team.	In discussion	Oct-23	Oct-23	166k - Gone through Busines planning not supported for 2023/24	TBC	2	31st March 24	In progress	Claire Shipley
9.0	High	**Family Services**	Surge of respiratory presentations RSV peak expected in Nov and Flu peak expected in Jan	Palivizubab vaccination for vunerable babies to be administered Staff flu vaccination programmme Purchase air filters at £800 each x 10 Refresh training on use of specific respiratory support equipment Co-hort flow chart to be adhered to Promote admission and early discharge with H@H service	Yes - £8k required	Impact on patient flow	Palivizubab vaccines awaiting national guidance Need agreement to purchase the air filter units All other elements in progress	Oct-23	Oct-23	£8k - Discussions progressing	TBC	2	Oct-23	In progress	Claire Shipley
10.0	High	**Family Services**	Measles outbreak	Staff training on identifying measles and the management of All staff to be fit mask tested Full PPE including visor to be worn in all suspected and confirmed cases Pateints need to be isolated in a single ventilated cubicle Staff vaccination status to be checked, if no record, for screening and proceed to vaccine if not covered Use of the air filter units if purchased	No	Impact on bed capacity when requiring cubicles Staff sickness if off with measles cross infection to other patients	Vaccination status is being scoped and working with Occupational Health to immunise those staff who need it Fit mask testing to start asap	Oct-23	Sep-23	as above for the Repairs	TBC	2	Dec-23	In progress	Claire Shipley
11.0		**Family Services**	Safe use of the fastrack service from ED, and ensuring adult patients are not being cared for in the paediatric bay	Ensure fastrack pathway is updated, agreed and shared across all relevant divisions Ensure staff are aware of the pathway and if initiated it is logged on the correct documentation Ullysses to be completed if adult patients are using patient cubicles in ED or the resus bay.	No	Impact on patient flow through PAU Inappropiate attendances to PAU	Fastrack pathway is being reviewed by the medical team.	Oct-23	Sep-23	None	N/A	2	Ongoing	In progress	Claire Shipley
1.0	Patient Flow	**Corporate/Trustwide (Wendy Millard/Matt Overton)**	Use of Redirooms to increase isolation facilities to the maximum	Currently reviewing process for management and storage. Meeting arranged with Medical engineering.	Yes - £2068	Would see reduction in bed capacity with use of redirooms but would avoid whole bay closure with additional isolation beds available	Acceptable number of Redirooms. Refresher training on use provided Sep-23. Repairs required for several Rediroom, costing available for DPOW awaiting payment authorisation	Oct-23	Sep-23	£2068- Discussions progressing	?	2	Oct-23	in progress	Linda Barker
2.0	Patient Safety	**Corporate Trustwide**	FIT Testing - managers/leads to ensure staff FIT tested as a priority prior to winter	To identify lead and delivery of FIT testing Practice development team will support with train the trainer sessions for FIT testing	No	No identified training lead for FIT testing.	FIT Testers available within Services/Divisions. CPD Team to provide refresher traing. Progress/Plan requested . Lead to be established for future traing	Oct-23	Sep-23	N/A	N/A	2	Oct-23	in progress	Linda Barker
3.0	Patient Safety	**Corporate/Trustwide (Associate Chief Nurses)**	HEPA filters	Filters to be replaced in all HEPA Filters	No	If filters not replaced inadequate HEPA filtration	All HEPA filter have had filters replaced in preparation for winter	Oct-23	Sep-23	N/A	N/A	2	Sep-23	in progress	Linda Barker
4.0	Paient Flow	**Corporate Trustwide**	Multi-testing trigger information - to link n with medicine to discuss respiratory pathways	Medicine Division IPC & Flow Response Escalation Plan in place	No	No budget to provide rapid respiratory testing out of hours risk to patient flow	Medicine to confirm no change to plan	Oct-23	Sep-23	N/A	N/A	2		in progress	Jill Mill
5.0	Service Delivery	**Corporate/Trustwide (Wendy Millard)**	Infection Prevention potential staffing gaps due to recent retirements	Team reviewing budget and vacancies against staffing requirements. To prioritise service delivery	No	Unable to delivery full service if gaps in team. Increased on call requirement for senior team members	Plans to recruit Band 7 IPCN. Work load will be priorities over the winter period to ensure safe delivery of service. Utilise Bank Staff as necessary. On Call programme will be covered - duties to be reviewed with Chief Nurse	Oct-23	Sep-23	Budget already established	Budget already established	2		in progress	Linda Barker
1.0	Patient Flow	**Pharmacy - Clinical (Simon Priestley)**	Additional Pharmacy Technician support focussed on Discharge Lounges at both acute sites to aid patient flow. Following the MADE event funding was agreed at PLACE to recruit to these posts. Due to the time required to recruit funding was subsequently withdrawn (identified once posts recruited to). These posts help educate patients on discharge of correct usage of medication to prevent readmission and deliver the Discharge Medicine Service CQUIN.	Retain 2.0wte Band 5 (M-F) current over establishment position due to funding withdrawal.	No - Business case is required	Staff turnover impacts ability to maintain this. Any vacancies in the wider staff group means the discharge lounge support is at risk of being reduced to maintain the ward based clinical services.	Ability to maintain 1.0wte DPOW and 1.0wte SGH over establishment helps mitigate gaps due to staffing turnover and also help the service flex to increased demands / mitigate pharmacist vacancies. Recurrent funding to be sought in 24/25 business planning based on savings delivered through Discharge Medicines Service referrals and associated reduced admissions.	7 months	Sep-23	Maintained within current staffing underspend due to vacancies.	Outline Business Case to be developed to provide recurrent funding.	2	Apr-24	Staffing in place as over-established posts.	Simon Priestley
2.0	Clinical Outcomes	**Pharmacy - Ward Support (Simon Priestley)**	Additional ward based Pharmacy Support Workers to support movement of medicines and putting stock medicine deliveries away, reduce omitted doses, improve availability of medicines for discharge and reduce waste from re-supplies. Business case submitted as part of 23/24 business planning but not approved.	Recruit additional 4.00 wte Band 3 PSW.	Yes - £69858 Business Case submitted for 2023/24 but not approved	Supports ward based staff and removes some activities from the Nurses. Without additional investment, unable to increase activity.	No action until additional funding is approved.	7 months	Sep-23	69858 - not approved in 2023/24	Outline Business Case.	2	Apr-24	No Progress	Simon Priestley
1.0	Patient Safety	**Surgery Critical Care and Clinical Sciences - recovery staffing for critical care**	To support the delivery of critical care through winter pressures by allocating nursing staff to recovery to allow critical care support when pressures arise.	Agency staff to be used as and when needed.	Yes - £3,333 per site per 24 hour period.	Staff being recruited.	Awaiting decision	Oct-23		£3.3k per 24 hours period per site providing providing 2 registered nurses to support recovery	SCC Division	2	As soon as required as per agency request	In Progress	Debbie Bagley
6.4	Low - part of annual business planning process	**Medicine**	ED consultant overnight	Review of capacity versus demand and the drop in performance overnight highlights the requirement for a senior decision maker to be on site 24/7. This will be a higher priority within the new buildings due to the size of the space that is being covered and the requirement for leads for - Overall department (EPIC), Resus, Ambulance handover and Triage. A review of the current model against the requirements for the service is being produced to look at the financial implications of extra clinical staffing. 23/08/22 Simon and Jill to discuss	Yes - £292,800	Review of capacity versus demand and the drop in performance overnight highlights the requirement for a senior decision maker to be on site 24/7. This will be a higher priority within the new buildings due to the size of the space that is being covered and the requirement for leads for - Overall department (EPIC), Resus, Ambulance handover and Triage. A review of the current model against the requirements for the service is being produced to look at the financial implications of extra clinical staffing	x1 for each ED ; 0000-0800 at consultant agency rate 23/08/22 Through normal Business Planning.	whole year	Nov-22	£292,800	ED new build staffing model/ Ambulance handover targets	High -No improvement in ambulance handover OOH and flow with risk to quality of patient care	Nov-22	In Progress	AK/NG
2.0	Patient Safety	**SCC&CS - Critical Care Outreach Service**	Extend hours and staff numbers, even if fixed term to support ED and wards during winter with critically ill patients	Paper to be resubmitted for consideration by Finance leads.	Yes - £158,000 for 5 month period	Due to the number of acutely ill pts within the acute site increasing over a winter the approach required to manage this is to enhance the CCO team to ensure the pts are managed and proactive planning and treatment plans supported. Without this we run the risk to pts deteriorating and requiring a higher level of care. Lack of flow and back up within ED	This was part of business planning for 23/24 and one of the divisional high priorities. Through the deteriorating pt agenda it has been highlighted as a significant risk but currently no funding stream confirmed. **Advised to use underspend in nursing budget to cover Winter months with an addional Band 7 RN.**	TBC	Sep-23	Approx £159,000 for 5 month period	To utilise vacancy underspend to facilitate temporary increase in capcity for winter	3 - mitigated temporarily	Nov-23	In Progress	Debbie Bagley
1.0	High	**Medicine**	Consultant & CT at both sites on weekends for Resp specialty cover-inreach on weekdays and weekends/BH. Detail to be added once reviewed with Dr Yasso	Exploration of joint workforce of critical care and respiratory for weekend and B/H	Yes -	The risk exists every year. Inequity of service to patients who come in on a weekend . Delay in input / assessment creating patient safety risk whilst waiting for specialty in reach. Increase in 12 hr breaches in ED.Flow. Delay in care for NIV patients over a weekend. Complexity, acuity and numbers increase in winter - risk is there all year but remarkebly increases during winter.	**6 months** **Advised that Winter comes every year , therefore this needed to part of business planning demand and capacity analysis for 2023/24.**	Nov-23	tbc	(5 months / 22 weeks) costed at agency rate £67,200 per site = £134,400 TOTAL	Unfunded to be picked up though buiness planning process	3	Not started		Jill Mill

2.0	High	**Medicine**	Escalation / Winter Ward - Nursing	Have an agreed establishment to enable additional beds to be opened to manage acute bed pressures	Yes - £1,182,000	x1 30 bedded ward (or two 15 bedded areas on each site) (4+4;4+4;4+4) + CareNav & WM 2days (1x B7 ; 2x B6) assume RN at agency rate phased approach to nursing establishment to additional bed capacity to be agreed with CN	**4 months** **Advised that Winter comes every year , therfore this needs to part of business planning demand and capacity analysis for 2023/24.**			**£1,153,000 (for 5 months) staffing - would expect they need c £29,000 for nonpay = TOTAL £1,182,000**	**HIGH**	**3 - Not approved - overspend on budget**	**Not started**		**Jill Mill**
3.0	High	**Medicine**	Escalation / Winter Ward - Medical Staff	Have an agreed establishment to enable additional beds to be opened to manage acute bed pressures	Yes - £414,500	depends on beds to cover - cost is based on a 30 bedded ward (or two 15 bedded areas on each site) ; x2 cons/specialist x1 SpDR and x2 junior, all at agency rate	**4 months** **Advised that Winter comes every year , therfore this needs to part of business planning demand and capacity analysis for 2023/24.**			**(5 months / 22 weeks) costed at agency rate = £414,500**	**Moderate**	**2 - Not approved - overspend on budget**	**Not started**		**Jill Mill**
4.0	High	**Medicine**	Xmas/NY Bank Holiday - additional staff	Medicine to discuss contingencies to ensure satisfactory staff cover	Yes - £11,200	Consultant 9-5 & Resp Cons/MG 4 hours for 7 days. Based on previous winters Medicine are asked to put on the above. The bank holiday period this winter is a 4 day period and will need the level of cover in previous years. The GIM model will provide the level of cover required. The risk is Delay in input / assessment creating patient safety risk whilst waiting for specilaty in reach Increase in 12 hr breaches in ED. Flow. Delay in care for NIV patients over a weekend.		**Nov-23**		**£11,200 (7 days cost)**		**2 - Not approved - overspend on budget**			**Jill Mill**
5.0	High	**Medicine**	7 day twice daily review on IAAU / Short Stay. GIRFT six to fix recommendation	Acute Medical Unit (AMU) – twice daily review on AMU, 7-days per week which should consist of: - an initial structured face-to-face ward round (F2F WR) - followed by an afternoon board round (BR) and targeted face-to-face review or a structured second ward round (WR). - All ward rounds should have a registered nurse present who is cognisant about the patients to be reviewed. This recommendation also includes short stay ward(s) associated with the AMU. This is already in place in principle - to be made more robust by the Acute Medicine rota iplemented from October 2023.	The weekend cover will only be in place once the GIM model is in place. Delay in input / assessment creating patient safety risk whilst waiting for specilaty in reach Increase in 12 hr breaches in ED. Flow. Delay in care for NIV patients over a weekend.	The weekend cover will only be in place once the GIM model is in place. Delay in input / assessment creating patient safety risk whilst waiting for specilaty in reach Increase in 12 hr breaches in ED. Flow. Delay in care for NIV patients over a weekend.				**No Costs**		**2 - Not approved - overspend on budget**			**Jill Mill**
6.0	High	**Medicine**	daily BR and WR on Medical /Specialty wards/ GIRFT six to fix	Base Medical/Specialty Wards – a daily structured BR followed by a structured WR on weekdays for all patients unless it has been determined that the review would not affect the patient's care pathway. Need to implement consultant of the week model in GIM / Specialty Inpatient areas.	TBC	Delay in input / assessment creating patient safety risk whilst waiting for specilaty in reach Increase in 12 hr breaches in ED. Flow. Delay in care for NIV patients over a weekend.				**No Costs**		**2**			**Jill Mill**
7.0	High	**Medicine**	Improve hospital avoidance	Link Acute Frailty and SDEC with community response team and Diagnostics, VW for resp and frailty	TBC	Multiple stake holders		**whole year**	**ongoing**	**No Costs**		**2**		**In Progress**	**Jill Mill**
8.0	Medium	**Medicine**	GIM inpatient and integrated frailty model	GIM Team of senior clinical staff at each hospital site to ensure consistent consultant / senior decision maker care model with MDT approach to ensure daily reviews of all inpatients to support 7-day working/ inpatient care and meet national best practice standards and freeing up specialists to provide in-reach in acute and emergency areas. Supports creation of effective discharge model to enable patient flow; creates a team of senior clinical staff to fulfil national requirements for reduction in LoS. Support admission avoidance. To deliver frailty at the front door, linking with community frailty services providing proactive and reactive care as per national frailty strategy. Link in with peri-operative care with SCC patients	Yes	Continued patient flow issues. No improvement in performance (length of stay/mortality/hospital attendances/admission of frail/elderly. Unable to meet emergency care standards due to lack of regular senior decision making and specialty input. More attendances and unnecessary admission of frail and elderly patients leading to high risk in hospitals. Inability to meet BPT requirements. Increased reliance on locums at time of surge - impact of high costs. Continued requirement of yearly surge and winter pressure planning leading to increased spend and lack of continuity of care. Risk to health and well-being of staff due to continued organisation pressure at workplace - risk of burnout and loss of goodwill	Was part of 2023/24 Business planning process. Not approved. Alrternative route of funding being progressed.		**ongoing**	**GIM OBC (5 months PYE) = £312,900 ; assume non recruitment for agency = £535,000 Not approved - alternative route of funding progressed.**		**2**			**Jill Mill**

ACTION LOG & TRACKER 2020 / 2021

Northern Lincolnshire and Goole NHS Foundation Trust

MEETING NAME

Date, Month & Year

Minute Ref	Subject	Action Point	Lead Officer	Due Date	Progress	Outcome	Evidence Stored? (if required)

Key:

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

Kindness · Courage · Respect

					N
Attendees	**12/07/2022**	**26/07/2022**	**09/08/2022**	**23/08/2022**	**06/09/2022**
Ashy Shanker (Chair)	Attended	Attended	Attended	Attended	Attended
John Awuah	Attended	Attended	Absent	Absent	Absent
Maria Wingham	Attended	Attended	Attended	Attended	Attended
Matt Overton	Attended	Attended	Attended	Attended	Absent
Ashley Leggott	Attended	Attended	Attended	Attended	Attended
Hayley Ellson	Absent	Attended	Attended	Attended	Attended
Surgery					
Matt Thomas	Absent	Absent	Absent	Absent	Absent
Jenn Orton	Absent	Absent	Absent	Absent	Attended
Debbie Bagley	Absent	Absent	Absent	Absent	Absent
Peter O'Sullivan	Absent	Absent	Absent	Absent	Attended
Ruth Kent	Absent	Absent	Absent	Absent	Absent
Hayley Briggs	Absent	Absent	Absent	Absent	Absent
Victoria Marshall					
Medicine					
Asem Ali	Absent	Absent	Absent	Absent	Absent
Anwer Qureshi	Absent	Absent	Attended	Absent	Absent
Sarah Smyth	Attended	Absent	Absent	Absent	Attended
Simon Buckley	Absent	Absent	Absent	Attended	Absent
Jo Foster	Absent	Absent	Absent	Absent	Attended
Jill Mill	Absent	Absent	Attended	Attended	Attended
Family Services*					
Preeti Gandhi	Absent	Absent	Absent	Absent	Absent
Vijaya Hebbar	Absent	Absent	Attended	Attended	Absent
Nicki Chatterton	Absent	Absent	Absent	Absent	Attended
Umaima Aboushofa					Attended
Debbie Bray	Absent	Attended	Absent	Absent	Absent
Jane Warner	Absent	Absent	Absent	Absent	Absent
Community & Therapies*					
Ant Rosevear*	Attended	Attended	Absent	Absent	Attended
Iona Johnson*	Absent	Absent	Absent	Absent	Absent
Claire Shipley	Absent	Absent	Absent	Absent	Absent
Neveen Samuel	Absent	Absent	Absent	Absent	Absent
Donna Smith	Attended	Attended	Attended	Absent	Absent
Paula Broomhead	Absent	Absent	Absent	Absent	Absent
Pharmacy					
Simon Priestley	Attended	Absent	Attended	Absent	Absent
Rachael Craven	Attended	Attended	Absent	Attended	Attended
Pathlinks					
Nick Duckworth					Attended
Shakti Dave					
Estates					
Mark Edgar	Absent	Attended	Attended	Absent	Absent

Heidi Metcalf	Absent	Absent	Attended	Absent	Absent
Facilities					
Keith Fowler	Absent	Attended	Absent	Attended	Absent
Karl Cliff	Absent	Absent	Absent	Absent	Absent
Michelle Smith	Absent	Attended	Attended	Attended	Absent
James Lewis	Absent	Attended	Absent	Attended	Attended
Informatics					
Alex Bell	Attended				
Sarah Pashley		Attended	Attended	Attended	Attended
Medical Director's Office					
Kishore Sasapu	Absent	Absent	Absent	Absent	Absent
~~Angie Legge~~	Absent	Absent	Absent	Absent	Absent
Chief Nurse					
Jenny Hinchliffe	Absent	Absent	Absent	Absent	Absent
Linda Barker	Attended	Attended	Attended	Absent	Attended
Jayne Girdham				Attended	
Procurement					
Ivan Pannell					Attended
Finance					
Matt Clements	Attended	Attended	Absent	Attended	Attended
Brian Shipley	Absent	Absent	Absent	Absent	Absent
Chief Executive					
Katie Stubbins	Attended	Attended	Attended		Attended
Sarah Howson				Attended	
Workforce					
Nico Batinica					
Recruitment					
Dave Sprawker					
Occupational Health					
Helen Mumby					

LAG 22/23 Winter Planning Group - Attendance Sheet						
20/09/2022	04/10/2022	18/10/2022	01/11/2022	15/11/2022	29/11/2022	13/12/2022
Attended	Attended	Attended	Attended	Attended	Attended	
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03/01/2023	17/01/2023	31/01/2023	14/02/2023	28/02/2023

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Jonathan Lofthouse, Group Chief Executive
Contact Officer/Author	Wendy Booth, Interim Governance Advisor
Title of the Report	**Board Assurance Framework**
Purpose of the Report and Executive Summary (to include recommendations)	**Purpose** The report provides the current version of the Board Assurance Framework (BAF) as at Q2. **Recommendations** The Trust Board is asked to a) receive and review the BAF; b) note that, in respect of the risks to the achievement of the Trust's strategic objectives, there has been no movement in the overall risk ratings since the Q1 report; c) note plans for a Group Chief Executive led Risk & Assurance Group to be convened to identify any additional gaps in controls and assurances within the BAF and to agree and drive delivery of the planned actions. Similarly to identify, manage & mitigate the underpinning high rated risks on the Trust's risk register; d) note that a more detailed update will be provided in the Q3 report; e) note that, as part of the development of the group model, work will also be undertaken in due course to align the strategic objectives of the two trusts and, in turn, the BAF.
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	✓ 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)	Covered within the report	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Covered with the report	
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

Board Assurance Framework - 2023 / 24

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber and North Yorkshire (HNY) Integrated Care System (ICS) ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Board Assurance Framework - 2023 / 24

The Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided – low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red - Risk Score 15 - 25 (High)	

Risk Management

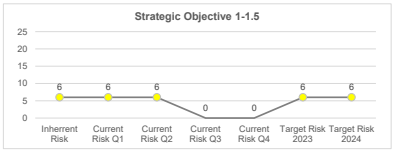
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using their feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Board Assurance Framework - 2023 / 24

Strategic Risk	High Level Risk Description and Risk Consequence / Likelihood Assessment	Risk Appetite	Owner	Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard 	Low	Chief Medical Officer and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy 	Low	Director of Strategic Development	Trust Board
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate 	Low	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care 	Low	Chief Information Officer	ARG / Trust Board
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope 	Low	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. 	Low	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities 	Moderate	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital 	Moderate	Director of Strategic Development	Trust Board
SO4	The risk that the Trust is not a good partner and collaborator 	Moderate	Director of Strategic Development	Trust Board
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	Chief Executive	WC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	3	3	3			3
Risk Rating Score	15	15	15			15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery & AHP Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group
- Vulnerabilities Group
- Incident control group chaired by NHSE to support Paediatric Audiology service.

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board, Learning from deaths annual and quarterly reports.
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- NICE Guidance Assurance Report to Q&SC
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- 15 Steps Accreditation Tool
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission
- Health Scrutiny Committees (Local Authority)

Planned Actions

Action	Quarter / Year	Assurance
Continue to develop metrics as data quality allows	Ongoing	Green
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q3 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements (we are in testing phase).- Completed	Q2 2023/23	Blue
Review and implement changes to Audiology Service	Q3 2023/24	Amber
15 steps Star Accreditation Programme commenced	Ongoing	Green
Delivery of the Quality Priorities for 2023/24 improving patient outcomes in 5 specific areas.	Q4 2023/24	Green
Delivery of the 2023/24 CQUIN schemes to improve quality of care for patients	Q4 2023/24	Green

Future Risks

- Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train.
- Transition from SI reporting framework to PSIRF approach.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:

No 2347 Deteriorating patient risk, Surgery = 15
No 2992 Lack of Changing Places facility at SGH = 16
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3114,Delays in children being reviewing in Paediatric Endocrine Service, may lead to failure to treat and manage the child's condition, leading to significant physical, mental issues, that could be life limiting = 20
No 3144, Paediatric Audiology Service, risk of harm to babies where hearing loss diagnosis is delayed or incorrect = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16 (Risk closed on Ulysses due to incorrect risk rating).
No 3196, Breast imaging service loss of capacity, will impact on delivery of 2ww service and delay patient pathways = 15
No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 9 (previously 15)
No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	4	4	4			3
Risk Rating Score	20	20	20			15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)
- Emergency Department and Medicine Specialties Quality & Safetly Groups
- Planning and Performance

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, A&E Delivery Board, MDT Business Meetings, System-wide Ambulance Handover Improvement Group, PCIP, PFIG, Planning and Performance
- Integrated Performance Report to Trust Board and Committees.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- ECIST & GIRFT Support Team Visits Scheduled for Nov 2023

Planned Actions

Action	Quarter / Year	Assurance
Progress with implementation of General Internal Medicine/Frailty Model and the link as a wider integrated frailty model across Northern Lincolnshire	Q2 2023/24	Yellow
	Q3 2023/24	
Review of clinical pathways linked to HAS programme 1 Humber Clinical Collaborative Programme (HCCP), seven specialties	Q2 2023/24	Amber
	Q3 2023/24	
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
		Blue
Develop divisional dashboards	Q2 2023/24	Yellow
	Q4 2023/24	Amber
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
	Q3 2023/24	
Completion of theatre refubishment programme	Q2 2023/24	Green
		Blue
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
	Q3 2023/24	Yellow
Implementation of Gynaecology Service Review including the support the Integrated Acute Assessment Unit (IAAU) model of care	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q3 2023/24	
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green
Cancer Transformation Programme with detailed improvement plans agreed with Divisions to deliver Best Practice timed pathways, plus joint pathway work with HUTH for cross-organisational elements of pathways	Q4 2024/25	Yellow

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.
Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2773, Lack of scanning capacity s leading to a risk of delayed diagnosis = 16
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3201, Clinical capacity within colposcopy = 15
No 3204, One year wait for new referrals to see a Consultant Paediatrician into the ADHD post diagnostis support service = 15
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15 20
No 3196, Breast Imaging Service loss of capacity = 15
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 3045, Medical Workforce Vacancies in Gastroenterolgy = 16
No 3114, Delays in Children being reviewed in DPOW Paediatric Endocrine Service = 20
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2775, Scunthorpe MRI scanner past end of 7 year life, lack of capital availability, impact will be reduced capacity to deliver scans for some cancer pathways = 20
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover) = 16

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Board Assurance Framework - 2023 / 24

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	4	4	4			4
Likelihood	3	3	3			2
Risk Rating	12	12	12			8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2023/24
- Humber and North Yorkshire Integrated Care System
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS)
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board (JDB)
- Committees in Common (CIC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC
- Humber and North Yorkshire Integrated Care System
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
CIC / NED / Governor reviews	Q4 2022/23	Blue
Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
Citizens Panel reviews	Q2 2023/24	Green
To undertake continuous process of stocktake and assurance reviews NHSE and Clinical Senate review	Q1 2023/24	Blue
Joint OSC - reviews	Q2 2023/24	Blue
To undertake continuous engagement process with public and staff	Q2 2023/24	Blue
Stakeholder Mapping	Q1 2023/24	Blue
Public Consultation (launched 24 Sept 23 - 5 Jan 24)	Q2/Q3 2023/24	Green
NHSE Gateway review (pre-consultation)	Q2 4 2023/24	Blue
ICB Executive Assurance Board / IC Board Approval	Q4 2023/24	Green
Final report from Clinical Senate review (due Q1)	Q1 2023/24	Blue
HAS Risk Workshop with ICB Executives (30 May 23)	Q1 2023/24	Blue
Case studies for each proposed service change	Q3 2023/24	Green
Public exhibition events	Q3 2023/24	Green
Decision Making Business Case	Q3/4 2023/24	Green
NHSE Gateway review (post-consultation)	Q4 2023/24	Green
Capital short form business case	Q4 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts
- Decoupling maternity/neonates from HAS programme (impact on paediatrics)

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning and Digital Strategy

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	4	4	4			4
Risk Rating	20	20	20			20

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 7 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Quarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Complete refurbishment of old SGH ED (completion end of Q43)	Q3 2023/24	Red
Complete BLM 23/24 programme	Q4 2023/24	Amber

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
•Grimsby 21% CIR of the BLM
•Goole 11% CIR of the BLM
•Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	3	3	3			3
Likelihood	2	2	2			2
Risk Rating	6	6	6			6

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 30 October 2023

Lead Committee: Audit, Risk and Governance Committee / Trust Board

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Positive Assurance:

- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Risk Moderate, High Assurance, 2023

Planned Actions

Action	Quarter / Year	Assurance
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Pkus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q4 2023/24	Green
IPR - further review of current the IPR to align with how the Group model evolves. (ie. adding digital, finance and estates)	Q4 2023/24	Green
Ongoing work to secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Depending when NHSE EPR digitisation funding is made available which is likely to be in Q3/Q4 2023/24	Q4 2023/24	Amber
The Data Warehouse with core activity data sets will be completed and running on the new platform by Feb 2024 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q4 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q2 2023/24	Blue
Continuing work on reconfiguration of local Digital Services functions to align to group structure increasing resilience and its ability to deliver strategic change.	Q4 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Achieve DSP Toolkit compliance - currently approaching standards.

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training (critical that operational managers across all divisions ensure that staff completed the training)

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership
- Approved funding to procure a Single Enterprise EPR, cloud hosted for the NLaG and HUTH.

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	4	4	4			4
Likelihood	3	3	3			2
Risk Rating	12	12	12			8

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 October 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group.
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- IPC protocols implemented including mask wearing and rapid testing process
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning (Strategic & Tactical Group)
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group
- Executive Led Bed Occupancy and Length of Stay Review

Assurance (internal & external)

Internal:

- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP, Strategic & Tactical Group, Emergency Preparedness, Resilience and Response Steering Group, Bank Holiday Planning Group, Executive Led Bed Occupancy and Length of Stay Review

Positive:

- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance

External:

- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards rated substantial compliance for 2022/23
- NHSE review of emergency planning self-assessment 2021/22 rated substantial compliance
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance
- EMAS Audit of Trust CBRNe/HAZMAT arrangements with no recommendations (2022/23)

Planned Actions

Action	Quarter / Year	Assurance
Relaunch of loggist training and provision (previous action was Green)	Ongoing	Blue
Review of Evacuation Plan (previous action was Yellow)	Ongoing	Blue
Continuous Review of Evacuation Plan	Ongoing	Yellow
Planning for and response to industrial action (multiple unions)	Ongoing	Green
Inclusion of details of BC plans tested/implemented duirng exercises/incidents documented in reports.	Ongoing	Green
Rolling Schedule of annual business continuity plans	Ongoing	Green
Major Incident table top exercises underway with new Strategic Health Commanders	Ongoing	Green
Review of Major Incident Plan and Critical Incident Plan	Q2 2023/24	Green
NHSE Core Standard for EPRR 2023/24 compliance and assurance	Q2 2023/24	Green
Flu / COVID Public Health campaign for Vaccinations	Q3 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 2023/24	Green
Winter Planning Group commenced for 2023/24	Q4 2023/24	Green

Future Risks

- COVID-19 surge.
- Availability of clinical consumables, equipment and some medications post EU Exit / Ukraine
- Costs and timeliness of deliveries due to EU Exit / Ukraine
- Additional patients with longer waiting times RTT, Cancer and Diagnostics.
- Increase in seasional outbreaks (influenza, norovirus) impacting on bed capacity.
- National industrial action Medical Staff within healthcare and other sectors impacting on workforce levels and elective recovery plan
- Increased risk of cyber attacks due to sanctions imposed on Russia.
- Risk of energy supply disruptions over winter period
- Risk to delivery of EPRR Work and Training Programme due to ongoing industrial action workload

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2023/24.
- Lower than expected uptake of influenza vaccination.

Gaps in Assurance

- BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.
- Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).
- Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.
- Recruitment pipeline to address nurse staffing shortfalls and reduce reliance on agency.

Links to High Level Risks Register

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	3	4	4			3
Risk Rating	15	20	20			15

Risk Appetite Score: Low (4 to 6)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023

Lead Committee: Workforce Committee

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- People Directorate - People Strategy Annual Delivery Implementation Plan 2023/24
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Workforce Development Portfolio Governance Boards, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board.

Positive:
- IPR decreasing trends
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Develop and care for our own staff to improve retention (People Plan 23/24)	Q4 2023/24	Green
Develop the attraction and development of new staff (People plan 23/24)	Q4 2023/24	Green
Continue to improve our culture and staff engagement (People Plan 23/24)	Q4 2023/24	Green

Future Risks

- Pockets of low staff morale impacting turnover
- Seasonal illness may impact available workforce numbers
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Change impact of HASR and Group plans on NLaG clinical and non clinical strategies.
- Reliance on international pipelines to reduced vacancy position. Further local succession planning and future talent identification required.
- Increased demand on people services due to significant volumes of staff recruitment - potential for delays
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda
- National strike action driven by pay detracts from local ability to deliver cultural satisfaction.

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Attract, recruit, retain staff to work in the geographical area.
- Culture and staff engagement.

Gaps in Assurance

- Vacancy postion reducing overall
- Consultant vacancy position remains high. remain high particulary in medical areas
- Agency spend remains high
- Turnover reducing, but above target remains high.

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20
No 3209, Risk to Junior Medical Cover - Recruitment Delays to Acute TG CT = 16
No 3217, Breast Imaging Workforce Depletion, and delays to deliver care occuring to cancer standards = 15

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment
- Place based educational collaboratives

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber and North Yorkshire Integrated Care System.

Risk to Strategic Objective 3 - 3.1: The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	4	4	4			2
Risk Rating	20	20	20			10

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 10 July 2023

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify Cost Improvement Programme (CIP) schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2023/24
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Internal Audit Reports - Internal Control - significant assurance

External:
- Approval received at ICS Level for 2023/24 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2023/24
- Monthly meetings with NHSE Regional Team as a successor to Financial Special Measures regime.

Planned Actions

Action	Quarter / Year	Assurance
There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2)		Green
Review of nationally specified control actions currently underway with a view to introduction.	Q2	Green
Exercise to identify and complete CIP planning process also underway	Q2	Green
HAS business case planned to go to public consultation	Q3	Green
Develop workforce plans for non-registered nursing and medical staffing	Q2	Red

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Vacancy levels in medical and nursing driving an unplanned level of spend
- Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Cost Improvement Programme not fully formed.
- Delivery plan to support activity targets no fully formed.
- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets
- Inability to recruit and retain staff to meet financial plannnig assumptions
- Have we systems in place to facilitate level of recruitment
- Systems and processes in place to facilitate reduction in turnover rate
- Uncertainty of existing systems to recruit and retain staff.

Gaps in Assurance

- Trustwide Budgetary Control System, not working to deliver financial balance with current plans
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total
- No assurance recruitment or retention will improve
- Not meeting productivity targets for theatres and outpatients

Links to High Level Risks Register

No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20

No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE = 15

No 3202, Non-delivery of Medicine Divisional Finance CIP = 16

No 3221, Badgernet Implementation, due to potential failure to obtain funding, may result in an adverse impact on patient safety and Trust reputation = 15

No 3226, Risk of not being able to support delivery of new work relating to quality and audit workstreams, due to PAS/Lorenzo development freeze, may result in negative impact on patients quality of care and financial loss = 16

Future Opportunities

- Closer ICS working
- Provider collaboration and formation of the Group
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	5	5	5			5
Likelihood	3	3	3			3
Risk Rating	15	15	15			15

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 24 October 2023

Lead Committee: Trust Board

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE - HAS Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- NHSE attendance at AAU / ED Programme Board
- CiC Minutes
- Place Boards

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23 Q1 2024/25	Yellow
Review and seek if there are ways of applying for future rounds of PSDS funding	Q2 2023/24	Green
Develop a strategic capital planning framework aligned with joint Board and integrated Place Strategies	Q4 3 2023/24	Yellow
Capital short form business case for HAS models	Q4 2023/24	Green

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber and North Yorkshire Integrated Care System (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	4	4	4			4
Likelihood	3	3	3			2
Risk Rating	12	12	12			8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 5 July 2023, 24 October 2023

Lead Committee: Trust Board

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY ICS.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common
- Acute and Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)
- Place Boards

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process
- Consultation Institute Review
- Place Boards and Place Working Groups established

Internal:
- Minutes of HAS Executive Oversight Group, HNY ICS, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams
- Place Boards and Place Working Groups established
- Collaborative of Acute Providers Board

Planned Actions

Action	Quarter / Year	Assurance
HAS Programme:		
• Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Blue
• Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Blue
• Joint OSC - reviews	Q2 1 2023/24	Blue
• NHSE Gateway review	Q2 2023/24	Blue
• ICS Board approval	Q2 2023/24	Blue
• Public Consultation (launched 24 Sept 23 - 5 Jan 24)	Q2/Q3 2023/24	Green
• Decision Making Business Case	Q3/4 2023/24	Green
• HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Blue
Collaborative of Acute Providers:		
• Development of H&NY Planned Care Strategy/Framework	Q3 Q1 2024/25	Yellow

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Decoupling maternity/neonates from HAS programme (impact on paediatrics)

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

Description of Strategic Objective 5: To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2024
Consequence	4	4	4			4
Likelihood	3	3	3			2
Risk Rating	12	12	12			8

Risk Appetite Score: Moderate (8 to 12)

Date of Assessment: 6 June 2023 (Trust Board)

Reviewed: 12 July 2023, 24 October 2023

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS, Leadership and Culture Transformation Committee
- CQC and NHSE Support Teams
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders, VB Leadership Development, LIDA
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSE Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair, Chief Executive, Chief Financial Officer, Chief Information Officer, Interim Chief People Officer, Interm Director of Strategic Development and Interim Director of Estates and Facilities with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Integrated Care System.

Assurance (internal & external)

Internal:
- Leadership Strategy
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS, Leadership and Culture Transformation Committee.
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Board and Committee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:

External:
- NHS Staff Survey.
- CQC Report
- ICB Leadership forum

Planned Actions

Action	Quarter / Year	Assurance
Delivery against the Trust Leadership Strategy (2020 - 2024)	Q4 (23/24)	Green

Future Risks

- Funding for all leadership programmes is non-recurrent
- National policy changes.
- Impact of HASR and Group plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Higher turnover of staff due to poor levels of leadership
- CQC rating and recommendations
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No ongoing investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration - particular focus on local education providers
- System wide collaboration to meet control total
- Group model and wider access to leadership development.

Board Assurance Framework - 2023 / 24	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated yellow - in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Shaun Stacey, Group Chief Delivery Officer
Contact Officer/Author	Matt Overton, Associate Director of Central Operations & Ashley Leggott, EPRR Manager
Title of the Report	**Annual Report for Emergency Preparedness, Resilience and Response (EPRR) for 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	This Annual Report provides a summary of the EPRR activities for the period of 1st April 2022 to 31st March 2023 including details of the incidents that the Trust has responded to, the exercising and training that has taken place internally and with partner agencies, and the current position of the EPRR work programme aligned to the local risks the Trust and our community face. In summary, the NHS continues to increase its focus on EPRR for the planning, response and assurance systems for potential incidents due to the ongoing risks identified. The Trust is fully engaged in local and regional planning and exercising and has responded to multiple incidents, reducing the disruption to our services and ensuring our critical functions continue to deliver for our patients and community. The Trust has received substantial compliance ratings from audits and assessments of our EPRR preparedness and has a challenging EPRR work and training programme in place. New national guidance has been issued over the past year and has been incorporated into our emergency plans and business continuity management system as part of our continuous improvement. The Finance and Performance Committee is asked to approve the annual report for submission to the Trust Board (Public).
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	✓ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: EPRR Group Operational Management 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 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4

	☐ 1 - 1.5 ✓ 1 - 1.6 **To be a good employer:** ☐ 2	**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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Chief Operating Officer

Annual Report for Emergency Preparedness, Resilience and Response (EPRR) for 2022/23

Report Date:	10th August 2023
Version:	1.0
Number of Pages:	28
Report Author:	Matt Overton, Associate Director of Central Operations Ashley Leggott, EPRR Manager
Director Sign-Off:	Shaun Stacey, Chief Operating Officer (Accountable Emergency Officer)

1.0 Background and Introduction

The NHS needs to be able to plan for and respond to a wide range of incidents and emergencies which could affect health or patient care. These could be anything from extreme weather conditions, an infectious disease outbreak, a major transport accident, a cyber security incident or a terrorist act. This is underpinned by legislation contained in the Civil Contingencies Act 2004, the NHS Act 2006 and the Health and Care Act 2022. This work is referred to in the health service as Emergency Preparedness, Resilience and Response (EPRR).

Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) is classed as a Category one responder as per the Civil Contingencies Act 2004, which places a statutory duty for the Trust to:

- Assess risks
- Plan for emergencies
- Undertake business continuity management
- Warn, inform and advise the public
- Cooperate with partner agencies
- Share Information with partner agencies

This Annual Report will provide a summary of the EPRR activities for the period of 1st April 2022 to 31st March 2023 including details of the incidents that the Trust has responded to, the exercising and training that has taken place internally and with partner agencies, and the current position of the EPRR work programme aligned to the local risks the Trust and our community face.

2.0 EPRR Assurance

The Trust is required to participate in several audit and assurance processes as part of a three-year cycle to evaluate our current state of preparedness and identify any gaps in our resilience.

2.1 NHS England Core Standards for EPRR

The overall NHS compliance with the statutory requirements for EPRR is evaluated through the NHS England Core Standards for EPRR. NHS England is responsible for gaining assurance on the preparedness of the NHS to respond to incidents and emergencies, while maintain the ability to remain resilient and continue to delivery critical services. This is achieved through the EPRR annual assurance process.

The Trust completed its self-assessment against the core standards for 2022, followed by a peer review process and scrutiny from the Humber and North Yorkshire Integrated Care Board (HNY ICB) prior to sign off by the Trust Board. The outcome was then submitted to the North East and Yorkshire Local Health Resilience Partnership (LHRP) and reported through to the national team.

NLAG received a 91% compliance rating against the core standards which is classed as ‘Substantially Compliant’. The deep dive subject for 2022 was evacuation and shelter. The table below shows the breakdown of the compliance ratings.

Domain	Total Applicable Standards	Fully Compliant	Partially Compliant	Not Compliant	Not Applicable
Governance	6	6	0	0	0
Duty to risk assess	2	2	0	0	0
Duty to maintain plans	11	9	2	0	0
Command and control	2	2	0	0	0
Training and exercising	4	4	0	0	0
Response	7	5	2	0	0
Warning and informing	4	4	0	0	0
Cooperation	4	4	0	0	3
Business continuity	10	10	0	0	1
CBRN	14	12	2	0	0
Total	**64**	**58**	**6**	**0**	**4**

Deep Dive	Total Applicable Standards	Fully Compliant	Partially Compliant	Non Compliant	Not Applicable
Evacuation and Shelter	13	9	3	1	0
Total	**13**	**9**	**3**	**1**	**0**

Percentage Compliance	91%
Overall Assessment	Substantially Compliant

Assurance Rating Thresholds
- Fully Compliant = 100%
- Substantially Compliant =99-89%
- Partially Compliant = 88-77%
- Non-Compliant = 76% or less

The Trust was assessed as partially compliant with six of the 64 core standards with an action plan to address these developed as part of the EPRR work programme. A copy of the action plan can be found at Appendix A.

For 2023, NHS England is taking a different approach to the core standards assurance process. Trusts will complete the self-assessment against a revised set of core standards with additional detail and requirements stated for each individual core standard, and will need to upload and submit all evidence for each core standard to an online portal. NHS England and the ICB will then review and evaluate each piece of evidence against these new increased requirements and provide check and challenge to compliance ratings. This new approach was piloted last year in the Midlands and resulted in a significant drop in compliance ratings across the majority of providers against the increased requirements.

NLAG, along with other NHS providers within our ICB, are part of a regional planning group established to support joint assessment and collaborative working on this year's core standards process to share best practice. The initial submission for 2023 is due by the 29th

September 2023 prior to the check and challenge process and the final compliance rating will be presented to the Trust Board before the 31st December 2023.

2.2 Audit Yorkshire's Internal Audit of EPRR Arrangements

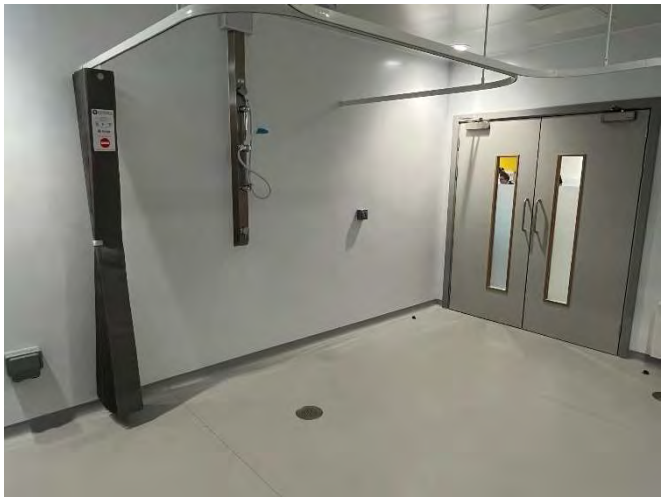
In October 2022 the Trust received the final report from Audit Yorkshire's internal audit of the Trust's Business Continuity and EPRR. The report concluded that there is significant assurance that plans are in place in order to effectively respond to an incident and maintain the continuity of services. The audit reviewed a wide variety of aspects across the business continuity management system and EPRR framework and provided four recommendations to be taken forward. The four recommendations included reviewing policies and plans to align with the recently published NHS England EPRR Framework 2022, that high and very high risks are reported quarterly to the EPRR Group, that business continuity plans overdue review are escalated where relevant, and that testing of individual business continuity plans is formally recorded. These recommendations have been implemented.

2.3 Annual EMAS Audit on NLAG CBRN Preparedness

As part of the annual EPRR assurance cycle and in line with contractual standards set out bu the Department of Health and Social Care to support the NHS England EPRR Framework, East Midlands Ambulance Service (EMAS) conducted an audit on NLAG's Chemical, Biological, Radiological and Nuclear (CBRN) preparedness during March 2023.

The audit included serviceability and maintenance of equipment, emergency plans in place and the specialist training provided in-house by the Trust. NLAG successfully passed the audit with no gaps in planning identified. A potential barrier that was noted was the difficulties in releasing operational frontline ED 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. At DPOWH it was noted the number of staff trained had increased and there was a planned training programme in place to ensure all staff receive the training.

It was highlighted during the EMAS audit visit that the new decontamination rooms at both DPOWH and SGH ED were the best they had seen within the whole of the East Midlands and that the planning and design of this area was evident in the final design.



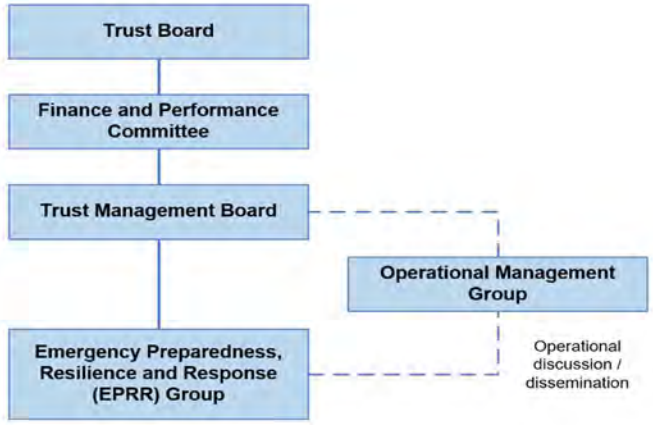
Bespoke designed decontamination rooms are now operational at DPOWH and SGH ED that replace the need for deployable decontamination tents. The decontamination room has separate one-way airflow system to prevent contamination of the ED and dedicated drainage to an underground contaminated water storage tank to prevent contamination of the local sewage system

3.0 EPRR Governance

The Trust has an established EPRR Group as the primary meeting to develop, implement, promote and maintain the plans, procedures, training and exercises to fulfil the EPRR agenda. The EPRR Group is chaired by the Trust's Emergency Planning Manager and includes representation from each Directorate and Division.

The EPRR Group has recently been reviewed and in light of the increased challenges to the EPRR agenda from an expanding national scope to the post-covid recovery of overdue training and exercising impacting all Trusts, it was decided to increase the frequency of the EPRR Group from bi-monthly to monthly, with an extended default meeting time from 1 hour to 1.5 hours per meeting, and to review the terms of reference.

Below is a structure chart of the EPRR Group's governance reporting through to the Trust Board.



4.0 Testing, Training and Collaborative Working

As a Category one responder, NLAG must carry out training and exercising of our emergency plans and contribute towards collaborative exercising of local partner agency emergency plans. The EPRR Training Programme (Appendix C) lists the internal and external training and exercises completed during 2022/23 and those currently planned for 2023/24.

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 8.0 within this report refers to live incidents that have occurred during the reporting period of 1st April 2022 to 31st March 2023.

4.1 Live Decontamination Exercise

The new Emergency Departments at DPOWH and SGH, which opened October 2022 and March 2023 respectively, included purpose-built and designed decontamination rooms within the departments next to a dedicated Major Incident storeroom. This improves the Trust's equipment to respond to self-presenting casualties from a CBRNe/HAZMAT incident while also reducing the responding time and has removed the need to the deployment of external decontamination tents.

The Trust plans to conduct a live exercise at both sites to support staff familiarisation with the procedures and process they've learned during training to deal with a live incident of this nature

and to test the new equipment during a scenario. This was also a recommendation from our annual EMAS CBRN Audit and forms part of the EPRR Training Programme for 2023/24 (Appendix C).

4.2 CBRNe/HAZMAT Training

Emergency Department 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 operational procedures for the purpose-built decontamination rooms.

Dedicated major incident storerooms are now in place at DPOWH and SGH ED with custom shelving for Powered Respiratory Protective Suits (PRPS) and adequate room for getting changed ready to respond

4.3 Bank Holiday Preparedness

The Bank Holiday planning approach for the operational impacts and mitigations is 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 Strategic Health Commanders (Gold On-Call) and Tactical Health Commanders (Silver) that are on the rota for that period.

The Trust's planning approach to Bank Holidays has been viewed positively within the ICB and has been recently shared with York and Scarborough Teaching Hospitals Foundation Trust for them to replicate and implement as part of their planning.

4.4 Collaborative Working with Partner Agencies

In respect of partnership working with local partner agencies, the Trust attends the Local Resilience Forum (LRF), the LRF's Sub-Groups, and the Local Health Resilience Partnership (LHRP). 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.

During 2022/23 NLAG participated in the following planning events / exercises:

- LHRP Workshop for National Electricity Transmission Failure (June 2022)
- Humber LRF Cyber Incident Response Exercise (June 2022)
- Humber LRF OpHyrax – National Just Stop Oil Protests (multiple)

- Humber LRF Flood EX (November 2022)
- Humber and North Yorkshire ICB Exercise Artic Willow - Winter preparedness, industrial action, energy shortages, adverse weather, flooding (December 2022)
- Industrial Action planning and response (March 2023 onwards)
- Bank Holiday Planning (multiple)
- National oxygen supply challenges (January 2023)
- National Exercise Mighty Oak – National Power Outage (March 2023)

4.5 Learning Lessons from Terrorist Attacks

NLAG is fortunate to have not been directly affected by terrorist attacks. However, there is still learning that can be gained and incorporated into our emergency plans from the lessons learned from recent terrorist attacks within the UK. Debrief reports that are made available to the EPRR Team or inquiry reports (e.g. Manchester Arena bombing) are reviewed and any learning incorporated into our planning and exercising. Learning from other incidents is also captured through the Local Resilience Forum meetings and shared through the EPRR Group where relevant.

4.6 New EPRR National Guidance

In July 2022, new EPRR national guidance was 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 evidence 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 which started with strategic level from July 2022. At present 95% of staff who are required to be trained as Strategic Health Commanders have completed their training. The rollout continued for the tactical level in 2023 and 64% of staff who are required to be trained as Tactical Health Commanders have completed their training. Training continues to be provided by NHS England with training registers monitored through the Trust's EPRR Group.

Along with the new training programme for the Health Commanders there is a requirement for each individual to maintain a CPD folder that provides evidence of continued learning and demonstration of the skills and knowledge required to perform this role. The Health Commander Portfolio has not yet been published by NHS England but will be rolled out within the Trust once released.

As part of the restructure of the Site Management Team and the Trust's on-call arrangements, a new Gold On-Call Development Pack has been created and rolled out to all Strategic Health Commanders on the Gold On-Call rota. The pack details the competencies and training

required to undertake the Gold On-Call duties and a series of bespoke training sessions have been developed and delivered to meet these.

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 Integrated Care Systems established last year. These changes are incorporated into the Trust's emergency plans and escalation procedures.

5.0 Business Continuity Management System

The Trust has a well embedded Business Continuity Management Strategy which includes a policy, guidance and plans at both Directorate and service level. There are currently 157 service-level business continuity plans across the Trust covering all Divisions and Directorates. Each plan identifies critical and non-critical functions within each service that would be required to be maintained during an incident, or that can be stood down to support critical functions. Each plan is required to be reviewed on an annual basis by the nominated service lead with compliance monitored through the EPRR Group. Plans can, and do, get reviewed and updated more regularly if required when new threats or risks are identified.

All service-level business continuity plans have been implemented over recent years as part of the pandemic response and several plans were also implemented as part of specific incidents. Any lessons to be learned from the exercise/incident is captured as part of the exercise/incident debrief and included in an action plan. At present there is no formal process for the testing of individual service-level business continuity plans, as these are tested during EPRR training or exercises (e.g. table top, multi-agency exercises).

NHS England issued a Business Continuity Toolkit in May 2023 with new guidance on how to align NHS business continuity planning to the ISO 22301 standard. A revised approach to business continuity started during early 2023 which was then updated to incorporate the new national toolkit and will result in three main changes in approach:

- All post-exercise/post-incident reports will feature a section that captures and explicitly names every business continuity plan that was implemented as part of the exercise/incident and lessons to be learned
- The EPRR Group will require each Directorate/Division to report testing schedules and compliance alongside their existing review schedules. A peer review process for business continuity plans will support the review schedule
- A full review of the service-level business continuity plan template has taken place and the transition to a Microsoft Word template instead of Excel has started being rolled out to support more user-friendly presentation and alignment to the new NHS England Business Continuity Toolkit

6.0 EPRR 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 updated guidance and planning requirements to ensure the Trust maintains its compliance and readiness to respond to an incident.

The EPRR work programme was significantly impacted during the covid-19 response from 2020 onwards and has been further hampered by the current period of ongoing industrial action. The EPRR Team will always prioritise the current risks and threats requiring an EPRR

focus to support the maintaining of critical services, with the EPRR work programme being revised accordingly.

7.0 EPRR Risks to the Trust

The EPRR work programme and business continuity arrangements are based on nationally and locally identified risks. The National Risk Register feeds into the Local Risk Register, developed and maintained through the Local Resilience Forum (LRF). The Local Health Resilience Partnership (LHRP) also focuses on health specific risks with NLAG linked in with both LRF and LHRP planning. During Q3 2022/23 a new Humber and North Yorkshire ICS EPRR Risk Register was launched and the top risks disseminated through to all business continuity leads.

The current top risks for NHS providers within the North East and Yorkshire region are:

Risk Area	Detail	Comments
Flooding	Tidal surge, raising river levels, flash floods	Due to the extent of coastline and the volume of water that drains into the Humber basin we are at higher risk than some of our neighbouring ICBs of a flood incident
Energy Supply Failure	Gas, Electric	Oil not seen as a risk at present
Digital Technology	Cyber attack IT Failure Mobile Telecommunication systems	Possibly no high risk than neighbours, but cross boundary flow and complexities of Yorkshire/North Lincs divide increases the risk Telecomms can be problematic due to geography and, if total failure will cause significant challenges due to ICB footprint
Infectious diseases	HUTHT is local Infectious Disease Centre Currently experiencing outbreaks of: • Flu • Noro • Covid • Avan Flu • Monkeypox • (and the rest)	As well as planning for our internal infectious disease outbreak we need to consider wider outbreaks which may impact upon HUTHT and HUTHT's capacity to manage local infectious disease outbreaks
Industrial Action	Both internal and external action	Planning for impending industrial action across the NHS is ongoing Wider industrial action may impact on transport/supplies/etc.
Public Disorder/Mass Casualties	Across the footprint we have a variety of venues which attract large crowds, when this occurs in multiple venues within a close geographical area the risk of one or more mass casualty events escalates	With the City of Hull and the City of York there are multiple large venues which can all be in use at the same time. The capacity within associated Health Facilities may be limited and quickly escalate to a scenario where multiple locations are required to support both within and outside of eth ICB There are smaller areas, which are more isolated e.g. Whitby; where significant public gatherings occur on a regular basis
Major Social Care Provider Failure	The impact of social care constraints has already been felt	If a major social care provider fails, this will have significant impact across all systems
COMAH Sites	Throughout the Humber there are multiple sites which, if an incident happens, will require significant Health input	Impact not just restricted to site; smoke plumes of other airborne particles may be distributed over a significant geography dependant upon the climate conditions at the time. Flow of chemicals, etc into water course may cause wider health impacts if get into drinking water.

(Table taken from NEY Local Health Resilience Partnership Risk Register Report)

In August 2023 the Government published the 2023 National Risk Register. The updated risks and scoring included in this document will be reviewed through the Humber LRF to update the Humber Community Risk Register, followed by a review within individual Trusts and at LHRP level.

8.0 Incidents – Implementation of Emergency Plans

Between 1st April 2022 and 31st March 2023, the Trust activated its emergency plans to support the response to the below incidents:

Description of Incident	Date	Emergency Plans Activated
Junior Doctor Industrial Action	March 2023-Ongoing	• Business Continuity Plans • Incident Coordination Centre Plan
Scunthorpe Electrical Infrastructure Failure	December 2022	• Business Continuity Plans

Advance Computer Software Group	August 2022	• Business Continuity Plans
Heatwave	July 2022	• Heatwave Plan
NLAG COVID-19 Pandemic	Jan 2020 - 2022	• 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

8.1 Junior Doctor Industrial Action

Three unions representing Junior Doctors announced their intention to take periods of industrial action for Junior Doctors against the national position on pay and working conditions. Junior Doctors from the British Medical Association (BMA), the Hospital Consultants and Specialists Association (HCSA) and the British Dental Association (BDA) took part in 72 hours of continuous industrial action between 13th-16th March 2023.

As part of the ongoing industrial action, Junior Doctors then took part in further industrial action during April, June and July 2023, with further dates planned for ongoing action. On each occasion the Trust has established a strategic planning group for the planning of each of the periods of action. As part of the planning group the following key actions were implemented:

- Local engagement with unions including agreement on picket lines and welfare provision
- Divisional strike plans for services developed which detailed activity plans, critical functions, workforce redeployments and mitigating actions
- All elective activity was reviewed by Divisions and a rolling cancellation approach was adopted for April's industrial action. This enabled Divisions to stand down the minimal amount of elective activity to enable redeployment to maintain critical services and reduce the impact
- A focus to maintain P1/P2 elective activity wherever possible was part of the planning approach and no cancer elective procedures were rescheduled. Any rescheduled activity was risk assessed within the Division and rebooked at the earliest opportunity based on clinical priority
- Guidance and communication for managers and medical staff with FAQ on industrial action and cover arrangements
- Training delivered for Consultants and SAS grade Doctors on clinical admin systems to maintain patient flow and delivery of patient care
- Situation reporting processes to ensure accurate information could be accessed and used to support decision making during the industrial action
- An engagement script was provided to Clinical Leads and Rota coordinators to aid in consistent and supportive communications with Junior Doctors

The Trust established an Incident Coordination Centre (ICC) that operated 24 hours a day throughout the period of the industrial action. The ICC had a Strategic Health Commander who led the response in conjunction with a lead from the Chief Medical Officer's Office and Chief Nurse's Office. There was EPRR support available to the ICC and a senior operational lead present on-site 24 hours during the period with a battle rhythm for each day which included internal operational calls and external system calls with the ICB SITREP timings.

During the period of industrial action there were no reported patient safety or harm incidents relating to the industrial action. As part of planning for April's industrial action the planning group took lessons learned from March and incorporated them into the development of plans and processes. Divisional strike plans were in place to ensure that critical services were maintained and the impact kept to a minimum for disruption to elective recovery.

8.2 Scunthorpe Electrical Infrastructure Failure

On 14th December 2022 an electrical infrastructure failure occurred at SGH at approximately 08:10. This interruption to the electrical supply impacted several areas across the site including Butterwick House. The interruption to Butterwick House caused the IT datacentre to lose power as the Uninterrupted Power Supply (UPS) batteries are designed to provide power for a short period of time until the emergency generator starts up, however, the generator did not operate due to where the electrical failure occurred.

The loss of power to the IT datacentre resulted in IT servers going down for all sites and Community Services within the Trust for a short period of time. The power interruption also affected the heating source on the Stroke Unit and Hyper Acute Stroke Unit (HASU) at SGH which, on assessment of potential risk, the decision was made to move the patients from these units to another location within SGH for up to 24 hours until further checks on the heating system could be completed. All critical services were maintained and continued to be delivered throughout the incident and there was no patient harm caused.

No emergency plans were implemented during the incident, but the below business continuity plans were implemented to maintain critical services:

Service-Level Business Continuity Plan
Operations Centre - DPoWH
Operations Centre - SGH
Outpatients Department
Diagnostics Systems Team
IT Operations
Switchboard
WebV Systems
Estates Team
Single Point of Access - North Lincolnshire
Antenatal Clinic and ADU
Child Development Centre
Community Maternity Services
Gynaecology Clinics
Gynaecology Assesment Unity and inpatient areas
Maternity Services Management & Admin Team
Maternity Theatres
Maternity Wards
Neonatal Care
Paediatric Community Team

Service-Level Business Continuity Plan
Paediatric Inpatient Wards
Paediatric Outpatients
Pink Rose Suite
Integrated Acute Assessment Unit DPOWH
Integrated Acute Assessment Unit SGH
Cardiology Day Case Unit
Cath Lab SGH
Dermatology
Diagnostic Investigation Unit
Emergency Care Centre DPOW
Emergency Care Centre SGH
Medical Specialties
Medical Wards SGH & GDH
Medicine Ward DPoWH
Planned Investigation Unit
Stroke Services
Anaesthetics
Audiology
Breast Imaging

Service-Level Business Continuity Plan
CT Scanning
Day Surgery Unit and Wards
Endoscopy
Dental Unit
Fracture Clinic
General Radiology
HOBS High Observation Bay
Intensive Care Unit
MRI Scanning
Neurophysiology
Nuclear Medicine
Ophthalmology Unit
Pharmacy
Pre-Assessment Service
Physiological Measurements
Surgical Wards
Theatres
Ultrasound

A post-incident debrief was carried out and a post-incident report developed with an action plan of lessons to be learned. The action plan with the current updates is at Appendix D.

8.3 Advance Computer Software Group

On Thursday 4th August 2022, Advanced Computer Software Group Limited (Advanced) identified an incident in their systems impacting several systems that they host. Their services are used by a range of Health and Adult Social Care services, including NHS111.

NLAG uses two of the systems affected, eFinancials and Odyssey. eFinancials is used Trustwide and throughout HUTH for financial activities such as purchase ordering and invoicing. Odyssey is used in the Single Point of Access (SPA). The SPA invoked their business continuity plans to ensure continuation of the SPA service and the Finance Department invoked their business continuity plans for services affected by eFinancials.

Digital services blocked access to Odyssey as a precautionary measure until we received assurances from Advanced that there was no residual risk to our IT systems. As the eFinancials system was not directly affected the decision was taken not to continue blocking access to it. This incident was concluded for the Trust in October 2022.

8.4 Heatwave

A Red Extreme Heat Alert and Heatwave Level 4 was issued for Monday 18th and Tuesday 19th July 2022 covering most of the UK including Northern Lincolnshire with temperatures expected to reach 40c. Within Northern Lincolnshire the highest recorded temperature was 40c on Tuesday 19th July, with the highest recorded temperature across the UK in Coningsby Lincolnshire with a temperature of 40.3c.

The Trust implemented the Heatwave Plan throughout this period of extreme heat and the EPRR Team issued all heat health alerts via Trust communication platforms and during the daily operational calls three times daily. Staff were reminded of their required responsibilities of monitoring patients that could be more affected due to the high temperatures. Working areas were kept cooler by closing of windows and blinds/curtains. Staff were also reminded of the correct escalation routes to report concerns relating to the high temperatures. Across the period of the alert temperatures did not drop below the very high teens overnight and during the day peaked at 40c.

The Trust saw an increase in the number of patients attending the Emergency Departments during this period but was able deal with this increase in activity, however, this did contribute to an impact on national performance targets that were already affected by existing operational pressures.

There were a small number of associated incidents reported that had been caused due to the extreme heat, including the temperature within Theatres at GDH, three lifts, service data centre and Theatres at SGH. The Estates Team responded to each of these reported issues and worked to rectify each issue. The Theatre chillers were failing to achieve adequate cooling meaning procedures had to be cancelled and the lift motor rooms were overheating, which meant movement around site was becoming restricted. Work has been completed to try to reduce the risk of these issues reoccurring during future periods of extreme heat.

8.5 Covid-19 Response

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 change in 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 five

and seven testing was stopped at the end of April 2022 with the continuing admission and day three testing continuing until the end of May 2022 when day three testing was also stopped. The requirement to wear face masks within the hospital was removed in June 2022 but remained within clinical areas (e.g. wards, ED). All restrictions that were removed are continually under review by the Infection Prevention and Control Team to ensure the ongoing safe management of covid within the Trust.

On 19th May 2022 the NHS response was stood down from NHS level three incident with the focus of transitioning into the recovery phase, which the Trust continued to follow national guidance.

The national Covid-19 inquiry has now commenced with NLAG preparing for potential future requests for evidence issuing all staff and targeted communications 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, with the group coordinating preparations and attending inquiry training delivered by the Trust's legal team Capsticks.

8.5 Medical Oxygen Delivery Systems and Monitoring

On 7th November 2020 there was a major incident declared to respond to a potential risk of Trust's oxygen supply infrastructure being unable to meet the patient demand for piped oxygen. As part of the post-incident investigation a series of operational plans and assurance checks were put in place to ensure the potential risk is routinely monitored and managed.

The Trust has a number of operational and emergency plans that are used to prevent and respond to an oxygen delivery incident. These include the Oxygen Provision Monitoring and Alarm Activation Plan (DCM488), flow rates and WebV information, and the Estates Emergency On-Call Manual.

In addition to the operational plans the monitoring of the oxygen delivery flow rate to ward areas is monitored by the Operation Centres to ensure that ward areas that are pulling a higher demand are highlighted at the earliest opportunity and can be reviewed to ensure the pull on the ring is not exceeding the maximum flow rate. If it is noticed that the oxygen flow rate is exceeding the stated flow rate for an area, this is raised with department staff to check for accuracy and then escalated to Estates.

The Operations Centre have access to the flow meters live teleweb on the Hub which allows live data feedback. If flow rates were to cause an issue within a ring, then the early warning local alarms would sound to alert staff in the area of a potential issue.

Designated Nursing Officer (DNO) training has been expended to include all Site Matrons and Site Managers to provide further resilience 24/7 onsite within Operations.

The Medical Gas Committee meets on a monthly basis. Committee membership includes representation from all Divisions, Pharmacy, Estates and Facilities, Central Operations, EPRR, Medical Gas Authorised Persons and Authorised Engineer, Nursing colleagues and a Clinician (Anaesthetist). The standing agenda items include national and BOC supplier information, project updates, oxygen demand and capacity review, equipment update, training update, alerts, risks and incidents.

All works relating to the Medical Gas Pipeline System and changes involving medical gas cylinders are brought to the meeting for discussion and to ensure compliance with Health Technical Memorandum 02-01: Medical Gas Pipeline Systems (Part A and Part B) and NHS C0871 Performance of Healthcare Cryogenic Liquid Oxygen Systems Nov 2021. Any derogations from the above are discussed and, where supported, are raised with the Quality and Safety Committee for consideration. Where derogations are not supported assurance is

sought that changes are made to ensure compliance. A Quality Control Assessment is undertaken as part of commissioning and works sign off. The Medical Gas Committee provides a monthly highlight report and minutes to the Quality Governance Group and Health, Safety and Fire Group.

9.0 Summary and Next Steps

In summary, the NHS continues to increase its focus on EPRR for the planning, response and assurance systems for potential incidents due to the ongoing risks identified. The Trust is fully engaged in local and regional planning and exercising and has responded to multiple incidents, reducing the disruption to our services and ensuring our critical functions continue to deliver for our patients and community.

The Trust has received substantial compliance ratings from audits and assessments of our EPRR preparedness and has a challenging EPRR work and training programme in place. New national guidance has been issued over the past year and has been incorporated into our emergency plans and business continuity management system as part of our continuous improvement.

10.0 Trust Board Action Required

The Trust Board is asked to:

- Note the EPRR arrangements in place including testing and exercising of plans and live incidents that have taken place during the reporting period
- Note the current top risks identified by the Local Health Resilience Partnership
- Note the current compliance against the NHS England Core Standards for EPRR
- Note the EPRR work and training programme for 2023/24 (Appendix B and C)

Appendix A

Action Plan for Compliance with NHS England Core Standards for EPRR 2022/23

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	Trust Full and Partial Site Evacuation Plan which includes evacuation triage, temporary shelter locations and process for onward transfer with patient tracking. Trust Major Incident Plan. Trust Incident Coordination Centre Manual details how the trust establishes and run an ICC including multi-agency links. Regional exercise participated in regarding RACC at Airedale site. During the Covid-19 pandemic Oxygen Incident phase 1 of plan was implemented to evacuate wards to suitable alternative locations which superseded the need for an exercise of the plan. The plan is included within the training workplan for 2023 and will be looking at date around May/June with the hope of running as a Emergo style exercise	Partially Compliant	Testing of the Trust Full and Partial Site Evacuation Plan included in EPRR Training Programme. No testing completed within recent years due to covid-19 response. The Evacuation plan will be reviewed and updated to include the latest national guidance.
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust's Policy and Procedure for Lockdown includes the incident response plan and action cards. The Trust has conducted a Project Argus exercise (ACT Strategic) in July 2018 and was looking at further CT training during 2020 which had to be cancelled due to the pandemic. The Trust are planning on a lock down training exercise within the next year	Partially Compliant	Testing of the Trust Policy and Procedure for Lockdown Plan included in EPRR Training Programme. No testing completed within recent years due to covid-19 response.
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	• Documented processes for identifying the location and establishing an ICC • Maps and diagrams • A testing schedule • A training schedule • Pre identified roles and responsibilities, with action cards • Demonstration ICC location is resilient to loss of utilities, including telecommunications, and external hazards • Arrangements might include virtual arrangements in addition to physical facilities but must be resilient with alternative contingency solutions.	Trust Incident Coordination Centre Manual details how the Trust will establish and run an ICC including multi-agency links. The ICC Manual includes maps and room diagram's, pre-set telephone extensions and email addresses. The physical room, telephones including analog phones and equipment is tested every six months or when established for use during a live incident. Printed copies of emergency plans are located in the Major Incident Cupboard within both sites ICC's along with practical items e.g. tabards/log books. Printed copies of all Business Continuity Plans are located in each Operations Centre for quick access during IT/Network outage. The organisation has multiply sites and can run an ICC from either of its two main sites. The ICC was established at the start of the Covid-19 pandemic and has continued to operate fully throughout the pandemic response. Each ICC major incident cupboard requires full stock take and reorder.	Partially Compliant	Both ICC's need a full review and restock due to the prolonged use during covid-19 incident response

Ref	Domain	Standard name	Standard Detail	Supporting Information - including examples of evidence	Organisational Evidence	Self assessment RAG	Action to be taken
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The Trust has a pool of staff that have received the training internally from a trained trainer to national standard. The basic rules for completing a log book is included within the Manager On-call training package. Due to the heavy demand and use of loggists during the prologned covid-19 incident reponse, there is a need to increase the number of trained loggist across the Trust with a relaunched training programme commencing in October 2022.	Partially Compliant	Relaunched training programme to increase number of trained loggists commencing in October 2022
58	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.	Rotas of appropriately trained staff availability 24	CBRNe/HAZMAT training is provided to all ED 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 ED 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. High levels of staff turnover within the ED workforce has also contributed to a reduction in trained numbers.	Partially Compliant	Increase numbers of ED 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 resource pull from each ED
67	CBRN	Staff training - decontamination	Staff who are most likely to come into contact with a patient requiring decontamination understand the requirement to isolate the patient to stop the spread of the contaminant.	Evidence training utilises advice within: • Primary Care HAZMAT/ CBRN guidance • Initial Operating Response (IOR) and other material: http://www.jesip.org.uk/what-will-jesip-do/training/ • Community, Mental Health and Specialist service providers - see Response Box in 'Preparation for Incidents Involving Hazardous Materials - Guidance for Primary and Community Care Facilities' (NHS London, 2011). Found at: http://www.londoncn.nhs.uk/_store/documents/hazardous-material-incident-guidance-for-primary-and-community-care.pdf • A range of staff roles are trained in decontamination technique	CBRNe/HAZMAT Training is provided to all ED medical staff, Nursing staff, HCA's, Receptionists and Flow Coordinators. The training includes required national elements such as JESIP IOR, Step 123+, Dry and Wet Decontamination including videos. Face to Face training was temporarily suspended durign the covid-19 incident response but has since recommenced from July 2021. This has resulted in a backlog of training to be provided so not all ED staff are currently within training compliance. High levels of staff turnover within the ED workforce has also contributed to a reduction in trained numbers.	Partially Compliant	ED training programme for CBRNe/HAZMAT to continue to increase staff compliance levels now recommenced

The deep dive topic for 2022 was evacuation and shelter. Below were the four deep dive elements which were deemed as partially or not compliant. These four items have been incorporated into the latest draft of the Trust's Hospital Full and Partial Site Evacuation Plan (DCM171) which is currently going through its comment and approval process.

Ref	Domain	Standard	Deep Dive question	Organisational Evidence	Self assessment RAG	Action to be taken
DD1	**Evacuation and Shelter**	**Up to date plans**	The organisation has updated its evacuation and shelter arrangements since October 2021, to reflect the latest guidance.	The plan is in the process of been updated to reflect the latest guidance and will be completed by mid October 2022	Partially Compliant	Plan to be updated to include the latest national guidance issued
DD3	**Evacuation and Shelter**	**Incremental planning**	The organisation's evacuation and shelter plan clearly defines the incremental stages of an evacuation, including in situ sheltering, horizontal, vertical , full building, full site and off-site evacuation.	The Trusts plan outlines each incremental stages of an evacuation and the types of evacuation but terminolgy does not match so in the review this will be updated to ensure they match latest guidance	Partially Compliant	Plan to be updated to include latest terminology
DD8	**Evacuation and Shelter**	**Patient receiving**	The organisation has arrangements in place to safely receive patients and staff from the evacuation of another organisations inpatient facility. This could with little advanced notice.	The Trusts plan does not cover receiving of patients and staff from other organisations specifically but as a Trust we would be able to facilitate mutual aid if required as part of a Major Incident.	Partially Compliant	To include a specific section within the updated plan to cover receiving patients from another Trust's evacuation
DD12	**Evacuation and Shelter**	**Equality and Health Inequalities**	The organisation has undertaken an Equality and Health Inequalities Impact Assessment of plans to identify the potential impact evacuation and shelter arrangements may have on protected characteristic groups and groups who face health inequalities.	All Trust plans are developed with Equality and Health Inequalities in mind, however, a specific impact assessment has not been documented	Not Compliant	An Equality and Health Inequalities Impact Assessment to be completed on the updated plan

Emergency Preparedness, Resilience and Response Work Programme 2023-24

Emergency Preparedness, Resilience and Response Work Programme 2022-24				
Subject	**Task**	**Deadline**	**Status**	**Notes**
Work in Progress and Updates				
EPRR Core Standards 2022	Self assessment completed along with peer review and ICB challenge. Submitted to ICB before submission date October 20222	**N/A**	**Completed**	Reported submitted through governance route into Trust Board
EPRR Core Standards 2023	Self assessment in process, ICB meetings attended to discuss new format for 2023	**31/12/2023**	**In Progress**	Evidence being uploaded at present under the new format
EPRR Annual Report 2022	Completed and submitted to relevant groups before submission to Trust Board	**N/A**	**Completed**	Reported submitted through governance route into Trust Board
EPRR Annual Report 2023	Completed and awaiting to progress governance submissions to relevant groups before submission to Trust Board	**01/11/2023**	**Completed**	Report going through governance process
Adult Critical Care Services Surge Procedures				
Management of surge and escalation in critical care services SOP for Adults Critical Care	National Policy	**01/10/2023**	**In Progress**	Awaiting response from national team on latest version
Management of surge and escalation in critical care services SOP for Adults Respiratory ECMO	National Policy	**01/10/2023**	**In Progress**	Awaiting response from national team on latest version

Adverse Weather Response Tools				
The Cold Weather Plan for England	Ensure relevant actions can be activated during Cold Weather Alerts	**N/A**	**N/A**	Replaced by new national plan
Adverse Weather Health Plan 2023	Ensure relevant actions are embedded into the Trusts response to adverse weather events	**01/11/2023**	**In Progress**	For Review prior to Winter 2023
Adverse Weather Coordination Template	Excel Spreadsheet	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Cold Weather Assurance SITREP Example	Excel Spreadsheet	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Emergency Accommodation for Staff on DPOWH Site Template	Word Template	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Hotel Accom near DPOWH Template	Word Template	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Redeployment of Admin Staff Availability Sheet	Word Template	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Volunteer Drivers and Additional Vehicles Details Template	Excel Spreadsheet	**01/11/2023**	**To Do**	For Review prior to Winter 2023
Burns Plan				
Burns Major Incidents and Burns Mass Casualty Incident Plan	Regional/National Plans	**01/10/2023**	**In Progress**	Awaiting response from national on updated plan
Management of Surge and Escalation in Critical Care Services - SOP for Burns Services	Regional/National Plans	**01/10/2023**	**In Progress**	Awaiting response from national on updated plan
Business Continuity Plans				
Business Continuity Policy **DCP219**	Review policy	**2025**	**Completed**	Reviewed and updated May 2022. Next review due March 2025
Business Continuity Plan Template	Update BCP template to follow national framework for BCP from NHSE	**N/A**	**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	**N/A**	**Completed**	Updated Hub page with new guidance and information provided for all staff to access

Business Continuity Plans	BC Plans circulated to be reviewed - Updated by Divisions	**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**	**Ongoing**	Updated monthly on return of service plans into the EPRR group
Training and Exercise Section	To look at a training session for managers	**01/12/2023**	**Ongoing**	Ongoing support to managers who complete BCPs from the EPRR Team
Business Continuity Plan Tests	Validate BCPs through scenario testing	**Monthly**	**Ongoing**	Divisions to bring testing and live application of BCP into the EPRR Group monthly meeting
CBRN/HAZMAT				
CBRN/HAZMAT Plan **DCM109**	Review and update plan	**N/A**	**Completed**	Plan approved at the EPRR Group, minor changes required due to change in counter measures which will be updated to reflect the change August 2023
DPOW Exercise	Live Decontamination exercise at DPOW	**01/06/2024**	**To Do**	Training to be completed on new decontamination facilities using a simulated exercise to test the departments response and new equipment
SGH Exercise	Live Decontamination exercise at SGH	**01/06/2024**	**To Do**	Training to be completed on new decontamination facilities using a simulated exercise to test the departments response and new equipment
CBRN/HAZMAT Training	Deliver 'train the trainer' sessions to A&E trainers and assist in improving compliance by supporting training delivery	**Rolling Programme**	**Ongoing**	2022- PRPS instructors coursed delivered to a number of Trust staff Feb 2022. Department training to staff in PRPS is ongoing at both sites
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 – 2024**	**Ongoing**	EMAS Audit of both sites completed in March 2023 no major concerns raised. EMAS Audit 2024 dates to be confirmed
COMAH Site information	Review COMAH Site information held on the Hub	**01/12/2023**	**In Progress**	To carry out review of COMAH Site information held within NLAG and on site visits.
EPRR Group				
Terms of Reference **DCT083**	Review TOR	**01/09/2023**	**Completed**	Reviewed and updated August 2023. TMB for approval August 2023. Next due for review August 2026
Emergency Planning Hub Site				
Emergency Planning	All documents linked to EPRR Available on the Hub	**Monthly**	**Ongoing**	Updated documents uploaded onto the Hub page after approval

Fuel Plan				
Fuel Plan	National Fuel Plan utilised and available on the Hub	**31/12/2023**	**TBC**	V4.0 March 2017 on hub - to review updated National Plan
Heatwave Plan				
Heatwave Plan **DCM066**	Review and update plan	**N/A**	**Completed**	To be utilised with the new National Adverse Weather Plan
Incident Coordination Centre				
Incident Coordination Centre Manual **DCM178**	Review and update plan	**01/04/2024**	**Completed**	Review due April 2024
DPOW Major Incident Cupboard	Review and ensure sufficiently stocked	**01/10/2023**	**Ongoing**	Awaiting new stock to be delivered
SGH Major Incident Cupboard	Review and ensure sufficiently stocked	**01/10/2023**	**Ongoing**	Awaiting new stock to be delivered
On-Call Strategic Health Commander Training	deliver strategic health commander training sessions	**21/08/2023**	**Ongoing**	Sessions being delivered by M. Overton
Neighbouring Hospitals Info Pack	Create info pack on neighbouring hospitals for the ICC	**Completed**	**completed**	Information reviewed and updated January 2023
Loggist Training Refresher Sessions	Relaunch Loggist training sessions for loggists	**Ongoing Rolling Programme**	**Ongoing**	Loggist training sessions planned throughout the next year
Switchboard Cascade Test	To test Switchboards Major Incident Response	**Ongoing**	**6 monthly**	2022 tests completed and ongoing 2023 tests every 6 months
Investigations, Action Plans, Assurance Frameworks and Submissions				
NHS England Core Standards for EPRR Self-Assessment and Submission	Completed 2022-23 self-assessment, Trust Board approved and submitted to NHS England before deadline. Ongoing work for this year's submission with new process implemented	**31/12/2023**	**On going**	Collection and upload of evidence on going will be completed before the deadline.
Lockdown Policy				
Policy and Procedure Lockdown **(DCP195)**	Review and update plan	**March 2025**	**on going**	For Security (LSMS) to review and update. Awaiting date of test of procedures to be completed

Major Incident Plan				
Major Incident Plan **DCM176**	Review and update plan	**31/08/2023**	**Complete**	Review complete awaiting approval from EPRR Group
Critical Incident Plan	Review plan	**31/08/2023**	**Complete**	Review complete awaiting approval from EPRR Group
Major Incident Plan Table Top Exercises	Exercise arranged for 30th August 2023	**30/08/2023**	**To do**	Exercise arranged awaiting to be completed and further dates to be planned bi-monthly
Mass Vaccination / Treatment				
NLAG Plan to Support Mass Vaccination/Treatment **DCM156**	Review and update plan	**01/07/2025**	**To Do**	Up to date next review July 2025
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**	Next review due June 2024
Pandemic Flu Plan				
Pandemic Flu Plan **DCM147**	Review plan	**01/09/2026**	**To Do**	Review due April 2026
Partial or Total Site Evacuation				
Hospital Full and Partial Site Evacuation Plan **DCM171**	Review and update plan	**01/09/2022**	**In Progress**	Awaiting approval before submission to the EPRR Group for final approval for upload
Site Evacuation Exercise	Organise and conduct a Site Evacuation Tabletop Exercise	**01/06/2024**	**To Do**	To be arranged for 2024
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	**Ongoing**	**To Do**	All documentation to be reviewed and updated on the Trusts RD page for partner agencies to access
Surge and Escalation Management				
Patient Flow, Escalation and Surge Policy (including Full Capacity Protocol) **DCP301**	Review policy	**01/03/2026**	**Completed**	Next review due in March 2026
NEY FINAL Major Trauma Regional Escalation Framework V1.0 19012021		**01/10/2023**	**To Do**	To be reviewed
Training Needs Analysis				
Training Needs Analysis	Review TNAs	**01/11/2023**	**To Do**	To be reviewed to align with new Health Commander national occupational standards
Trust EPRR Risk Register				
Procedure for EPRR Risk Assessments Policy	Review procedure	**01/06/2026**	**Completed**	Next for review 2026
EPRR Risk Assessments	Complete additional risk assessments	**31/12/2023**	**To Do**	All risks to be reviewed taking into account the latest 2023 National Risk Register published in August 2023
EPRR Risk Assessment Annual Summary Report	Provide summary report to EPRRSG	**31/12/2023**	**To Do**	Current risks to be reviewed

Emergency Preparedness, Resilience and Response Training Programme – 2022-2024

Key:	Completed	Planned	Cancelled

Date	Training	Training Type	Provided By	NLAG Attendance	Multi-Agency
2022					
05/04/2022	Climate Change	Training	Met Office	Ashley Leggott	Multi-Agency
11/04/2022	Manager On Call	Training	NLAG	NLAG Staff	NLAG
28/04/2022	Meteorology for Responders	Training	Met Office	Ashley Leggott	Multi-Agency
03/05/2022	Summer Weather Hazards	Training	Met Office	Ashley Leggott	Multi-Agency
09/05/2022	Space Weather	Training	Met Office	Ashley Leggott	Multi-Agency
18/05/2022	Atmospheric Dispersion	Training	Met Office	Ashley Leggott	Multi-Agency
28/06/2022	Cyber Exercise	Exercise	Humber LRF/EA	Matt Overton/ Tonya Fredrickson	Multi-Agency
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-Agency
20/07/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
22/07/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
25/07/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
15-17/08/2022	CBRNe/HAZMAT	Training	NLAG	ED DPOW	NLAG
16/08/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
12/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
13/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
18/09/2022	Flood EX	Exercise	Humber LRF/EA	NLAG Staff	Multi-Agency
21/09/2022	Emergency Services Show	Talks	Multi Agencies	Ashley Leggott/Matt Overton	Multi-Agency
22/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
28/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
30/09/2022	Principles of Health Command	Training	NHSE/I	NLAG Staff	Multi-Agency
10/10/2022	Winter Weather Hazards	Training	Met Office	Ashley Leggott	Multi-Agency

14-18/11/2022	Flood EX	Exercise	Humber LRF/EA	Ashley Leggott/Matt Overton	Multi-Agency
22/11/2022	Loggist	Training	NLAG	NLAG Staff	NLAG
29/11/2022	Loggist	Training	NLAG	CHCP	CHCP
29/11/2-23-02/12/2022	Exercise Artic Willow	Exercise	NHSE	Ashley Leggott/Matt Overton	Multi-Agency
14-15/12/2022	Electrical Incident SGH	Incident	NLAG	NLAG Staff	NLAG
15/12/2022	RCN Strike	Incident	NHSE	NLAG Staff	Multi-Agency
21/12/2022	RCN Strike	Incident	NHSE	NLAG Staff	Multi-Agency
2023					
January	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
12/01/2023	Loggist	Training	NLAG	NLAG Staff	NLAG
09/01/2023	CBRNe/HAZMAT DPOW	Training	NLAG	NLAG Staff	NLAG
16/01/2023	CBRNe/HAZMAT DPOW	Training	NLAG	NLAG Staff	NLAG
18-19/01/2023	RCN Strike	Incident	NHSE	NLAG Staff	NLAG
18/01/2023	Loggist	Training	NLAG	NLAG Staff	NLAG
23/01/2023	CBRNe/HAZMAT DPOW	Training	NLAG	NLAG Staff	NLAG
27/01/2023	Loggist	Training	NLAG	CHCP	NLAG
08/02/2023	Loggist	Training	NLAG	NLAG Staff	NLAG
16/02/2023	Loggist	Training	NLAG	NLAG Staff	NLAG
February	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
01-03/03/2023	RCN Strike	Incident	NHSE	NLAG Staff	NLAG
13-15/03/2023	Junior Doctor Strike	Incident	NHSE	NLAG Staff	NLAG
21/03/2023	Covid-19 Capstick Training	Training	Capstick	Covid-19 Enquiry Team	NLAG
March	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
23/03/2023	Loggist	Training	NLAG	NLAG Staff	NLAG
March	CBRNe/HAZMAT	Training	NLAG	NLAG Staff	NLAG
28-30/03/2023	Exercise Mighty Oak	Exercise	NHSE	Ashley Leggott/Matt Overton	Multi-Agency
03-04/04/2023	HMIMMS	Training	HMIMMS	Ashley Leggott/Matt Overton	
April	Loggist	Training	NLAG	NLAG Staff	NLAG
11-15/04/2023	Junior Doctor Strike	Incident	NHSE	NLAG Staff	NLAG
April	CBRNe/HAZMAT x2	Training	NLAG	NLAG Staff	NLAG
May	Major Incident TT	Exercise	NLAG	NLAG Staff	NLAG
May	Tactical Coordinating Group Training	Training	Humber LRF	Matt Overton/Ashley Leggott	Humber LRF

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	Training	NLAG	NLAG Staff	NLAG
14-16 June 2023	JN Dr Strike	Incident	NLAG	NLAG Staff	NLAG
August	CBRNe/HAZMAT	Training	NLAG	NLAG Staff	NLAG
30 August 2023	Major Incident TT	Exercise	NLAG	Strategic/Tactical Health Commanders	NLAG
20 September 2023	Emergency Services Show	Exercise	External	Matt Overton/Ashley Leggott	External
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
October	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
2024					
2024 - TBC	Live CBRNe/HAZMAT Exercise at DPOWH	Exercise	NLAG	NLAG Staff	Multi-Agency
2024 - TBC	Live CBRNe/HAZMAT Exercise at SGH	Exercise	NLAG	NLAG Staff	Multi-Agency

Electrical Infrastructure Failure – Post-Incident Action Plan

Action	Lead	Timeframe	Update / Completion
Review the UPS power back systems within IT datacentres	Steve Matten, Associate Director of IM&T	31st May 2023	**Active and ongoing** - A list of all Uninterruptable Power Supply Units (UPS) has been given to Estates and Facilities in priority order. We are currently awaiting Estates and Facilities to complete their review and feedback options
Review data back-up systems for IT services including the use of the Cloud	Steve Matten, Associate Director of IM&T	31st May 2023	**Closed and complete** - We have moved this piece of work into a wider piece of work which is reviewing Data Storage, Backups and Disaster Recovery covering HUTH and NLAG as part of the delivery of a single Digital service to both Trusts.
Wards and Departments to review their cyber crash boxes ensuring they are updated, maintained and all staff are aware of the location	Divisional Matrons	28th February 2023	**Closed and complete** - Ward boxes reviewed by ward leadership teams and aware of additional support through ops centres. Audit process ongoing to report into the EPRR Group for future assurance
Review of back up system to EPMA	Paulash Haider, Assistant Chief Pharmacist	31st March 2023	**Closed and complete** - Due to EPMA servers being restarted relatively quickly, the business continuity fallback to paper was not needed so other than a delay in accessing the system, service was not significantly affected
Review of BCP for areas that are highlighted as specialist locations (e.g. Hyper-Acute Stroke Service (HASU) and ensure they have pre-identified relocation areas	Divisional Matrons	31st March 2023	**Closed and complete** - Relocation would be done based on individual patient assessment. Based on any specific incident we would then be able to consider different environments to support higher levels of care dependent on length of time

			needed and alternative ward structures e.g. oxygen availability. The new BCP template contains a specific section and prompt to capture any pre-identified suitable relocation areas
Review of Switchboard BCP focusing on when IT outages occur	Cath Butterill, Head of IT Operations	31st March 2023	**Closed and complete** - Testing of business continuity plans with test runs for Switchboard staff so they are confident in the new process have been completed. Switchboard has updated their documentation

NLG(23)214

<table>
<tr><td>Name of the Meeting</td><td>Trust Board of Directors</td></tr>
<tr><td>Date of the Meeting</td><td>5th December 2023</td></tr>
<tr><td>Director Lead</td><td>Shaun Stacey, Group Chief Delivery Officer</td></tr>
<tr><td>Contact Officer/Author</td><td>Matt Overton, Associate Director of Central Operations
Ashley Leggott, EPRR Manager</td></tr>
<tr><td>Title of the Report</td><td>NLAG Compliance with the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) for 2023/24</td></tr>
<tr><td>Purpose of the Report and Executive Summary (to include recommendations)</td><td>
This report provides the outcome of the Trust's annual assessment of compliance with the NHS England Core Standards for EPRR for 2023/24.

This year NHS England has changed the assurance process, expanding the compliance requirements for each core standard and requiring uploading of evidence for a revised check and challenge process. NLAG provided 3,450+ pages of evidence across 220 individual documents as part of the submission.

Although there were no core standards identified as non-compliant, partially compliant core standards do not count towards the overall compliance rating. For this reason, the Trust scored 40% overall compliance which results in an overall compliance rating of non-compliant.

<table>
<tr><th colspan="4">Post-check and Challenge</th></tr>
<tr><td>Self-Assessment Assurance Rating:</td><td>Non-compliant</td><td>Percentage Compliance:</td><td>40%</td></tr>
<tr><td>Evidence provided:</td><td colspan="3">Total 220 individual documents (3,450+ pages)</td></tr>
<tr><td>Number of core standards applicable</td><td>Fully compliant</td><td>Partially compliant</td><td>Non-compliant</td></tr>
<tr><td>62</td><td>25</td><td>37</td><td>0</td></tr>
</table>

The core standards rated as partially compliant were due to the Trust being unable to provide documented evidence to cover 100% of the individual core standard's requirements or where additional detail is required to be included in the relevant plan to cover 100% of the standard.

An action plan has been developed to address the core standards that were rated partially compliant and is included within Appendix B with timescales to convert these to fully compliant within the next 12 months. The action plan will be monitored for completion through the EPRR Group and NLAG's internal governance with external updates provided to the ICB and Local Health Resilience Partnership (LHRP).
</td></tr>
</table>

	NHS England acknowledged the reduction in compliance ratings experienced by all NHS providers within the ICB and stated it is recognised that Boards may be concerned by the reduction in compliance ratings, however, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery. As part of the Local Health Resilience Partnership (LHRP) check and challenge meeting it was clarified that NLAG's 40% has achieved the highest acute provider compliance ratings against the new process. There are clearly themes of partial compliance against certain core standards which require a collaborative approach to resolving (e.g. mass casualty planning across the ICB) and NLAG will proactively engage with partner organisations on addressing these. The change in assurance process for this year has resulted in a drop in compliance against the NHS England Core Standards for EPRR due to partial compliance with 60% of the core standards (2022/23 the Trust was partially compliant with 9% of the core standards). Whilst the Trust's primary ability to respond to EPRR incidents has not changed, the increased requirements in the new process has identified further changes and additions required to our existing plans and the need to collate additional evidence throughout the year to provide documented evidence for next year's assurance process. These identified actions will support the Trust's EPRR continuous improvement and the work and training programme. The Board is asked to: • Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2023/24 (Appendix A) • Note the action plan to address partially compliant core standards (Appendix B)
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ✓ Finance & Performance Committee ☐ Operational Management Group ✓ Other: Executive Team
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

Northern Lincolnshire and Goole NHS Foundation Trust

Directorate of Chief Operating Officer

NLAG Compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR) for 2023/24

Report Date:	9th November 2023
Version:	1.2 - (revised 29th November 2023)
Number of Pages:	20
Report Author:	Matt Overton, Associate Director of Central Operations Ashley Leggott, EPRR Manager
Director Sign-Off:	Shaun Stacey, Group Chief Delivery Officer (Accountable Emergency Officer)

1.0 Background

NHS England has a responsibility to gain assurance on the preparedness of the NHS to respond to incidents and emergencies, whilst maintaining the ability to remain resilient and continue to delivery critical services.

This is achieved through the Emergency Preparedness, Resilience and Response (EPRR) Annual Assurance process which assesses each NHS provider's current compliance against the NHS England Core Standards for EPRR.

Each year the NHS England Core Standards for EPRR are reviewed and revised by the national team prior to circulation to commence the assurance process. This year for 2023/24 has seen an amended assurance process for the North East.

2.0 NHS England Core Standards for EPRR Assurance Process

The previous assurance process (up to and including 2022/23) involved the Trust completing a self-assessment against the core standards, followed by a peer review and scrutiny from the Humber and North Yorkshire Integrated Care Board (HNY ICB), previously scrutinised by the Clinical Commissioning Groups, prior to sign off by the Trust Board. The outcome was then submitted to the North East and Yorkshire Local Health Resilience Partnership (LHRP) and reported through to the national team.

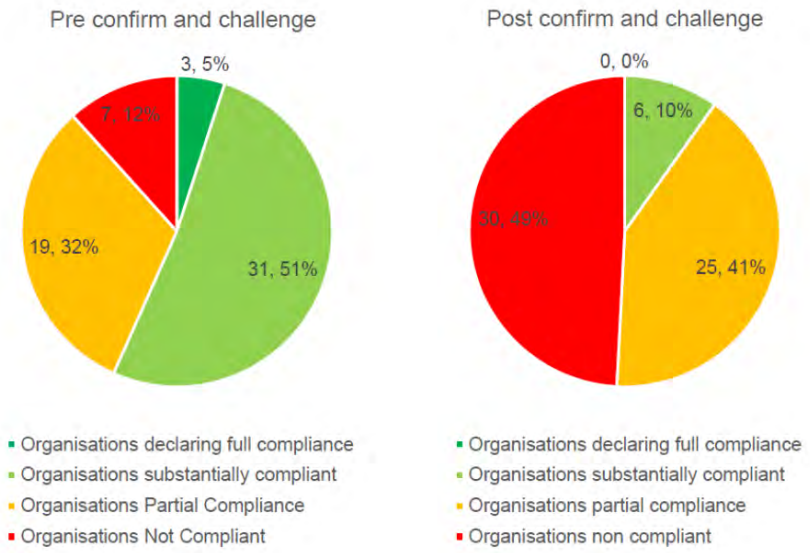
This year's 2023/24 process has now significantly changed for the North East. The Trust was required to complete a self-assessment against the updated core standards for 2023/24, including an expanded set of additional compliance requirements provided in an 82 page PowerPoint pack (previously embedded at Appendix D but removed for Trust Board). Alongside the completion of the self-assessment Trusts were required to upload all documentation as evidence cross-referenced to each core standard. For NLAG this involved uploading and cross-referencing 3,200+ pages of evidence across 188 individual documents. This submission was provided ahead of the 29th September 2023 deadline.

NHS England and independent ICB colleagues then reviewed the Trust's uploaded evidence against the self-assessment compliance ratings as part of a check and challenge process and provided back a response on 13th October 2023 detailing a list of challenges. NLAG were provided a five working day deadline to review these challenges and provide further additional evidence or accept the revised compliance ratings. NLAG uploaded 782 pages of evidence across 43 individual documents as part of the additional evidence phase and resubmitted ahead of the 23rd October 2023 deadline.

On 27th October 2023 NLAG received the final outcomes of the check and challenge process from NHS England. These outcomes were incorporated into the self-assessment submission for re-submission as the Trust's final outcome submission using a large multi-tab Excel spreadsheet (previously embedded at Appendix C but removed for Trust Board). The next stage of the process was the check and challenge meeting with each provider's Accountable Emergency Officer (AEO) at the North East and Yorkshire LHRP on 21st November 2023. The annual assurance process concludes with the Trust's statement of compliance for 2023/24 being presented to the Trust Board before 31st December 2023 (this report) and inclusion in the next Trust Annual Report publication.

This new assurance process for 2023/24 was first piloted last year in the Midlands Region for 2022/23. The Midlands results, as detailed in the diagram below, display the significant change in compliance ratings from the previous process to the new increased requirements and evidence-based review process.

NHS Midlands Region Levels of Pre and Post Confirm and Challenge from 2022/23 Pilot



The changes in assurance levels indicated that there were areas of collective and individual action which would improve resilience at both an organisational and system level for patients and communities. This enabled Midlands colleagues to identify areas for collaborative working in delivering key actions associated with their resilience.

NHS England state that introducing this model in the regions was about establishing a baseline compliance level – a hard reset of our readiness following protracted periods of response and in order to identify greater opportunities for collaboration and system improvement.

The rationale for a change in process provided by NHS England is that over recent years the EPRR world has seen both significant disruption and major change, from our exit from the European Union, COVID-19 pandemic, Manchester Areana attack, and the recent series of industrial action. The demands on Accountable Emergency Officers, EPRR professional and Boards in ensuring robust, resilient systems for patients and communities, has never been greater.

3.0 Trust's Compliance with NHS England Core Standards for EPRR 2023/24

The Trust's EPRR team completed the self-assessment rating against the core standards during August/September 2023 with the following initial submission:

Pre-check and Challenge			
Self-Assessment Assurance Rating:	Partially Compliant	Percentage Compliance:	87%
Evidence provided:	188 individual documents (3,200+ pages)		
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	54	8	0

NHS England completed the check and challenge process of the evidence provided and the outcome of the final submission is:

Post-check and Challenge			
Self-Assessment Assurance Rating:	Non-compliant	Percentage Compliance:	40%
Evidence provided:	Total 220 individual documents (3,450+ pages)		
Number of core standards applicable	Fully compliant	Partially compliant	Non-compliant
62	25	37	0

There were no core standards identified as non-compliant.

The core standards rated as partially compliant were due to the Trust being unable to provide documented evidence to cover 100% of the individual core standard's requirements or where additional detail is required to be included in the relevant plan to cover 100% of the standard.

An action plan has been developed to address the core standards that were rated partially compliant and are included at Appendix B with timescales to convert these to fully compliant within the next 12 months. The action plan will be monitored for completion through the EPRR Group and NLAG's internal governance with external updates provided to the ICB and LHRP.

The assurance rating thresholds for the overall compliance rating are:

- Fully Compliant = 100%
- Substantially Compliant = 99-89%
- Partially Compliant = 88-77%
- Non-compliant = 76% or less

Although there were no core standards identified as non-compliant, partially compliant core standards do not count towards the overall compliance rating. For this reason, the Trust scored 40% overall compliance which results in an overall compliance rating of non-compliant. The Statement of Compliance is included at Appendix A.

For comparison, NLAG's compliance last year with the NHS England Core Standards for EPRR for 2022/23 was rated as substantially compliant with a peer reviewed and scrutinised score of 91% compliant.

NHS England acknowledged the reduction in compliance ratings experienced by all NHS providers within the ICB and stated it is recognised that Boards may be concerned by the reduction in compliance ratings, however, it is important to note that this does not signal a material change or deterioration in preparedness but should be considered as a revised and more rigorous baseline in which to improve plans for preparedness, response and recovery.

As part of the Local Health Resilience Partnership (LHRP) check and challenge meeting it was clarified that NLAG's 40% has achieved the highest acute provider compliance ratings against the new process. There are clearly themes of partial compliance against certain core standards which require a collaborative approach to resolving (e.g. mass casualty planning across the ICB) and NLAG will proactively engage with partner organisations on addressing these.

3.0 Deep Dive Subject for 2023/24

Each year alongside the main NHS England Core Standards for EPRR self-assessment process there is also a national deep dive subject. This year's deep dive subject was EPRR Training. The deep dive subject is not incorporated into the same check and challenge process as with the main core standards but is a solely self-assessment process.

The Trust reviewed the ten standards within this deep dive and rated five of the standards as fully compliant and five as partially compliant. The five partially compliant standards relate to the requirement to review and update the Training Needs Analysis for roles to align with the latest Minimum Occupational Standards for EPRR and training compliance levels. The actions to address these partially compliant standards are included in the action plan at Appendix B.

4.0 Summary and Next Steps

The change in assurance process for this year has resulted in a drop in compliance against the NHS England Core Standards for EPRR due to partial compliance with 60% of the core standards. This drop in compliance is being experienced across the whole ICB and NLAG continues to hold the highest compliance ratings of acute providers in the ICB. Whilst the Trust's primary ability to respond to EPRR incidents has not changed, the increased requirements in the new process has identified further changes and additions required to our existing plans and the need to collate additional evidence throughout the year to provide documented evidence for next year's assurance process. These identified actions will support the Trust's EPRR continuous improvement and the work and training programme.

As part of our next steps:

- The Trust's EPRR Team will update the EPRR Work Programme and Training Programme to include the required work identified in the action plan within Appendix B, including corporate and divisional colleagues who hold lead roles for identified actions
- The Trust's EPRR Group will monitor the completion of the action plan and the Trust will provide regular updates to the ICB EPRR Team and the LHRP on progress
- The Trust's EPRR Team will continue to engage in collaborative working with partner agencies and the other Acute NHS Providers within our ICB on the updating of our emergency planning arrangements, exercising and testing. The Trust's EPRR Team will also work closely with the Hull University Teaching Hospitals EPRR Team to share our best practice on core standards where we have been rated as fully compliant and jointly address the partially compliant elements through collaborative working

5.0 Trust Board Action Required

The Trust Board is asked to:

- Approve NLAG's Statement of Compliance for the NHS England Core Standards for EPRR 2023/24 (Appendix A)
- Note the action plan to address partially compliant core standards (Appendix B)

Appendix A

North East & Yorkshire Emergency Preparedness, Resilience and Response (EPRR) Assurance 2023-2024

STATEMENT OF COMPLIANCE

Northern Lincolnshire and Goole NHS Foundation Trust has undertaken a self-assessment against required areas of the EPRR Core standards self-assessment tool v1.0.

Where areas require further action, Northern Lincolnshire and Goole NHS Foundation Trust will meet with the LHRP to review the attached core standards, associated improvement plan and to agree a process ensuring non-compliant standards are regularly monitored until an agreed level of compliance is reached.

Following self-assessment, the organisation has been assigned as an EPRR assurance rating of Non-compliant (from the four options in the table below) against the core standards.

Overall EPRR assurance rating	Criteria
Fully	The organisation is 100% compliant with all core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantial	The organisation is 89-99% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partial	The organisation is 77-88% compliant with the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-compliant	The organisation compliant with 76% or less of the core standards the organisation is expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plans will be monitored on a quarterly basis to demonstrate progress towards compliance.

I confirm that the above level of compliance with the core standards has been agreed by the organisation's board/governing body along with the enclosed action plan and governance deep dive responses.

Signed by the organisation's Accountable Emergency Officer

Shaun Stacey — Group Chief Delivery Officer — 09/11/2023
Date signed

05/12/2023	05/12/2023	TBC - 2024
Date of Board/Governing Body meeting	Date presented at Public Board	Date published in organisation's Annual Report

Appendix B

Action Plan for Partially Compliant Core Standards

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
4	Governance	**EPRR work programme**	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	Evidence • Reporting process explicitly described within the EPRR policy statement • Annual work plan	A annual work and training programme is produced each year that covers a period of 3 years this is included within the annual report that is submitted to Trust board. >EPRR Annual Report for 2021/22 with Work Programme (p12-18) and Training Programme (p19-21) >EPRR Training Programme >EPRR Policy (p7) >EPRR Group Minutes (p3) **Additional Evidence Provided-** The EPRR work and training programme runs on calendar year basis and a recent copy of both is included in the EPRR Annual Report for 2022/23 in Appendix B (page 18-23) and Appendix C (page 24-26). This annual report was previously provided for over core standards but we have uploaded it agian for ease of reference as AE2 - EPRR Annual Report 2022/23. Each calendar year is provided in the appendix with the 2023 training programme showing rpogress to date (there is a key on page 24 showing green as completed) and includes the training programme for the rest of 2023 and some distance plans for 2024. The work programme provides details on updates for each item including those already completed and those in progress/planned. >AE2 - EPRR Annual Report 2022/23	Partially Compliant	Work Programme to be a quarterly item on the EPRR Group agenda to provide updates on status. Redesign the EPRR Work Programme format.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	To be implemented by November 2023 January 2024	
5	Governance	**EPRR Resource**	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	Evidence • EPRR Policy identifies resources required to fulfil EPRR function; policy has been signed off by the organisation's Board • Assessment of role / resources • Role description of EPRR Staff/ staff who undertake the EPRR responsibilities • Organisation structure chart • Internal Governance process chart including EPRR group	All EPRR roles required within the EPRR Policy are substantially recruited to and in post. Structure charts with accountability to the AEO and EPRR governance reporting up to the Trust Board. >EPRR Policy (p2-3 for governance, p3-6 for roles required) >Associate Director of Central Operations Job Description and Person Specification >Emergency Planning Manager Job Description >EPRR Group Terms of Reference (p2) >Central Operations Structure Chart **Additional Evidence Provided-** The Trust EPRR Policy provides a list of all roles/resources required to deliver the EPRR function within the Trust in section 4.0. This is the Trust's resourcing committment and the EPRR Policy has been appoved by the Trust Management Board. All of these roles are currently substantively recruited to and in post. These include: Shaun Stacey (COO/AEO), Matt Overton (Associate Director of Central Operations), Ashley Leggott (EPRR Manager) and Angela Hunter (Emergency Planning Officer).	Partially Compliant	Awaiting the methologies / tool kit from NHSE to fully demostrate this. In the mean time an update to the Trust EPRR Policy indicating the board are satified with the EPRR Resources	Ashley Leggott, EPRR Manager	March 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RA	Action to be taken	Lead	Timescale	Update
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	Evidence • Process explicitly described within the EPRR policy statement • Reporting those lessons to the Board/ governing body and where the improvements to plans were made • participation within a regional process for sharing lessons with partner organisations	Within the Annual Report we include detials such incidents and learnings from the last year that help to steer the EPRR work programme. Each emergency plan details that post-exercise or post-incident a debrief is conducted and lessons to be learned are captured and form part of a post-incident action plan. Action plans are monitored through the EPRR Group. Exercise and incidents are discussed at the EPRR Group which includes membership from all Directorates within the Trust. Example evidence of lessons learned provided. >EPRR Policy (p7) >Annual Report for EPRR 2022/23 (p.9-14) >Industrial Action Debrief to NEY System >Highlight Report to ARG from Oxygen Incident >Post-Incident Report from Electrical Infrastructure Failure >Email of sharing post-incident report with ULH **Additional Evidence Provided-** The organisation holds great importance on learning from incidents, both EPRR and non-EPRR. Additional evidence has been provided to address the reporting process to capture lessons to be learned from incidents, including how these are captured, overseen, embedded and shared with partners and external agencies when required. AE3 - Incident Reporting Policy and Procedure provides the Trust's approach and procedure to incident reporting and root cause analysis. AE4 - Policy for Dealing with Serious Incidents (Clinical and Non-Clinical) provides the Trust's procedures for how a serious incident is investigated and lessons to be learned identified and shared internally and externally. AE5 - Learnign Strategy provides the Trust's approach and processes for how learning is shared with all levels of staff as deemed appropriate for the incident. This includes mechanisms of communication and distribution.	Partially Compliant	The EPRR policy to explicitly include details on how EPRR learning will be captured, overseen, embedded and shared with partners	Ashley Leggott, EPRR Manager	March 2024	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	• Evidence that EPRR risks are regularly considered and recorded • Evidence that EPRR risks are represented and recorded on the organisations corporate risk register • Risk assessments to consider community risk registers and as a core component, include reasonable worst-case scenarios and extreme events for adverse weather	The Trust has an EPRR Risk Register which incorperates risks from the LHRP and Humber Community Risk Register also incorperating risks that have being indentified specifcally within the Trust. The register is due review and to be presented to the EPRR Group. >Policy for the Management of the Trust EPRR Risk Register >Trust EPRR Risk Register Overview 2023 >Policy for Developig and Maintaining the Trust Risk Register >Board Assurance Framework 1-06 Risk - Business Continuity >EPRR Policy (p6) >Humber Community Risk Register >2023 National Risk Register >EPRR Group Minutes including top LHRP risks discussed (p2) >LHRP Minutes when top risks discussed (P3-4) >EPRR Briefing slides to EPRR Group including top LHRP risks (p7-9) >Example of Corporate Risk Register Entry - Decon Tent >CBRN Audit Report by EMAS	Partially Compliant	NLAG risk assessments to be reviewed and an overview presented to EPRR Group for oversight. Any risks scored as 'very high' will be added to the Trust's corporate risk register.	Ashley Leggott, EPRR Manager	May 2024	
9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders stakeholders including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	Partner organisations collaborated with as part of the planning process are in planning arrangements Evidence • Consultation process in place for plans and arrangements • Changes to arrangements as a result of consultation are recorded	The consultation process in included in the EPRR Policy and within individual plans there is a section on consultation and dissemination. We do not hold evidence to demonstrate changes made from consultations with partner organisations. NLAG is an active participant at LRF Sub-Groups and LHRP where collaborative planning takes place. >EPRR Policy (p6) >LHRP membership >Example agendas and minutes from LRF Sub-Group collaborative planning	Partially Compliant	Save evidence of amendments made to emergency plans from consultation with key stakeholders going forward. Update EPRR Policy to explicitly cover this process.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	Ongoing from Sept 2023 March 2024	All plans under review or development that are shared for external partner consultation will now have a record of comments and amendments stored by the EPRR Team

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RA	Action to be taken	Lead	Timescale	Update
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	Arrangements should be: • current • in line with current national UK Health Security Agency (UKHSA) & NHS guidance and Met Office or Environment Agency alerts • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required • reflective of climate change risk assessments • cognisant of extreme events e.g. drought, storms (including dust storms), wildfire.	The heaatwave plan provides the specifics to respond to health alerts following the national released guidance on adverse weather plans. We have a plan for 4x4 response with Lincolnshire 4x4 Ltd for adverse weather. The Trust's Critical Incident Plan and/or Business Continuity Plans would be used alongside the Natioanl Adverse Weather Health Plan 2023 during cold adverse weather to maintain critical services. NLAG have a plan for supporting rest centres and evacuation in the community including the process for the identification of vulernable patients. >Heatwave Plan >NLAG and Lincolnshire 4x4 Response Ltd Plan >Critical Incident Plan >National Adverse Weather Health Plan >NLAG Plan to Support Evacuation in Community including Identification of Vulnerable Patients >SystmOne Reporting Identification of Vulnerable Patients Guidance >Post-Incident Report - Heatwave 2022	Partially Compliant	Develop an adverse weather plan for the Trust which collates the various existing adverse weather response arrangements into one document	Ashley Leggott, EPRR Manager	May 2024	
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Acute providers should ensure their arrangements reflect the guidance issued by DHSC in relation to FFP3 Resilience in Acute setting incorporating the FFP3 resilience principles.	The Trust has a developed pandemic influenza plan that covers the Trust's response to other infectious desease outbreaks as well. This was regularly updated during the Trust's response to the Covid-19 pandemic from the learning identified and guidance that was released. >Influenza Pandemic Plan >IPC Policy Statement >NLAG Plan to Support Mass Vaccinations / Treatment >FFP3 testing guidance x5	Partially Compliant	Revise Pandemic Influenza Plan and turn into Pandemic Plan	Ashley Leggott, EPRR Manager	February 2024	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a developed pandemic influenza plan that covers the Trust's response to other infectious desease outbreaks as well. This was regularly updated during the Trust's response to the Covid-19 pandemic from the learning identified and guidance that was released. >Influenza Pandemic Plan >IPC Policy Statement >EPRR Annual Report 2021/22 - lessons learned from covid-19 (p8-9) >NLAG Plan to Support Mass Vaccinations / Treatment >FFP3 testing guidance x5	Partially Compliant	Revise Pandemic Influenza Plan and turn into Pandemic Plan	Ashley Leggott, EPRR Manager	February 2024	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required Receiving organisations should also include a safe identification system for unidentified patients in an emergency/mass casualty incident where necessary.	While the Trust does not have stand alone policy for mass casualty incidents, we follow our actions within the regional and national plans for such events. The Trust's Major Incident Plan and ICC Manual provide the command and control structure and the key roles and responsibilities for the reponse. The Patient Flow, Escalation and Surge Plan provides actions to support increased discharge and bed capacity. >Major Incident Plan >ICC Manual >Yorkshire and Humber Mass Casualty Framework for Health >Patient Flow, Escalation and Surge Policy Including Full Capacity Protocol >LRF Mass Casualty Framework >EMAS Mass Casualty Plan >Burns Major Incident and Burns Mass Casualty Plan >Concept of Operations for Mass Casualties	Partially Compliant	A Trust Mass Casualty Plan to be developed to collate the existing actions for the Trust and align with the HNY Mass Casualty Plan once published. Major Incident Plan to be updated to include a section on how the hospitals will respond to a Mass Casualty event that links with the newly developed Mass Casualty Plan.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	May 2024 May 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
16	**Duty to maintain plans**	**Evacuation and shelter**	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff and visitors.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Full and Partial Site Evacuation Plan contains the detailed evacuation reponse to all three hospital sites and incorproates the latest NHS Evacuatin and Shelter Guidance v4. The Major Incident Plan and Incident Coordination Centre Manual details the command and control strucure including multi-agency links. The Trust participated in a regional exercise regarding RACC at Airedale site. During the Covid-19 pandemic Oxygen Incident phase 1 of plan was implemented to evacuate wards to suitable alternative locations which superseded the need for an exercise of the plan. >Full and Partial Site Evacuation Plan >NLAG Plan to Support Evacuation in Community including Identification of Vulnerable Patients > Major Incident Plan >Critical Incident Plan >ICC Manual **Additional Evidence Provided-** The recently reviewed Evacuation Plan is sufficient in content to provide an emergency response plan to an evacuation incident and we feel should be graded as compliant. Additional elements identified in recently released guidance will be incorproated into the plan as a further update but should not result in the core standard being partially compliant at present. Query - How was this guidance disseminated to Acute Providers? We have checked all received emails to the Trust's EPRR mailbox/SPOC and have no record of receiving this information. We have also checked with a neighbouring Trust who also did not receive any notification of this revised guidance.	Partially Compliant	The Trust Evacuation Plan to be updated to refer to the new NHS England Evacuation & Shelter Guidance 2023 information	Ashley Leggott, EPRR Manager	January 2024	
17	**Duty to maintain plans**	**Lockdown**	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff and visitors to and from the organisation's premises and key assets in an incident.	Arrangements should be: • current • in line with current national guidance • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust has a policy and procedure for lockdown which covers all aspects of implementing and managing a lockdown from a small area (e.g. department) to the whole hospital site. There ae specific plans for baby tagging and policy to respond to abductions. >Policy and Procedure for Lockdown >X-Tag Baby Tagging System SOP >Policy for the Response in the Event of Missing / Abducted Child or Young Person > Identification and Security of the Newborn >CBRNe/Hazmat Plan (p9)	Partially Compliant	The Policy and Procedure for Lockdown to be tested through an exercise and any lessons to be learned incorporated into an update ot the plan	Phil Young, Trust LSMS	March 2024	
19	**Duty to maintain plans**	**Excess fatalities**	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	Arrangements should be: • current • in line with current national guidance in line with DVI processes • in line with risk assessment • tested regularly • signed off by the appropriate mechanism • shared appropriately with those required to use them • outline any equipment requirements • outline any staff training required	The Trust's response and actions are detailed in the LRF Mass Fatalities Plan. The Mortuary services (delivered by United Lincolnshire Hospitals Trust) has business continuity arrangements in place to respond to incidents such as body capacity being exceeded, for yse during incidents such as a mass fatality incident. >LRF Mass Fatalities Plan >LRF Temporary Mortuary Plan >Mortuary BCP (Cellular Pathology Service) **Additional Evidence Provided-** The Major Incident Plan (AE13) (previousy submitted) includes the following: Action Card 29 (page 70) refers to mortuary capacity and working with the Coroner to establish temporary mortuary arrangements if required. Section 22 (page 15) refers to post-incident support and acknowledges mass casualty events can have strong impacts on staff. Action Card 33 (page 76-77) refers to hospital chaplain support to relatives of dead and injured. Action Card 34 (page 78) refers to relatives area supervisor offering support to relatives of injured/dead. We are not aware of any national guidance that mandates Acute Trusts to have a separate specific mass fatalities plan. The actions required of NLAG in the event of a mass fatalities incident are covered within the LRF Plans previously provided as evidence. >AE13- Major Incident Plan	Partially Compliant	The Trust Major Incident Plan to be updated to include the wider requirements of the organisation in complying with this standard - e.g. delays in the death management system, triggers for activated storage and the Trust's role in supporting the LRF response (e.g. psychosocial support for those affected in an incident not necessarily just staff). Develop a Mass Fatalies Plan to support the Major Incident Plan.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	February 2024 June 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RA	Action to be taken	Lead	Timescale	Update
21	**Command and control**	**Trained on-call staff**	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	• Process explicitly described within the EPRR policy or statement of intent The identified individual: • Should be trained according to the NHS England EPRR competencies (National Minimum Occupational Standards) • Has a specific process to adopt during the decision making • Is aware who should be consulted and informed during decision making • Should ensure appropriate records are maintained throughout. • Trained in accordance with the TNA identified frequency.	The Gold On-Call Development Pack is structured on the core competencies required for the role of Strategic Health Commander and aligns with the NOS. Multiple training sessions support the achievement of these competencies. 6 monthly switchboard cascades are carried (in and out of hours) to ensure staff are aware of the correct processes to follow and their respective action card number. >Gold On-Call Development Pack >Gold On-Call Central Operations Session PP >Gold On-Call EPRR Session PP >HNY ICB Training Needs Analysis Spreadsheet >Switchboard Cascade Test Report >Switchboard Cascade Template >ICC Manual (p7) **Additional Evidence Provided-** AE6 - Strategic Health Commander Training list was previously submitted as evidence under another core standard but has been resubmitted here to ease of reference. This provides a list of current Gold On-Call and Executive On-Call rostered staff and the SHC training date they attended. NLAG are still to receive a copy of the Health Commander portfolios that we should be using. In May 2023 the ICB shared with us a copy of draft portfolios to provide comments. In June 2023 we were updated that NHSE were reviewing these drafts to make them more user friendly. We have still not received the final portfolio copies to implement. In the meantime, NLAG has developed a Gold On-Call Development Pack of required training (previously provided as evidence). Also provided as evidence for other core standards is an example of a completed portfolio and COO/AEO sign off (re-uploaded as AE7 and AE8 for ease of reference). >AE6 - Strategic Health Commander Training List	Partially Compliant	Review of the MOS and map to a new TNA for each of the on-call staff	Ashley Leggott, EPRR Manager	March 2024	
22	**Training and exercising**	**EPRR Training**	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	<u>Evidence</u> • Process explicitly described within the EPRR policy or statement of intent • Evidence of a training needs analysis • Training records for all staff on call and those performing a role within the ICC • Training materials • Evidence of personal training and exercising portfolios for key staff	TNA for each key role linked to the action card. Training completed captured within the Annual Report for EPRR. Multiple examples of training materials provided in evidence for both strategic, tactical and operational levels. >Annual Report for EPRR - Training section (p5-7) >EPRR Policy (p7) >EPRR Training Programme >Covid-19 Second Wave Debrief >Switchboard Cascade Test Report >Major Incident Table Top Exercise Controller Pack >CBRNe/HAZMAT Training Session >Gold On-Call Development Pack >Gold On-Call Central Operations Session PP >Gold On-Call EPRR Session PP >Site Matron Development Pack >HNY ICB EPRR TNA Spreadsheet >CPD EPRR Portfolio for Ashley with ref to training qualification >NEY Principles of Health Command Learner Booklet >Example TNA for Decontamination Team **Additional Evidence Provided-** AE6 - Strategic Health Commander Training list was previously submitted as evidence under another core standard but has been resubmitted here to ease of reference. This provides a list of current Gold On-Call and Executive On-Call rostered staff and the SHC training date they attended. NLAG are still to receive a copy of the Health Commander portfolios that we should be using. In May 2023 the ICB shared with us a copy of draft portfolios to provide comments. In June 2023 we were updated that NHSE were reviewing these drafts to make them more user friendly. We have still not received the final portfolio copies to	Partially Compliant	Review of the MOS and map to a new TNA for each of the on-call staff	Ashley Leggott, EPRR Manager	March 2024	
24	**Training and exercising**	**Responder training**	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	<u>Evidence</u> • Training records • Evidence of personal training and exercising portfolios for key staff	A list of all training delivered or participated in is recorded in the EPRR Training Programme. Examples of training records are provided as evidence, such as the Gold On-Call Development Packs which all Strategic Health Commander Gold On-Calls have to complete and get signed off by the Chief Operating Officer (AEO), and the Trust lists of those SHC and THC trained. >Gold On-Call Development Pack >EPRR Training Programme >Strategic Health Commander Training Register >Tactical Health Commander Training Register >CBRNe/Hazmat Training Record >Example CBRNe/HAZMAT Training Assessments	Partially Compliant	Review of the MOS and map to a new TNA for key roles within emergncy plans. Training and exercise records to detail alignment with TNA and MOS.	Ashley Leggott, EPRR Manager / Service Lead for relevant TNA role area	March 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	As part of mandatory training Exercise and Training attendance records reported to Board	Training delivered through the year is included in the Annual Report for EPRR. Examples of training records are provided as evidence, such as the Trust lists of those SHC and THC trained. Training compliance is escalated through the EPRR Group and through the governance structure as required. Where relevant assessments as carried out at the end of training sessions to ensure the training objectives have been met. Examples provided. >Annual Report for EPRR - Training section (p5-7) >Strategic Health Commander Training Register >Tactical Health Commander Training Register >List of Trained Loggists >E&F On-Call Manager Training Records x 3 documents >CBRNe/HAZMAT Training Assessments >Loggist Training Session Assessment and Handout >Example Gold On-Call Q&A Assessment Completed >Example Gold On-Call AEO Sign Off Letter **Additional Evidence Provided-** EPRR is no longer part of the Trust's corporate induction programme for all new starters and is not classified as mandatory training. This will now be reviewed with the Training and Development Department who oversee the corporate induction programme. Individual post holders with key roles in the Trust response are provided with training and awareness, as per the evidence provided previously, but this does not currently extend to 'all staff'. We would ask that consideration is given to this core standard being partially compliant as key roles are currently covered (as per previously provided evidence) and the wider all staff mandatory training and awareness element is what is missing.	Partially Compliant	Set an EPRR package as mandatory training for all staff within the Trust. Explore options to include EPRR in the Trust's Induction Training Programme.	Ashley Leggott, EPRR Manager / Catherine Bosanquet, Head of Training and Development	August 2024	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24 hour access to a trained loggist(s) to ensure support to the decision maker	• Documented processes for accessing and utilising loggists • Training records	The Trust delivers loggist training in line with the national PHE/UKHSA loggist training material and is delivered by a trainer who has BTEC loggist trained themselves and has completed the national loggist instructor trainer the trainer course. A list of trained loggists is maintained and accessible 24/7. Examples of completed logbook entries and provided as well as the training materials. >Loggist Training Pack PP >Loggist Session Handout >List of Trained Loggists >Example of a Completed Logbook entries x4 >Gold On-Call EPRR Session PP (p30-36) >Loggist Training Assessment Form >ICC Manual - ref loggists (p7-8)	Partially Compliant	Loggist call out to be included in the Trust's communication major incidnet cascade tests	Ashley Leggott, EPRR Manager	December 2023	
33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	• Awareness within communications team of the organisation's EPRR plan, and how to report potential incidents. • Measures are in place to ensure incidents are appropriately described and declared in line with the NHS EPRR Framework. • Out of hours communication system (24/7, year-round) is in place to allow access to trained comms support for senior leaders during an incident. This should include on call arrangements. • Having a process for being able to log incoming requests, track responses to these requests and to ensure that information related to incidents is stored effectively. This will allow organisations to provide evidence should it be required for an inquiry.	The Trust has in place a command structure with Tactical commanders as the first contact for incidents, who would then escalate to the Strategic Health Commander. If media request were to be made contact to the communication team as per the Major Incident cascade list would be made. As per the Gold On-Call training pack, the Gold On-Call can contact the Executive On-Call during an incident who would complete media requests. The Associate Director of Communications is the primary contact as part of the cascade and when they are away on leave it is passed to one of the Communications Officers to cover. >EPRR Communications Protocol >EPRR Communications Protocol - ref to restrictions on sharing (p2) >Humber LRF Communication Protocol >Major Incident Plan - Comms section (p25) >Major Icnident Plan - Comms Action Card (p80) >Example Major Incident Cascade Sheet >Comms Logging Process Record >Data Protection and Sharing - Guidance for Emergency Planners and Responders >Gold On-Call Central Operations Session	Partially Compliant	A TNA for the communications officer role to be created that aligns to the MOS and is part of the EPRR Communications Plan	Ashley Leggott, EPRR Manager / Ade Beddow, Associate Director of Communications	February 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	• An incident communications plan has been developed and is available to on call communications staff • The incident communications plan has been tested both in and out of hours • Action cards have been developed for communications roles • A requirement for briefing NHS England regional communications team has been established • The plan has been tested, both in and out of hours as part of an exercise. • Clarity on sign off for communications is included in the plan, noting the need to ensure communications are signed off by incident leads, as well as NHSE (if appropriate).	The Major Incident Plan and ICC Manual provide the structure for communications flow during an incident. The Major Incident Plan has a Communications Officer Action Card 35. The Major Incident cascade test is completed a minimum of every 6 months incuding in and out of hours and includes the Communications Team. The Communications team has held a key part during recent incidents and are well exercised in the delivering their role linked to the Executive sign off of media messages. >EPRR Communications Protocol >Major Incident Cascade Test In Hours >Major Incident Cacasde Test Out of Hours >Major Icnident Plan - Communications Officer Action Card (p80) >ICC Manual >Humber LRF Communications Protocol >LRF Multi-Agency Communications Protocol	Partially Compliant	An exercise of the EPRR Communications Plan to be completed and evidence to idetnify any lessons to be learned.	Ade Beddow, Associate Director of Communications	February 2024	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	• Having an agreed media strategy and a plan for how this will be enacted during an incident. This will allow for timely distribution of information to warn and inform the media • Develop a pool of media spokespeople able to represent the organisation to the media at all times. • Social Media policy and monitoring in place to identify and track information on social media relating to incidents. • Setting up protocols for using social media to warn and inform • Specifying advice to senior staff to effectively use social media accounts whilst the organisation is in incident response	The Trust and LRF communications plans provide the arranegements and are supported by the Trust Social Media Policy. >EPRR Communication Protocol >Trust Social Media Policy >Humber LRF Communications Plan >Humber LRF Emergency Manual >Major Icnident Plan - Communications Officer Action Card (p80) >LRF Multi-Agency Communications Protocol	Partially Compliant	Development of a media strategy that covers how social media will be managed during an incident including process for recording media interactions and approval. Media training for relevent staff linked to MOS, EPRR Communications Plan and Media Strategy	Ade Beddow, Associate Director of Communications	May 2024 May 2024	
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	• Minutes of meetings • Individual members of the LHRP must be authorised by their employing organisation to act in accordance with their organisational governance arrangements and their statutory status and responsibilities.	The AEO or suitable deputy has been in attendance at all of this year's LHRP meetings. The EPRR Policy details the requirmenet to participate in the LHRP and authorises the suitable deputy to deputise for the AEO as required. NLAG participates in collaborative working, sharing of lessons learned from incidents and to the LHRP work programme as required. NLAG also participates in the newly formed LHRP Operational Group. >LHRP Minutes (past 12 months) x3 >Example LHRP Operational Group Minutes >EPRR Policy (p4-5) **Additional Evidence Provided-** While the AEO has not been present at LHRP within the last 12 months, a suitable Director level representative has been present at all LHRP meetings within the last 12 months with the delegated authority as required detailed in the Trust's EPRR Policy.	Partially Compliant	The Trust will ensure that the AEO attends at least 1 LHRP meeting within the 12 month period	Shaun Stacey, Chief Delivery Officer (AEO)	November 2023	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
46	**Business Continuity**	**Business Impact Analysis/Assessment (BIA)**	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	The organisation has identified prioritised activities by undertaking a strategic Business Impact Analysis/Assessments. Business Impact Analysis/Assessment is the key first stage in the development of a BCMS and is therefore critical to a business continuity programme. Documented process on how BIA will be conducted, including: • the method to be used • the frequency of review • how the information will be used to inform planning • how RA is used to support. The organisation should undertake a review of its critical function using a Business Impact Analysis/assessment. Without a Business Impact Analysis organisations are not able to assess/assure compliance without it. The following points should be considered when undertaking a BIA: • Determining impacts over time should demonstrate to top management how quickly the organisation needs to respond to a disruption. • A consistent approach to performing the	The Trust's Business Continuity Plan includes a BIA analysis. BCPs are review annually. Each Division/Directorate updates the EPRR Group on their BCP reviews and testing. Whenever a BCP is implemented it is captured within the post-incident report including lessons to be learned. The BCP inclduing the BIA is reviewed after a plan has been implemented in response to an incident. >Business Continuity Policy >Business Continuity Plan template >Audit Yorkshire Report on BC and EPRR >BIA Template >BIA Guidance >An example BCP completed - WebV Services	Partially Compliant	Develop a Trust level Strategic BIA and present to the EPRR Group	Matt Overton, Associate Director of Central Operations	August 2024	
47	**Business Continuity**	**Business Continuity Plans (BCP)**	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors • IT and infrastructure	Documented evidence that as a minimum the BCP checklist is covered by the various plans of the organisation. Ensure BCPS are Developed using the ISO 22301 and the NHS Toolkit. BC Planning is undertaken by an adequately trained person and contain the following: • Purpose and Scope • Objectives and assumptions • Escalation & Response Structure which is specific to your organisation. • Plan activation criteria, procedures and authorisation. • Response teams roles and responsibilities. • Individual responsibilities and authorities of team members. • Prompts for immediate action and any specific decisions the team may need to make. • Communication requirements and procedures with relevant interested parties. • Internal and external interdependencies. • Summary Information of the organisations prioritised activities. • Decision support checklists • Details of meeting locations	Service-level Business Continuity Plans are in place (150+) covering all services, detailing critical and non-critical functions across the organisation. >Business Continuity Policy >Business Continuity Plan template >Audit Yorkshire Report on BC and EPRR >BIA Template >BIA Guidance >An example BCP completed - WebV Services >Critical Incident Plan	Partially Compliant	Update the BC plan template to include: BCP checklist, roles and responsibilities for team members, prompts for immediate action or action cards for service level activivation and decision support checklists. All live BC Plans to be updated to the new BC Plan template at next scheduled review.	Ashley Leggott, EPRR Manager Angela Hunter, Emergency Planning Officer	January 2024 February 2024 onwards	
48	**Business Continuity**	**Testing and Exercising**	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	Confirm the type of exercise the organisation has undertaken to meet this sub standard: • Discussion based exercise • Scenario Exercises • Simulation Exercises • Live exercise • Test • Undertake a debrief <u>Evidence</u> Post exercise/ testing reports and action plans	The Trust has responded to live incidents where BCPs have been implemented as part of maintaining critical services during the response. The Trust has also partiicpated in multiple exercises which have tested the BCPs and their contents (e.g. BIA) such as Artic Willow (Winter Planning) and Mighty Oak (national power outage). Business Continuity is a standing agenda item on the EPRR Group for discussion with all Divisions/Directorates monthly. >Business Continuity Policy - ref testing (p7) >Business Continuity Plan template >Audit Yorkshire Report on BC and EPRR >Artic Willow Exercise >Mighty Oak Exercise >Electrical Infrastructure Failure Report >Industrial Action >Advance Computer Systems Incident >Covid-19 Response >An example BCP completed - WebV Services	Partially Compliant	Trust BCP tracker to be incorproated into the renewed EPRR Work Programme document and to also include the last test/exercise/activation date	Angela Hunter, Emergency Planning Officer	January 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	Evidence • Statement of compliance • Action plan to obtain compliance if not achieved	The Trust last submitted their compliance in June 2023. The email evidence and attachments include the audit report and management responses. >Email from Joint Data Protection Officer / Information Governance Lead >Data Security and Protection Toolkit Independent Assessment Report >DSPT Improvement Plan	Partially Compliant	DPST to achieve full compliance for 2024	Susan Meakin, Data Protection Officer and Lead for Information Governance	August 2024	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the	• Business continuity policy • BCMS • performance reporting • Board papers	The Trust's position on business continuity is included in the Annual Report for EPRR, with any required escalations through the EPRR governance route. Business Continuity is a Trust stratgeic objective on the Board Assurance Framework (BAF) which is routinely provided to the board. >Annual Report for EPRR (p8) >Board Assurance Framework 1-06 Risk - Business Continuity >Business Continuity Policy >Audit Yorkshire Report on BC and EPRR >EPRR Group Minutes (BC section p3-4)	Partially Compliant	BCMS to iidentify KPI monitoring for Trust BC arrangements. Trust BC Policy to be updated. New BC KPI's to be reported through EPRR Group quarterly and included in EPRR Annual Report for Trust Board.	Angela Hunter, Emergency Planning Officer Ashley Legott, EPRR Manager	May 2024 May 2024	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	• process documented in the EPRR policy/Business continuity policy or BCMS • Board papers showing evidence of improvement • Action plans following exercising, training and incidents • Improvement plans following internal or external auditing •Changes to suppliers or contracts following assessment of suitability Continuous Improvement can be identified via the following routes: • Lessons learned through exercising. • Changes to the organisations structure, products and services, infrastructure, processes or activities. • Changes to the environment in which the organisation operates. • A review or audit. • Changes or updates to the business continuity management lifecycle, such as the BIA or continuity solutions. • Self assessment • Quality assurance • Performance appraisal • Supplier performance • Management review	The Trust's Business Continuity Policy details the BCMS continuous improvement process approach and business continuity is a standing agenda item at EPRR Group each month. Identifying lessons to be learned through post-incident debriefs/reports and subsequent action plans feed into reviews of BCPs. Business continuity is a Trust strategic objective on the Board Assurance Framework with short and long-term objectives to reduce the risk through continuous improvement of systems. Recommendations from audits are incorproated and testing of BCPs through exercises supports improvement. The BC Plan template includes a debrief template to capture learning. >Annual Report for EPRR (p5-7 testing/exercising p8 business continuity and p9-14 on incidents) >Board Assurance Framework 1-06 Risk - Business Continuity >Business Continuity Policy >Audit Yorkshire Report on BC and EPRR >Business Continuity Plan template >EPRR Core Standrads Report 2022 >Electrical Infrastructure Failure Report >Industrial Action (SitReps) >Advance Computer Systems Incident >Covid-19 Response >Highlight Report on Oxygen Monitoring Assurance **Additional Evidance Provided-** The Trust's Business Continuity Policy previously provided (uploaded again as AE38 for ease of reference) provides detail on the exercising and testing priciples (section 5.4e and 5.5, Page 7). The Business Continuity Report for Finance and Performance Committee in May	Partially Compliant	Expand the BCP Policy to explain how lessons are implemented and monitored on progress and changes to BCP's. Improve governance of actions and updates from lessons identified by incorporating a dedicated lessons to be learned tab within the renewed EPRR Work Programme.	Angela Hunter, Emegerncy Planning Officer Ashley Leggott, EPRR Manager	January 2024 Feburary 2024	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	• EPRR policy/Business continuity policy or BCMS outlines the process to be used and how suppliers will be identified for assurance • Provider/supplier assurance framework • Provider/supplier business continuity arrangements This may be supported by the organisations procurement or commercial teams (where trained in BC) at tender phase and at set intervals for critical and/or high value suppliers	The Trust's procurement processes include the need for suppliers and contractors to provide assurance on their business continuity arrangements and this forms part of the scoring matrix at tender. However, we do not currently have a robust process of consistently assessing these or monitoring them when in contract. The Trust's BC plan template does include a section for supplier risk and interdependencies to be identified and a contact list of suppliers which prompts to store a copy of the suppliers BC Plan. >Business Continuity Policy (p8) >Business Continuity Plan template	Partially Compliant	Review of the Trust procurement process for the assessing and moinitoring of contracted supplier's business continuity plans and assurances	Ivan Pannell, Head of Procurement	August 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RA	Action to be taken	Lead	Timescale	Update
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	Details of accountability/responsibility are clearly documented in the organisation's Hazmat/CBRN plan and/or Emergency Planning policy as related to the identified risk and role of the organisation	The CBRNe/HAMZAT Plan identifies the roles and responsibilities for the required elements. The EPRR Policy support this from a governance and assuance perspective. EMAS conducted the Trust's annual review on our CBRNe/HAZMAT preparedness which included the plan and the roles and responsibilieis. >EPRR Policy >CBRNe/HAZMAT Plan >EMAS CBRN Audit 2023	Partially Compliant	Update the CBRN/HAZMAT plan to include explicit roles and responsibilities for planning, training and equipment maintenance associated with the Domain.	Ashley Leggott, EPRR Manager	March 2024	
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	Evidence of the risk assessment process undertaken - including - i) governance for risk assessment process ii) assessment of impacts on staff iii) impact assessment(s) on estates and infrastructure - including access and egress iv) management of potentially hazardous waste v) impact assessments of Hazmat/CBRN decontamination on critical facilities and services	The Trust has a risk assessment for deocntamination of self presenting casualties but it is overdue review. The Trust also has risk assessments on risk associated with a CBRNe/HAZMAT incident occurring which are also due for review. The CBRNe/HAZMAT Plan contains details of the resposne to different risks and provides the risk assessed process for decontamination to be followed. This is aligned to the CBRNe/HAZMAT training provided. >EPRR ARA 2360 - Risk Assessment for Decontamiation of Self-Presenting Casualties >Examples of risk assessments for CBRNe/HAZMAT Incidentsx 4 >Risk Register entry for decontamination tent (now resolved and no longer a risk) >CBRNe/HAZMAT Plan - ref waste, ref risks	Partially Compliant	EPRR risk assessments linked to CBRN/HAZMAT to be reviewed. A risk assessment on processes included within the CBRN/HAZMAT Plan to be carried out and documented.	Ashley Leggott, EPRR Manager. Ashley Leggott, EPRR Manager / Natalie Till, ED Matron / Bill Parkinson, Associate Director of Safety and Statutory Compliance	March 2024 March 2024	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans and response arrangements aligned to the risk assessment, extending beyond IOR arrangments, and which are supported by a programme of regular training and exercising within the organaisation and in conjunction with external stakeholders	Documented plans include evidence of the following: •command and control structures •Collaboration with the NHS Ambulance Trust to ensure Hazmat/CBRN plans and procedures are consistent with the Ambulance Trust's Hazmat/CBRN capability •Procedures to manage and coordinate communications with other key stakeholders and other responders •Effective and tested processes for activating and deploying Hazmat/CBRN staff and Clinical Decontamination Units (CDUs) (or equivalent) •Pre-determined decontamination locations with a clear distinction between clean and dirty areas and demarcation of safe clean access for patients, including for the off-loading of non-decontaminated patients from ambulances, and safe cordon control •Distinction between dry and wet decontamination and the decision making process for the appropriate deployment •Identification of lockdown/isolation procedures for patients waiting for decontamination •Management and decontamination	The Trust's CBRNe/HAZMAT Plan contains the planning and response arrangements aligned to the risks, including the IOR and action cards for all key roles. It includes links to external stakeholders and specialist advise. The EPRR Training programme details the CBRNe/HAZMAT training completed and scheduled. The Trust's Policy and Procedure for Lockdown supports the CBRNe/HAZMAT Plan for implementing a lockdown when required. The CBRNe/HAZMAT Training session covers all aspects of the CBRNe/HAZMAT Plan that are required to deliver the response. >CBRNe-HAZMAT Plan >EPRR Training Programme >CBRN Training Session >Trust Policy and Procedure for Lockdown	Partially Compliant	Update the Trust CBRN/HAZMAT plan to include additional detail: Effective and tested arrangements for activating decontamination unit (no evidence of last activation or test provided), management of contaminated waste, management of contaminated fatalities, continued delivery of ED services for non -contaminated patients and the description on how to obtain replacement PPE and PRPS	Ashley Leggott, EPRR Manager	March 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	Self assessment RA	Action to be taken	Lead	Timescale	Update
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health and Specialist service providers - see guidance 'Planning for the	This inventory should include individual asset identification, any applicable servicing or maintenance activity, any identified defects or faults, the expected replacement date and any applicable statutory or regulatory requirements (including any other records which must be maintained for that item of equipment). There are appropriate risk assessments and SOPs for any specialist equipment Acute and ambulance trusts must maintain the minimum number of PRPS suits specified by NHS England (24/240). These suits must be maintained in accordance with the manufacturer's guidance. NHS Ambulance Trusts can provide support and advice on the maintenance of PRPS suits as required. Designated hospitals must ensure they have a financial replacement plan in place to ensure that they are able to adequately account for depreciation in the life of equipment and ensure funding is available for replacement at the end of its shelf life. This includes for PPE/PRPS suits, decontamination facilities etc.	Service interavals is directed by Respirex through direct communication with the ED Lead CBRN Nurse and EPRR Manager. Once services have been booked service paperwork saved within EPRR documents. RAM Gene Process included within the CBRN PP presentation. The bespoke purpose built decontamination rooms at DPOWh and SGH ED have opened within the last 12 months and have ongoing maintenance packages agreed as part of the new build. Next to each decontamination room is a dedicated Major Incident Store Room where the PRPS and associated equipment for a wet or dry decon is stored. >CBRNe/HAZMAT Plan >PRPS Register >RAME Gene Process (P52-53) >Respirex service intervals >CBRNe/HAZMAT Training Session (slides 11-12) **Additional Evidence Provided-** The PRPS inventory register that was provided as evidence has not been updated recently to reflect the latest equipment maintenance, however, the equipment has been maintained on the individual equipment's review schedules, including Respirex service of PRPS suits (AE26, AE27, AE28), RAM Gene calibration and recertification (AE23, AE24) which goes above the required standard. PRPS are stored in bespoke designed Major Incident Storeroom within the new EDs with a photograph provided (AE25) that shows suits are in date and ready for use. >AE23 - RAM Gene calibration and recertification records for 57473 >AE24 - RAM Gene calibration and recertification records for 57474 >AE25 - Photograph of PRPS equipment in date and ready to use in the Major Incident Sotreroom within ED >AE26 - Respirex Shelf Life Extension to PRPS Records for May 2023	Partially Compliant	Update Trust CBRN/HAZMAT plan to include EPPM for equipment and how inventories will be managed, faults reported and schedules. Refresh CBRN/HAZMAT equipment inventories.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	February 2024 February 2024	
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out of date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident, where applicable. Equipment is maintained according to applicable industry standards and in line with manufacturer's recommendations The PPM should include: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation	Documented process for equipment maintenance checks included within organisational Hazmat/CBRN plan - including frequency required proportionate to the risk assessment • Record of regular equipment checks, including date completed and by whom • Report of any missing equipment Organisations using PPE and specialist equipment should document the method for it's disposal when required Process for oversight of equipment in place for EPRR committee in multisite organisations/central register available to EPRR Organisation Business Continuity arrangements to ensure the continuation of the decontamination services in the event of use or damage to primary equipment Records of maintenance and annual servicing Third party providers of PPM must provide the organisations with assurance of their own Business Continuity	The Trust's equipment PPM is included in the CBRNe/HAZMAT Plan, training and is monitored through the PRPS Register and the Estates maintenance systems for the new ED builds. Suitable storage is provided for all equipment in the dedicated Major Incident Store Rooms in each ED next tot he decontamination rooms. Also included as evidence is the risk register entry for the old tent, which is no longer required or in use, but was identified as not having an adequate PPM in place so was picked up and monitored through the governance process before being resolved when the new ED builds went live. >CBRNe/HAZMAT Plan >PRPS Register >CBRNe/HAZMAT Training Session - RAME Gene Process >Respirex service intervals >Example risk register for old decon tent (no longer in use) >Invoice/record from decon tank maintenance **Further Evidence Provided-** Revised compliance rating accepted. AE23 - RAM Gene calibration and recertification records for 57473 AE24 - RAM Gene calibration and recertification records for 57474 AE25 - Photograph of PRPS equipment in date and ready to use in the Major Incident Sotreroom within ED.	Partially Compliant	Update Trust CBRN/HAZMAT plan to include EPPM for equipment and how inventories will be managed, faults reported and schedules. Refresh CBRN/HAZMAT equipment inventories.	Ashley Leggott, EPRR Manager Ashley Leggott, EPRR Manager	February 2024 February 2024	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	Documented arrangements for the safe storage (and potential secure holding) of waste Documented arrangements - in consultaion with other emergency services for the eventual disposal of: - Waste water used during decontamination - Used or expired PPE - Used equipment - including unit liners Any organisation chosen for waste disposal must be included in the supplier audit conducted under Core Standard 53	The Trust's CBRNe/HAZMAT Plan details the waste disposal steps post-incident. Attached evidence provided to show specialist contractors who empty the decontamination tank routinely or post-incident. the PRPS Register captures suits that have been disposed or retired in line with Respirex procedures. >CBRNe/HAZMAT Plan >PRPS Register >Invoice/record from decon tank waste disposal/maintenance	Partially Compliant	Update Trust CBRN/HAZMAT plan to include greater clarity on waste disposal methods including storage, water management and arrangements for patients removed clothing and personal effects and which includes contact numbers	Sally Yates, Logistics Manager / Keith Leech, Estates Manager / Ashley Leggott, EPRR Manager	February 2024	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	lf assessment RA	Action to be taken	Lead	Timescale	Update
63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	Identified minimum training standards within the organisation's Hazmat/CBRN plans (or EPRR training policy) Staff training needs analysis (TNA) appropriate to the organisation type - related to the need for decontamination Documented evidence of training records for Hazmat/CBRN training - including for: - trust trainers - with dates of their attendance at an appropriate 'train the trainer' session (or update) - trust staff - with dates of the training that that they have undertaken Developed training prgramme to deliver capability against the risk assessment	The Trust has named train the trainers who are supported by the EPRR Manager. All have received the required instructor training to deliver the training session. The training session has been bespoke developed to match NLAG's CBRNe/HAZMAT Plan and also meet national guidance. Additional staff have been identified to become instructors and are awaiting a train the trainer course. >CBRNe/HAZMAT Plan >Staff Training Records List >CBRNe/HAZMAT Training Dates Bookings >Example CBRNe/HAZMAT Assessment Form >Train the Trainer List	Partially Compliant	Arrange additional PRPS instructors training through EMAS to ensure required number to sustain ongoing training programme	Natalie Till, ED Matron	March 2024	Awaiting dates from EMAS for further PRPS instructor courses
64	Hazmat/CBRN	Staff training recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of	Evidence of trust training slides/programme and designated audience Evidence that the trust training includes reference to the relevant current guidance (where necessary) Staff competency records	All CBRNe/HAZMAT training is delivered by an instructor who has attended the PRPS train the trainer course. All training is in line with the CBRNe/HAZMAT Plan and national guidance. DPOWH has a large proportion of their staff trained. SGH is behind on their training and has a smaller propotion. >CBRNe/HAZMAT Plan >Staff Training Records List >CBRNe/HAZMAT Training Dates Bookings >Example CBRNe/HAZMAT Assessment Form >Train the Trainer List	Partially Compliant	Deliver increased CBRN/HAZMAT training programme to ensure SGH ED increases their compliance. Update CBRN/HAZMAT to clearly identify the KPI for required training compliance.	Natalie Till, ED Matron Ashley Leggott, EPRR Manager	Ongoing from Sept 2023 March 2024	CBRNe/HAZMAT training sessions booked at SGH for coming months
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	Evidence • Exercising Schedule which includes Hazmat/CBRN exercise • Post exercise reports and embedding learning	The last CBRNe/HAZMAT live exercise took place in September 2018 (Exercise Glass). A live exercise of the CBRNe/HAZMAT Plan is overdue and is going to be planned for 2024. >Exercise Glass - CBRNe/HAZMAT Live Exercise >EPRR Training Programme	Partially Compliant	Live exercise of the CBRN/HAZMAT Plan to be delivered to validate the plan and process for the new decontamination rooms	Ashley Leggott, EPRR Manager / Natalie Till, ED Matron	August 2024	
DD1	EPRR Trainin	EPRR TNA	All response roles, including health commander roles described within all EPRR plans, frameworks and arrangements (including business continuity) are included in the organisation's Training Needs Assessment (TNA).	Training needs analysis roles includes incident response roles and health commanders	The Trust TNA includes relevent key roles that would have a response role during an incident. The document is in the process of being updated to reflect the new terminology of Health Commander roles	rtially Compli	Review and update the Trust TNA's	Ashley Leggott EPRR Manager	Mar-24	

Ref	Domain	Standard name	Standard Detail	Supporting Information	Organisational Evidence	elf assessment RA	Action to be taken	Lead	Timescale	Update
DD2	**EPRR Trainin**	**Minimum Occ**	The organisation's operational, tactical and strategic health commanders TNA and portfolios are aligned, at least, to the Minimum Occupational Standards and using the Principles of Health Command course to support at the strategic level.	Health Commander portfolios	Each role has being reviewed with the new TNA to ensure they have the ability to attend the relevant course. At present there has not been a release of the Operational Health Commanders training programme from the national team but once released staff will be invited to attend. The Strategic and Tactical Health Commanders are monitored on their attendance and completion of the appropriate course	rtially Compli	Review and update the Trust TNA's. Commence training of Operational Health Commanders once national course released	Ashley Leggott EPRR Manager	Mar-24	
DD3	**EPRR Trainin**	**EPRR staff tr**	The organisation has included within their TNA those staff responsible for the writing, maintaining and reviewing EPRR plans and arrangements (including Business Continuity and incident communication).	Training needs analysis roles includes EPRR staff	All staff within the EPRR team are included within the Trusts TNA. At present staff who are completing divisional BCP are currently not included in the TNA but this is in the process of being reviewed.	rtially Compli	Review and update the Trust TNA's including addition of BCP reviewers	Ashley Leggott EPRR Manager	Mar-24	
DD6	**EPRR Trainin**	**Training Data**	The organisation monitors, and can provide data on, the number of staff (including health commanders) trained in any given role against the minimum number required as defined in the TNA.	Organisational training records	The Trust EPRR team monitors the number of staff that have completed their required training for their role within EPRR. The TNA is due review and needs to have the minimum numbers required to be trained explicity documented. There are currently enough trained staff in roles to meet the minimum requirement to deliver the rota but the numbers aren't explicity provided	rtially Compli	Review and update the Trust TNA's	Ashley Leggott EPRR Manager	Mar-24	
DD7	**EPRR Trainin**	**Monitoring**	Compliance with the organisations TNA is monitored and managed through established EPRR governance arrangements at board level and multi-agency level.	Board level reports highlighting training compliance within EPRR TNAs. LHRP reports highlighting training compliance within EPRR TNAs.	Within the Trust Annual Report for EPRR the current compliance with Strategic and Tactical Health Commander training is included. Also the current percentage/compliance for CBRNe/HAZMAT within the EDs is reported into the EPRR Group	rtially Compli	Review and update the Trust TNA's	Ashley Leggott EPRR Manager	Mar-24	

Appendix C

Final Submission of NLAG Assessment of Compliance with the NHS England Core Standards for EPRR 2023/24

Embedded spreadsheet:

Embedded file removed for Trust Board – Full action plan provided at Appendix B

Key of spreadsheet tabs:

- **Dashboard** – Overview summary of domains and overall compliance rating
- **EPRR Core Standards** – Detailed assessment of each individual core standard including lists of evidence provided
- **Deep Dive** – Detailed assessment of each deep dive core standard
- **Action Plan** – Action plan to address all partially compliant core standards

Appendix D

Expanded Compliance Requirements for NHS England Core Standards for EPRR 2023/24

Embedded 82 page PowerPoint pack:

Embedded file removed for Trust Board

NLG(23)215

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Dr Kate Wood, Group Chief Medical Officer Ellie Monkhouse, Chief Nurse Fiona Osborne, Non-Executive Director	
Contact Officer/Author	Fiona Osborne, Chair of Quality & Safety Committee	
Title of the Report	**Quality & Safety Committee Minutes – August and September 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The paper includes the minutes of the Quality and Safety Committee (QSC) meetings for August and September 2023	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Q&S 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)		
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 Tuesday 22nd August 2023 from 13:30-16:00
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director
In attendance:	
Dr Kate Wood	Chief Medical Officer
Ellie Monkhouse	Chief Nurse
Jenny Hinchliffe	Deputy Chief Nurse
Shaun Stacey	Chief Operating Officer
Richard Dickinson	Associate Director of Quality Governance
Lydia Goldby	Nursing Lead for Quality, Northeast Lincolnshire Health and Care
Debbie Bray	Associate Chief Nurse, Family Services
Jennifer Orton	Divisional General Manager – S&CC
Rachel Greenbeck	Deputy Head of Nursing/Service Lead
Ian Reekie	Lead Governor (observing)
Michelle Green	PA to the Chief Medical Officer **(minute taker)**

218/23 Welcome and Apologies for Absence

Apologies for absence were received from: Belle Baron-Medlam represented by Richard Dickinson, Jo Loughborough represented by Mel Sharp, Robin Hewson represented by Rachel Greenbeck,

219/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised all papers would be taken as read and attendees would be asked for a two-minute introduction of their papers emphasising any key points before moving on to questions.
The case of Lucy Letby was brought to the groups attention who had been convicted of murdering 7 babies and attempting to murder another 6 at the Countess of Chester Hospital. Fiona underlined how important it is for the

Committee to gain assurance with regard to our own procedures. That assurance is gained through thematic reviews of mortality regularly reviewed by MIG reported to the Committee through the highlight report, in addition to a deep dive report on mortality on the workplan.
Fiona advised that the Annual Organ Donation report has been deferred to November.
Fiona referred to the Maternity Neonatal report that had been circulated in the document pack but was not on the agenda. Ellie advised that she understood that once the maternity support programme was complete a decision would be made whether to go bi-monthly. Fiona advised that the workplan had been in place since January with the report going bi-monthly from July. Ellie requested the report return to monthly reporting on the basis that Board meetings are held bi-monthly and there are monthly requirements for Board level oversight as well as the need for a regular report for CNST purposes. Fiona agreed to take Ellie's concerns and request forward to the agenda set meeting on her behalf.

220/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

221/23 To Approve the Minutes of the Previous Meeting held on 25th June 2023

Ellie raised that there were a number of amendments that needed to be made to the minutes. It was agreed that Ellie would forward the changes to Michelle copied to Kate T and Fiona to amend the minutes outside of the meeting.

222/23 Matters Arising

Fiona advised a referral had been received from the Audit and Governance Committee regarding the Audit Yorkshire report on the WHO surgical safety checklist who had asked the Committee to seek assurance on the quality aspects of the report. A request for a deep dive report to address the concerns would be brought back to the Committee in September. It was noted from the Audit Risk and Governance Committee meeting there were 2 further limited assurance reports regarding Nutrition & Hydration and Complaints. It was queried where this will be picked up. Fiona advised no additional referrals had been received and she is checking if this Committee needed to pick them up.

ACTION: Fiona to follow up with the Chair of Audit, Risk & Governance with reference to the Audit Yorkshire Reports on Food & Hydration and Complaints

Ellie noted she did not agree with this audit report with regard to Nutrition & Hydration but there was limited time to look at issues. Part relates to things that already have plans in place and some to the Estates & Facilities element of food provision and quality. Ellie advised the Complaints audit has no issues it regards the process and how learning is applied, and these processes are currently being embedded.

223/23 Review of action log

137/23 Maternity Safety Oversight Update, request for update on three-year plan – this to be picked up next month when the report is received.

166/23 PSIRF awareness - Richard attended OMG. There was a positive interaction to support. **Action closed.**

172/23 LeDER details - Lydia confirmed item can be closed. **Action closed.**

175/23 Nursing & Midwifery Assurance Report - This is still on the nursing assurance report. Ellie noted bed states are still not correct meaning data returns are being skewed. The bed base needs re-setting. Shaun updated this is an operational matter. The challenge is there is an information variance which is taking some time to get together. It would be preferred the assurance be on the patients and quality of nursing care not the bed states. The Committee agreed the action should be closed. **Action closed.**

194/23 Maternity CNST incentive scheme - Due to come back to the committee in October.

209/23 Shaun has asked for a formal response from Shauna that the quality of clinical coding be maintained.

Regular Reports

224/23 Surgery Deep Dives

The report was taken as read. Jenn noted areas of focus are equipment lifespan, with 2 specific issues highlighted in the Scunthorpe site MRI scanner being out of use and hemofiltration equipment replacement. The divisions activities around the Quality Priorities were discussed, with focus on Deteriorating Patient (DP) and sepsis. The area of concern regarding the internal audit report regarding the WHO safe checklist report will come back to the next meeting.

Audiology mitigation and actions currently being taken around the audiology incident were discussed. An external national and regional specialists team are helping with this. An increase in capacity at weekends from external providers means high risk patients in Paediatric Audiology PTL and our Community Paediatric Clinic PTL Audiology will be seen by 1st October. Support being given with training of staff who have been impacted by the incident. OD work going ahead with staff to further support them. The National Team have given congratulations for delivery of how the incident has been dealt and the Trust has been asked to and is giving supporting to other Trusts. The whole of Audiology will be assured once through the process. The new Head of Service starts in October. A business case is ongoing to look at the establishment, and appointment lengths that are in line with national practice and also to include a new audiology booth at DPoW.

Regarding the hemofiltration machines at DPoW Kate T queried what mitigations are in place while waiting for repair as this is a high risk. Debbie responded a meeting is in place to discuss procurement and that costs have been reduced and repairs are being looked at. Kate W noted we can additionally lease machines into the organisation and SGH also have machines that can be used.

Fiona noted a level of assurance is needed to mitigate regarding this report. It may be the report needs to be filled in differently. Additionally, there are a number of items in the last report that are not showing as updated. There was a statement at the last meeting of deteriorating patients. Debbie responded that actions are in place with the ward manager and new clinical sister, and deteriorating patients was to be discussed in detail at a subsequent Quality and Safety Committee. There are no significant incidents. It was confirmed there is a level of assurance with ward B3. Regarding monitoring incidents regarding discharge, the numbers have reduced. There are still incidents related to discharge with B6 relating to medication. This is being worked on and monitored with governance and has improved.

ACTION: Debbie/Jennifer/Richard to have a discussion regarding progress from the last report, what is proposed to deliver before the next meeting, risks, bottle necks that need support and successes.

The high-volume low-complexity hub at Goole commenced. A quality improvement project was started and will continue throughout the hub working. This now has facilitated day cases in hips, knees and shoulders. First patients have been back for their follow up appoints. This is working well for some patients to go home the same day. A rehabilitation garden has now opened at DPoW. Colleagues are working weekends in the garden and a positive patient story has been received. JAG accreditation has been acquired at SGH for the next year. The CT scanner at SGH A&E is up and running.

Fiona noted the report is marked for approval and clarified that the Committee receive the report for assurance not approval which was ticked on the front sheet proforma.

225/23 End of Life (including C&T) Update

The report was taken as read. Rachel presented the item. Celebrating the implementation of the 7-day service in SGH which began at the beginning of August 2023. Feedback is this is being well utilised at a weekend. EOL training is continuing to rise. The use of respect forms is now rolled out in all areas. The main issue is with data and being able to evidence improvement as the data has moved from the Hub to WebV which has caused some problems. Raw data is being pulled and information to be available towards the end of the month.

Sue queried regarding page 8 Pain Assessment Tool as she couldn't see if the usage of the tool corresponded with the management of pain. Response was that the results of the tool don't show if the pain is being managed. There is still work to do on re-assessment.

Kate T queried if patient feedback showed quality and quantity of re-assessment as it would be good to see the effort reflects the work. Ellie noted the QI first phase covered

the recording of pain assessment. She clarified that staff are going back and reassessing the pain but not always documenting this as there need to be a clearer way of doing this on WebV to ensure this is captured. This second phase module will not be adapted till later in the year or next year due to competing priorities in the Digital Team.

Fiona queried if this needs to be highlighted in the board report that the second phase. Kate W noted that the proposed timing allowed the process to be reviewed so the change can be delivered in a sustainable way. It was agreed that the Board Highlight would reflect that manual collation of data will continue until an IT solution is in place and the work to deliver this is progressing in a sustainable manner.

Rachel noted regarding community nursing that WebV is not used for pain assessment and SystmOne has been looked at for pulling information. After discussion with Dr Adcock, it would be more beneficial to audit the responsiveness of pain relief from call to the end. This will be looked at separately.

Richard noted this is a Trust wide set of data. Regarding the patient experience metrics on page 10 it shows pain relief patient complaints are very low. This evidences that it's not about the provision of pain relief for patients but more about the process of how EoL pain assessments are documented.

Sue queried about the End of Life relatives booklet and if it has been designed to be fully inclusive as a comprehensive tool ie. Braille, other languages, culturally sensitive. Rachel will confirm this.

Action: Rachel to confirm if the End of Life relative booklet is inclusive and accessible e.g. Braille, other languages, culturally sensitive.

Fiona queried regarding the CQC report that it references management of patient records and queried if the reports references to Respect documents if this covers their concerns as the language used in both documents is different. Rachel confirmed that the Last Days of Life document in the EoL report corresponds to the CQC point referring to patient records. The QI team are working with pilot areas to make it digital looking at what works, what doesn't and what has to be included to ensure data can be pulled. Kate W noted for clarity where the EoL report states Respect, EPACCs or Care in the Last State of Life that this is the documentation that fulfils the CQC requirement.

Fiona queried that in the quarterly CLIP report End of Life has been added this quarter. Fiona queried despite the extensive good work that has been completed, are the actions sufficient or will it take time to embed? Rachel clarified was that the QI work will take time to embed then be rolled out.

Ellie noted End of Life care complaints are pulled out and treated differently through their own process and are dealt with quickly and with sensitivity for the patients and family. The Committee agreed this gave assurance.

226/23 Pressure Ulcers Deep Dive

The report was taken as read. Rachel advised the paper provided an update on the new process that had previously been presented to the Quality Safety Committee. A review

has been done on the risk assessment process using the Braden scale and to reduce unwarranted variation. A weekly review has enabled the 10-day timescale be met, learning is identified and immediate actions taken. It was noted there were a number of moderate harms related to catheter care in homes. Review of these cases show the securing device to the patient was not used. The bladder and bowel team have gone in to care homes to do education and training. A static position is now being seen despite an increase in number of visits. Last 6 months of data shows an equal split in care homes and patients own home. Issues with own home is around compliance and lapses in care. Domiciliary care needs to be looked at with education and training. Care homes with highest levels of pressure ulcers need a focus on moving and handling, slide sheets, pressure ulcers from shearing, incontinence team and pressure management. Turnover in care home of staff means there is the need for constant training. Once the Associate Chief Nurse is in place a process map needs to be done with staff to look at improvements. The wound clinic will have a rotation of teams to address a possible theory practice gap that can be put into practice.

Fiona thanked Rachel for turning the report around in a short space of time.

Sue queried that on page 5 it indicates it will take 6 months for the new templates, training etc to take effect although on the options table it states 1 year. Rachel advised that Braden has been implemented as a quick fix and PurposeT will take longer reflecting the 1-year expectation while the move across takes place.

Kate T noted the report was very comprehensive. It was noted that Sir John Mason House has particular issues. Kate T queried if task force has been sent in. Rachel advised that the intermediate care nursing staff need to be worked with more. This is a very small team so reliant on carers in the care home. Patients here are generally straight out of hospital meaning there could be an impact on development of PUs, often with significantly reduced mobility whilst rehabbing. Kate T referred to an SI recorded which Rachel clarified was an issue in delivery of equipment which was ordered over a bank holiday weekend which wasn't delivered in a timely manner.

227/23 IPR

The report was taken as read. Kate W updated that the SHMI data continues to remain in the "as expected" range. The infection diagnostic lead group is stable. There have been challenges obtaining sepsis data and they are looking at other ways of obtaining the sepsis data. Kate W advised they are constantly looking at other ways to triangulate episodes or instances of harm. Recording of adult observations are better. End of Life areas of concern are gaps of data due to the Lorenzo PAS freeze on data sharing. Mitigations are in place around manual data.

Fiona queried the statement that "previous methods of paediatric sepsis screening measurement are no longer appropriate" and asked for some clarification. Richard responded previous the audit method was back to front as they looked at identified patients at risk rather than the screening process. The audit tool to be used will look at several patients on the screening tool. Richard met with Debbie Bray and team in the

previous week. The tool has been designed and will be tested before taking this forward. A change in clinical practice will be needed. Support for clinicians to use the tool properly will be in place to ensure the patient is assessed correctly. Fiona further queried if there was sufficient resource to train the clinicians on use of the tool. Richard confirmed Debbie and the team were confident this can be put in place and that there is a mindset change as the clinicians and doctors haven't felt the need to document in this way. A practice change is an outcome. There is also the opportunity to use documentation captured elsewhere on the tool.

Sue queried that on page 27, relating to maternity and its instrumental 3rd and 4th degree tears, why are these increasing? Ellie has reviewed the maternity NHS digital dashboard which will be included on the maternity paper. There hasn't been the opportunity to triangulate this with the team but are within the expected range. This may relate to difficult and complex births. Details to come to the next meeting.

Ellie picked up the run chart for still births. There is a cluster of events that went through the maternity support advisors. Sadly, these are showing as exceptional circumstances and tragic events but nothing to be concerned about. Nothing is being picked up internally or externally regarding these through the PMRT processes.

Ellie brought to attention there has been a MRSA complex patient. Currently collating through the PIR process. This looks like cross contamination at line insertion. This is being picked up with the team and has been brought up to PRIM meetings around practice around care of lines etc.

Ellie noted the C difficile trajectory is 20 and reflects the Trust previous excellent record. This is challenging as on the Trust has had 4 cases already this year pre-winter. Nationally there are concerns of a general rise in C difficile. We have been approached regarding best practice. The Committee to be aware this is a tough ask but are regionally in a good position and the Trust compares well nationally and with peers. Fiona noted Richard had commented in the chat about the Trust C difficile rate performance was in the 93rd percentile on benchmark with peers up to March 2023.

It was noted that complaints have been responded to 100% on time meaning a great team effort. The Committee commended this result and the progress that had been made.

228/23 Nursing & Midwifery Assurance Report

The report was taken as read. Ellie updated that Grimsby stroke unit are currently under an enhanced surveillance process. The area has had an "intense support" 15 steps outcome which resulted in a quality surveillance approach. A deep dive is underway in staffing, dashboard and a retrospective look at what came back through from 15 steps previously. A concern is the area has had intense support previously, does better then drops back down suggesting best practice is not being adopted. Ellie advised the unit will have a 6-12 month surveillance to ensure the practice and culture is embedded. This will involve quality of care spot checks and audits throughout the week.

Ellie looking at the detail and length of the report with an aim to give a reduced version for the next meeting. The Committee welcomed this approach. Ellie advised that Chief Nurses in struggling organisations have been referred to look at what NLaG produce.

Fiona queried regarding the trend of the number of supportive care shifts falling. They are the lowest levels in 2 years without an increase in patient safety incident, and Fiona queried if the June levels can be expected going forward. Ellie advised it is seasonal. The processes to assess if a supportive shift is needed have been refreshed along with the short term staffing process. An overuse of supportive observation has been identified. The Afloat tool identifies and reduce the need for one to one supportive observation but allows various levels of observation to be in place. At the Safe Staffing meeting there is an open challenge around where supportive observation shifts have been asked for. A review of the Afloat and Safe Care Live gives a live update on patient acuity so only patients needing to be kept at arm's length get the shift booked. Additional there is now the ability to safely flex and adapt the staff around the organisation where there are higher acuity levels. There is assurance a robust process is now in place.

Fiona referred to the work Ellie had instigated to benchmark the Trust again the findings in the CQC report at HUTH and asked for Ellie to provide a brief update as from an assurance perspective this was an important piece of work. Ellie advised it was discussed in AOB at the Maternity Improvement Board. Jane Warner is providing support and is looking at themes and trends and reviewing internal processes. We need to be aware of the sensitivities of this exercise.

Fiona queried the midwife to birth ratio. In June the ratio was below what was expected and are we comfortable the service is safe? Response was yes, otherwise it would be closed, or beds would be reduced. There is a separate Opel levels of reporting and have adapted the National Maternity Opel safe staffing scores. This is used on a daily basis along with occupancy meaning staffing can be adjusted according to need.

229/23 Key SI update including Maternity

The report was taken as read. Richard clarified the information as the cover page mentions no new incidents for maternity services but refers to an incident as new within the body of the report although this had been reported in the previous month. The report illustrates a low level of harm reporting over the last few weeks meaning less SI Panel meetings have been needed. Open actions are now closed incidents with follow up actions. A never event report is due for sign off in September by Kate W. Kate W confirmed receipt of this.

Fiona queried the training schedule for staff of paediatric audiology timescale. Kate W updated the team are being supported to attend offsite training sessions. Training dates have been set. External providers are happy to provide support for the training. It was noted that staff have not recovered from the shock.

230/23 CLIP Report including Annual Report

The report was taken as read. Richard updated the report is a complicated read, noting the appendices give more oversight detail. Richard noted he was keen to change the report. The report give flavour for the rate of information received for complaints, PALS enquiries and litigation. There are almost 100 litigation cases currently being managed. There are 46 inquests for the last period. The run rate of inquests is growing along with the number of open cases also growing. This is due to the number of cases being concluded is slower than the rate of new ones coming in.

Fiona noted from an assurance point of view the main body of the report is a status report that doesn't give assurance. There needs to be a better way of reporting it as the details needed are in the appendices. It needs to be established what HUTH do regarding reporting to allow working together for a middle ground that works for all.

Ellie agreed a refresh is overdue as there is no context. There is a concern that sight of the report is quite late.

ACTION: Richard to work with HUTH equivalent to establish what is included in their CLIP report. If the information is ready prior to the next QSC meeting a small group to meet to look at it.

Richard noted another consideration is factoring in the cross over of work ie. legal. This needs to be done in a different way.

231/23 CQC Framework

The report was taken as read. Richard noted the summary paper shows an improvement towards full assurance. There are actions due, some have not progressed but are being prioritised by the team. It is being considered how support to the divisions and action leads can be taken to improve this. The body of the paper shows charts with progress over time. There are risks for delivery with capacity, operational pressures and financial restraints. Kate W noted that Belle is embarking on a piece of work with the divisions regarding finance. Conversations to then be had with commissioning colleagues as to what needs to be done differently.

Sue queried on page 5 the family services, the 22 MAT 10 spot check audit for 31st August, if this is on track. Response was that Belle has discussed with the team who have not prioritised addressing this problem yet, but the CQC found an issue with the checking process regarding stock rotation. This is not a complex task, and they are starting to explore how to build on this. There is a need to show there is progress even if actions aren't completed.

Kate T queried if the spot check audit is a regular thing or one off. Response was this type of action should progress to regular checks was being looked at.

Fiona queried regarding the MAT10 that the standard business process be that new stock goes to the back and when taking stock off the shelf that dates are checked.

Richard confirmed that the CQC action was it is more about consumable items that are not included in this standard stock rotation management.

232/23 Potential Deviations from National Documentation

Richard noted there aren't any potential deviations.

233/23 PSIRF update

The report was taken as read. Richard noted this is a gradual progress. There is more engagement with people going on training. Steps have been taken going forward on risk profiling. An incident response plan is being worked on with people that have been involved. The next meeting is later this week, with the expectation of a draft incident response plan with policy to be taken there. Contribution from Maternity services and Neonates is needed to match the profile. It is hoped that documents line up ready for a system change in October. We are on track to do LFPSE switch over in September, NHS England to confirm. This is the automatic uploading of incidents which will replace NRLS.

Fiona queried the statement at the top of page 5 "time saved should be reutilised on quality improvement activities improving the patient safety risk profile". Fiona asked given it is understood it will be clinicians doing the investigation, will the time saved from the report go back to clinical time rather than QI projects? Richard advised that this is realistic as it is guidance from NHS England. This releases time for investigation in more detailed ways, so staff are free to contribute towards the quality improvement work. This should reduce time needed for investigation over a longer period of time. This is distributed widely across all divisions. Fiona noted this will be difficult to deliver and will need to go through a process of change. Richard advised there will be more senior people doing these reports and will be more likely to contribute to QI initiatives.

234/23 Annual Patient Experience Report incorporating Annual Inpatient survey

The report was taken as read. Fiona asked the Committee to note this is the Annual Report being accepted on behalf of the Board and would go into the public domain rather than the detailed regular reports that we receive for timely assurance during the year.

Melanie Sharp noted the report is accurate and for wider viewing. The team are continuing with current strategy with a view to writing a new one next year with the new Patient Experience lead. The PALS position has greatly improved. Complaints continue to show an improved position. There was a decrease in July/August '22 due to prolonged annual leave. This has been closely monitored. Compliments recording to be looked at. FFT have seen an increase in patient feedback due to the temporary Patient Experience manager whose secondment has been extended to the end of December. National surveys feed into the patient experience group and the surveys form part of the Trust improvement plan. There are a lot of positives in the surveys. Next year will focus on the patient voice and learning will continue to be developed from complaints.

Kate T queried, if this is going to general public, would they understand the abbreviations. Response was these to be corrected. Kate T also was noted this was much broader than 2022. Response was this is just when the results come through.

Sue noted the FFT was fabulous. Sue also noted that 4.54 out of 5 speaking positively, this is not seen with the Trust staff survey. Is there a way of correlating staff recommending family and friends? Mel advised there had been a change seen in clinical areas and how proud staff are of where they are working. Staff feedback from 15 steps is really positive, but it is still unclear how this will correlate. Mel and Ellie agreed this should be investigated how we can communicate, and drive positives achieved through the patient experience to staff.

Kate W noted we need to make a positive for the organisation so people can see what we can see.

Kate T noted we need to celebrate success from external patients but also we need to find out why are staff not recommending services in the Trust to family and friends.

Fiona suggested a referral be raised to the Workforce Committee to say we have a positive set of patient feedback and need to know how we can support uplifting the staff survey in the same way.

ACTION: Ellie/Mel to work up the statistics and data to support the patient experience. Through the action log this can then be checked if we are at the stage to make a referral to the Workforce Committee.

Fiona queried regarding the family liaison officers, if they have been employed in areas where their interpersonal skills can be fully utilised to directly support patients in the main. Mel advised they have gone into different roles and responsibilities now. The few who are now employed elsewhere in the Trust still champion the patient experience.

Fiona asked the Committee if the report can be recommended to the Board as recommended on their behalf with the acronyms changed. The Committee agreed.

235/23 Annual Organ Donation Report

Item deferred until November.

Highlight reports

236/23 Quality Governance Group (QGG)

The report was taken as read. Fiona asked for clarification of the highlight “medicine safety transcribing for discharge referral needs investigation with the Care Plus Group”. Richard advised that there is a situation that occurs at DPoW where a document is used to ensure there is continuity of medicines management when going home. This involves transcribing onto a document by staff in a ward then the information is then copied into another document at its destination. James Hargreaves raised this as a concern and action has been taken as a consequence with discharge. James is meeting with discharge process leads and Richard has contacted Care Plus Group to speak with their

lead for discharge and together they will work through how to work through reducing the risk of transcribing error.

237/23 Mortality Improvement Group (MIG)

The report was taken as read. Fiona queried the reference to a deep dive into pneumonia and when this would be scheduled. Richard advised he would look into this as he didn't attend the meeting. The Committee looks at themes in deaths and this data shows seasonal variation which needs some understanding. Richard also advised that coding management needs to be working as it should. Data access is also due from CHKS which will give better information.

ACTION: Richard to include when the deep dive into pneumonia will take place in the next learning from deaths report.

238/23 Patient Safety Champions Group (PSC)

The report was taken as read.

Items for information

239/23 Quality Governance Group (QGG) minutes

Distributed for information.

240/23 Mortality Improvement Group (MIG) minutes

Distributed for information.

241/23 Patient Safety Champions group (PSC) minutes

Distributed for information.

242/23 Any Other Business

None raised.

243/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

The Committee agreed to add the following points to the highlight report to the Trust Board.

- **Sepsis** - Manual collation of data – to continue until an IT solution is in place although progress to ensure that it will be delivered in a sustainable manner is underway.
- **Patient experience report** – to be referred for approval to Board.
- Receive **End of Life quarterly report.**

244/23 Meeting review

- January onwards meetings to be face to face. Kate W noted the group structure needs to be confirmed. Ellie noted mileage is increasing and asked for a hybrid model be considered.
- Fiona queried with Ellie the referral from ARG and if there is anything that can be deferred? Response was it is not an issue for the team to produce what is needed.

245/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 26th September 2023
Time: 13:30-16:00
Venue: Virtual via MS Teams

The meeting closed at 16:00

QSC Annual attendance log

Name	July 2022	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023
Michael Proctor	✓	✓												
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓
Maneesh Singh	✓	x	✓											
Dr Kate Wood	x	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓
Ellie Monkhouse	x	✓	x	✓	x	✓	✓	✓	x	✓	x	x	✓	✓
Dr Peter Reading	✓	x	x	x	x	✓	✓	x	x	x	x			
Shaun Stacey	x	x	✓	✓	x	x	x	✓	x	x	x	✓	✓	✓
Susan Liburd				✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓
Kate Truscott				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

QUALITY & SAFETY COMMITTEE

Meeting held on Tuesday 26th September 2023 from 13:30-16:00
Via MS Teams

Present:	
Fiona Osborne	Non-Executive Director **(Chair of the meeting)**
Kate Truscott	Non-Executive Director
Sue Liburd	Non-Executive Director
In attendance:	
Dr Kate Wood	Chief Medical Officer
Carla Ramsay	Chief of Staff
Melanie Sharp	Deputy Chief Nurse
Fiona Moore	Head of Quality Assurance
Simon Priestly	Chief Pharmacist & Clinical Lead for Medicines Management
Aswathi Shanker	Deputy Director of Planning & Performance
Jennifer Orton	Divisional General Manager – S&CC
Michelle Drinkell	Lead Nurse - Projects
Beverley Hayward	Quality Improvement Manager
Ian Reekie	Lead Governor (observing)
Mich Green	PA to the Chief Medical Officer **(minute taker)**

246/23 Welcome and Apologies for Absence

Apologies for absence were received from: Richard Dickinson represented by Fiona Moore, Ellie Monkhouse represented by Melanie Sharp, Shaun Stacey represented by Aswathi Shanker, Debbie Bagley represented by Jennifer Orton and Beverley Hayward

247/23 Opening remarks

Fiona Osborne welcomed members to the meeting and advised all papers would be taken as read and attendees would be asked for a two-minute introduction of their papers emphasising any key points before moving on to questions.

The annual infection prevention control report has been deferred to October. There are no highlight reports or minutes from the Mortality Improvement Group (MIG) and Patient Safety Champions Group (PSC) as these meetings did not take place.

248/23 Declaration of Interests

There were no declarations of interest related to any agenda item.

249/23 To Approve the Minutes of the Previous Meeting held on 25th June 2023

July minutes were amended and approved.
August minutes were approved.

250/23 Matters Arising

There are no matters arising.

251/23 Review of action log

209/23 Clinical coding team service provision – Formal response received from Shauna McMahon and circulated to the committee. After discussion at the June Executive meeting the report was due to be re-presented at the July meeting. An action plan and way forward were due to be created. It was confirmed this is yet to be presented. The last Mortality Improvement Group (MIG) highlight report showed staffing and recruitment were a continued challenge. A change to the mortality coding and review process has been agreed and priority will be given to DPOW coding validation sessions where historically there are a greater number of diagnosis group changes made following review. It was reported that MIG are managing an issue titled 'Encoding resource and impacts of change to processes. This action to be closed and monitored through MIG.

224/23 Surgery Deep Dives – Richard Dickinson has met with the Divisional Governance and Quality Leads to discuss the principles of demonstrating the risks, challenges and actions planned. Highlights of positive change have been discussed, waiting on data. It was proposed to close this action but re-open if not fit for purpose at this meeting.

225/23 End of Life (including C&T) update – No feedback received. Mich Green to email Rachel for an update.

230/23 CLIP Report including Annual Report – Richard Dickinson has been in contact with the Hull University Teaching Hospitals (HUTH) team. HUTH have a monthly IPR report and a 6 monthly legal report. Richard has proposed to wait until the committees in common are in place. The CLIP report to be retained until the close of the year whilst working with HUTH for what is appropriate going forward. Action agreed to be closed.

234/23 Annual Patient Experience Report – Due to annual leave conversations progress has been delayed. Ellie Monkhouse to feedback ideas to the group next month.

237/23 Mortality Improvement Group (MIG) – Learning from Deaths report has been circulated to the group. Feedback from pneumonia deaths to be looked at during the meeting. Action agreed to be closed.

Regular Reports

252/23 Maternity Safety Oversight (inc Ockendon & metrics)

The report was taken as read. Nicky Foster updated that workforce vacancy rate remains challenging with 34.3 WTEs across the patch. 7 international midwives started in May and 1 has now been positively signed off at SGH. Another 4 international midwives to be supported in December. 17 newly qualified midwives will be joining next month.

Clinical Negligence Scheme Trust (CNST) – one main risk is consultant obstetrician. A paper was forwarded to Kate Wood outlining the CNST requirements, mostly in compensatory rest, the specialist clinical requirements and leadership role with an outcome to collaborate with HUTH. A meeting to take place in the next fortnight for a joint NLAG/HUTH discussion around the case of need outlining a way forward. The request is for 5 consultants, 3 in DPOW and 2 in SGH.

Triage service to commence 16th October.

Regional maternity team visit took place yesterday. Further evidence was produced, and it was confirmed the Trust will now exit the Maternity Safety Support Programme (MSSP) programme in November. Congratulations were given to the team. Fiona Osborne asked if this could be shared on the Highlight report to Board, and Nicky confirmed.

LMNS Assurance due on 23rd October. Invitations have been sent out to appropriate people.

Sue Liburd queried regarding page 1 assurance being made regarding the midwife to birth ratio. NLAG runs at 1:23 across both sites. What ratio should the committee be concerned about? Response was we are actually better than the national average of 1:28 as the lower the number the better. We report ratio's differently to other trusts as there shouldn't be so much variance.

Kate Truscott queried in the report there were 4 complaints from ward 26. It was queried if there was a theme. Response was this was looked in to and it wasn't a particular person or theme and that the ward manager is dealing with this.

Kate Truscott queried the progression of long-standing safety champion action log items for example trolleys/cage issues. Response was that Ant Rosevear is meeting with Keith Fowler next week and the trolley/cages issue is hoped to be resolved. Space has been identified for storage.

Kate Truscott communications team informed that a former midwife had been through NMC council proceedings, and an outcome achieved. It was queried if more are expected to come through the system. Response was that this was a historic 2017/2018. The action plan has been reviewed to ensure that all have been completed at the time.

Ashy noted the midwife to birth ratio doesn't give a true picture of responsibilities for community and acute midwifery. We need to be looking at continuity of carer, better births, maternity matters etc from a quality perspective and how this is recorded.

Fiona Osborne noted we are advised that vacancies are an issue yet the birth to midwife ratio is better than the recommended levels at 1:23. Fiona asked for clarification how this occurs as the two seem to be in contention.

ACTION: Nicky Foster to provide more information on vacancies vs safe staffing levels

Fiona queried whether more work on retention of staff needs to be adapted to retain staff as vacancy rates have not improved significantly over the numbers of international nurses recruited. Kate Wood suggested Nicky speaks with the recruitment team.

ACTION: Nicky Foster to bring an update/breakdown of leavers to the next meeting.

253/23 Pharmacy

The report was taken as read. Simon Priestley updated that workforce continues to be a challenge. There has been involvement from the Talent Acquisition Team looking at strategies for recruitment and retention. A member of the team has now brought forward some leads meaning pharmacist interviews are being fast tracked. A stand to be set up at Clinical Pharmacy Congress North in Manchester for the first time. This to be used as a recruitment platform. Promotional pharmacy videos have been developed. Staffing is affecting the medicines reconciliation figures. Medicines reconciliation within 24hrs of admission target is 80%, whereas actual delivery is 40%. The skills of the team are being built on to try and address this.

Kate Truscott commented that the University of Lincoln are very keen to support with undergraduates. Response was that talks are progressing to get students from Christmas or the next academic year.

Kate Wood commented at Exec meeting today pharmacy was discussed. Simon and Jo Good are looking at joint working to support challenges. Hull and Lincoln Uni are looking at additional pharmacy training.

Sue Liburd referred to page 12 and medicines reconciliation completion rates. 80% is still not being achieved by a people being seen by a pharmacist during their admission. Is there a patient safety concern to be considered? Response was that there was a concern with pharmacy not reviewing all patients. Data has been looked at to see how it matches with the service and it is operating a reduced weekend service. It has been identified this increases the percentage slightly if weekend figures are excluded. Simon Priestly stated that there is a case to support a 7-day service. Simon Priestly assured the Committee that the Pharmacy Team are addressing the concern. In addition to support it was noted there is also the discharge medications service where an electronic referral is sent to community pharmacy.

Fiona Osborne compared the March and September reports and noted the narratives were very similar. This makes it difficult to gain assurance that progress is being achieved. Simon Priestly committed to presenting updates on progress in the next report.

ACTION: Simon Priestly to ensure the next report shows what has changed and moved on since the last report.

The Committee agreed that medicines reconciliation rates should be highlighted to Board

Kate Wood asked that staffing be highlighted to Board. Additionally, the weight of patients has not been discussed yet. IT are trying to get a bot to take information out of WebV and put it in EPMA. There isn't a timeline available for this. Pharmacy technicians are trying to check and monitor if patients are receiving the right dose per their body weight. This needs to be highlighted to the Board that there is still not a solution for recording weights appropriately and accurately and is therefore a risk. Fiona Osborne noted there is a bigger issue around data that runs through all quality priorities. This to be covered within the Quality Priorities paper.

254/23 World Health Organisation (WHO) Surgical Checklist Deep Dive

The report was taken as read. Fiona Osborne stated that she and Jenn Orton had spoken before the meeting and had agreed a verbal assurance report would be received as the paper submitted did not cover the assurance from a patient safety perspective. Jenn Orton updated the group:

Compliance tool - We currently hold 92%-94% and is taken from a paper audit. The clarity is not always on the paper audit as it doesn't give the opportunity to give anything objective or subjective within it. Developed within the division 94%-97% would mean we are looking at auditing effectively. This audit closed electronically on 4th September 2023.

Development of Checklists - It was recognised that some checklists that had been audited weren't appropriate for the surgeries. Changes were made and developed to the checklist so it can be completed appropriately for the surgery. October data will be cleaned and revised which will allow for narrative per surgery, per speciality, data, trends and details.

De-brief – A meeting has taken place with Miss Smith (Consultant Breast Surgeon) and theatre team leads. A review of other Trusts is being carried out along with working with Calderdale. Debriefs were not always being documented, so no assurance was given. Calderdale have a number of innovations ongoing. One being boards, and the NLAG team have ordered these so every patients surgery is then written down after each surgery and at the end of in each theatre. A board outside also has comments aligned to the cases. Roll out will start with 2 specialities each month. Task and finish groups are set up. Breast and Ophthalmology, who are really engaged in the process, will start in November. Anaesthetics will be every month due to hitting every speciality. There will be no roll out in December. January will be Orthopaedics and Urology. February will be General Surgery and Gynae. March will be Oral Max Fax and ENT. A learning process will operate throughout and where something doesn't work with a speciality it will be adjusted for the next month. Embedding to be reviewed in April 2024.

Governance Process – recognising we are 94%-97% it is not always brought to attention within governance papers then documented and translated to QGG. This means it doesn't then come through to QSC. A rolling programme has been agreed with feedback

every month at Governance (theatre suite per month). The highlight report will then feed in to the QGG report with escalation by exception to QSC. All information also goes to Theatre Board monthly.

Thanks were given for a full explanation and assurance.

Kate Wood reminded colleagues we have a 98% compliance with the WHO checklist in surgery and critical care and a 93% compliance with the WHO checklist in maternity. From a safety perspective we should take assurance that there is excellent work on-going although the team are not resting on their laurels and are seeking to continually improve.

ACTION: Fiona Osborne to feedback key points raised today to the Audit, Risk and Governance Group.

255/23 15 Steps Annual Report

The report was taken as read. Michelle Drinkell updated the programme is becoming more established year on year based on annual gap analysis. This gives time for reflection, chance to look at current priorities and look at priorities going forward. There is a lot of work taking place with STAR accreditation on our areas with quality at the forefront. Standards are being embedded, achieved and sustained.

Fiona Osborne noted this is a superb programme and any identified problems are dealt with in a supportive way.

Kate Truscott noted after having done the training and undertaking some of the 15 steps, it was felt to be very beneficial and a really useful vehicle for patient assurance and staff experience.

Fiona Osborne queried if there were any key themes for the small number of areas that 'stepped back'. Response was results are dependent on the day. A 15 steps champion is being looked at to support new leaders looking at gaps. Supportive visits have become very important and 3 monthly visits now take place.

Melanie Sharp updated regarding the STAR accreditation and that a buddy scheme that has been set up will be really important.

Thanks were given to Michelle Drinkell and the team for all their work.

256/23 Integrated Performance Report (IPR)

The report was taken as read. Kate Wood highlighted the mortality data gap, weight bot gap, paediatric service data gap, Clostridium Difficile (C.Diff) and pressure ulcers in our care.

Melanie Sharp updated a call took place with Dame Ruth May around C.Diff as these are a national concern. The threshold may be challenging to meet but will be continually monitored. Pressure ulcers in the acute and community have slightly increased but there haven't been any category 3's. A weekly pressure ulcer meeting has been introduced where issues have been highlighted quicker and support has been put in where needed.

There are some complex and challenging patients. A react to red team are going into the community. There is a dramatic increase in number of patients the community team are seeing since last year. A piece of work is being undertaken to understand this complexity.

Fiona Osborne queried about the lowlight theme related to data and how the gap is being owned and progressed. Response was this has been a concern for a number of months. There has been good news with CHKS (a healthcare insights organisation) re the mortality data gap and training will take place next week giving a better understanding. Regarding the weight bot, there isn't a timescale in place yet. The Paediatric sepsis team are now working on data collection using clinical teams, not supported by the Digital team. End of Life information is proving challenging to extract the data. The Executive team are sighted on this but not able to do anything about it due to IT having to freeze everything as it links to the PAS Lorenzo programme. It was noted the Executive team will not be ignoring this.

Fiona Osborne queried if there is a danger of not being able to provide evidence that quality priorities have been delivered this year. Response was there isn't a danger of delivering the quality priorities as the outcome measures can be reported. Process of the balancing measures that sit under the overall outcome measures can't be reported on fully. If there was access to more than is being reported, delivery would have been greater.

257/23 Quality Priorities Deep Dive: Deteriorating Patient

The report was taken as read. Bev Hayward noted revamp work has taken place with the Deteriorating Patient and Sepsis Group. All divisions now bring a highlight report. Data and incidents are looked at. Critical Care outreach team are collating data which will help with issues and concerns. CQUIN target nationally is 30%, we are currently achieving 61.5% meaning improvements are being made with deteriorating patients.

Fiona Osborne queried regarding the outcome measures that the IPR shows 9 harm incidents in July and how is it being reviewed, and the learning adapted. Response was that due to the awareness of the oversight group the 9 harm incidents are low and minor harm.

Fiona Osborne queried regarding the support required slide, who the support is needed from and what action has been taken to secure the support. Response was the continued support is from the QI team. Rizwan Khan (QI Lead) is supporting with staff engagement and clinician support. Debbie will be escalating to MIG.

ACTION: Fiona Moore to update Richard to ensure progression on support required is included in the slides going forward.

258/23 Quality Priorities & Quality Account including Annual Report

The report was taken as read. The Quality Governance Group discussed next year's quality priorities. The summary page shows key themes from the patient safety response plan. Progression to next year was discussed and it was agreed to keep the current

quality priorities and roll them over. This is due to the challenge of data still being there and also because there is a limit on what data is available. It was unanimously agreed to further embed the changes in quality priorities.

Fiona Osborne queried if there was anything not included in the quality priority list that has been excluded due to the limits on data availability. Response was there wasn't anything excluded.

Fiona Osborne queried about paediatric sepsis audit data issues not being correctly recorded. Response was a new electronic Microsoft form has been developed based on the risk stratification tools provided by National Institute for Health and Care Excellence (NICE) guidance. Data collection has been mapped against what should happen against best practice and instead of working backwards looking at how the pathway should have been done, the data checks are done going forwards from the child coming through the door. This mirrors work being done on the WHO safety checklist.

Fiona Osborne queried the adult sepsis screening (completion in 15 minutes) showing as failing on the IPR and if it was being looked at now. Response was there is difficulty with the systems. The Emergency Department (ED) system is Symphony, and the ward system is WebV. The sepsis screening tool is in WebV meaning when patients attend ED for primary screening there is no link to take them through to WebV. Patients are getting seen within 15 minutes, however, due to duplication on systems this is not being recorded in time.

Kate Wood added we are not able to provide assurance through the metrics we are providing. How we provide assurance needs to be looked at to show how patients are being looked after safely and effectively. Kate assured the Committee there is a robust incident reporting system within the organisation. This picks up low and minor harm and also serious incidents would be declared if patients have been missed and have deteriorated. Critical care outreach team would also escalate and raise concerns in this regard.

Fiona Moore updated other means of getting assurance would be the Summary Hospital-level Mortality Indicator (SHMI) rate of patients with all infection groups. This shows we are below the England average and the level has been sustained.

259/23 Nursing & Midwifery Assurance Report (with key focus)

The report was taken as read. Melanie Sharp updated the format of the report had changed and welcomed feedback. Focus continues to be recruitment. There have been 90 conditional offers made with a further 23 internationally educated nurses, 17 midwives and 15 paediatric. There are focused recruitment drives for key areas still taking place. 37 red flags were reported. 23 were reported due to low staffing levels. Assurance was given that all staffing levels are mitigated daily by Matrons. This may mean moving staff for peak activity times for a few hours or by using a rota system. This is working well. Red flags nationally are being reviewed to ensure they remain current and applicable. Discussions have taken place with the Safe Staffing and Workforce Committee around changes to red flags.

Community nursing demand has risen from 13k to 21k. 80% of the visits are for wound care. Work is taking place to confirm what type of wound care is needed.

Complexity of complaints remains and matches the national picture of complexity of complaints.

Kate Truscott queried about the recruitment drive and the low number of uptake for nursing apprenticeships. If people haven't got the correct academic qualifications is this having an impact. Response was there is a strict national guide to follow. Any staff that don't meet the criteria are supported in other career pathways or helped with education. Kate Truscott further queried if colleges were supporting by identifying any learning difficulties ie. Dyslexia.

ACTION: Melanie to find out if colleges are identifying any learning difficulties.

ACTION: Kate Truscott / Sue Liburd to have a discussion regarding apprenticeships and what support is available ie. Lost certificates in connection to the Workforce Committee discussions that have already taken place.

Fiona Osborne queried with red flags if there should be hard and fast objective rules that would automatically trigger a red flag rather than subjective triggers e.g., waiting for someone to raise one. Response was there are hard and fast rules that Ulysses doesn't always report. Work needs to be done with this. The list of red flags is being looked at to shorten it so there are core red flags. These need to be mirrored nationally.

Fiona Osborne welcomed the reduction in length of the new report. It was felt the exec summary or conclusion could be changed to show what it needs to concentrate on ie. big successes, big wins, where support is needed and mitigations that are being introduced. Melanie Sharp confirmed the points were taken on board.

260/23 Key SI Update incl Maternity

The report was taken as read. Fiona Moore noted there have been no serious incidents that require escalation to the Quality and Safety Committee that are outside of Maternity. Maternity was addressed earlier when Nicky Foster was in the room (252/23). There were no further questions.

261/23 Quality Impact Assessments (QIA)

The report was taken as read. Fiona Moore updated 2 QIA's were received for check and challenge. 1 relates to respiratory, physio on call and service provision, the training and what they can and cannot be called for. 1 relates to the surgery division for sterilisation project of equipment where they need to purchase and set up a maintenance contract and a service level agreement. Both have been reviewed and have a risk rating of 0. Comments and feedback have been sent back for narrative and clarity on points to make the QIA's more robust prior to sign off. This will not affect the risk rating.

There are 11 applicable on the paper where QIA's have been requested or are not applicable and excluded as per the policy.

262/23 Care Quality Commission (CQC) Framework

The report was taken as read. Fiona Moore updated progress has been made in closing full assurance actions from 14 last month and 18 this month. Good improvement has been made with limited assurance actions from 32 to 29. A number of actions remain open that are past their original close date. This is due to a full review of actions and agreeing the scope.

Kate Wood noted there has been slow progress due to industrial action. Additionally, the teams have realised they need to expand the scope of what is expected.

Thanks were given to clinical and non-clinical staff during this period who have kept the organisation safe during this period.

Fiona Osborne queried regarding expanding the scope if this was scope creep or due to extending the scope of work to meet the outcomes required. Response was the scope had been widened the scope of the actions following the full review as it was a greater understanding of the ask. Additionally, some actions are waiting for further spot checks are to be done.

Fiona Osborne queried under PH01 and PH02 that a band 6 clinical technician was required and was not mentioned in this report. Response was that the pharmacy team are under immense pressure with vacancies and are looking at delivering in the broader pharmacy services. One option is to develop 3 ward-based support workers at band 3 who will support pharmacy technicians freeing up some pharmacy technician's admin time. This in turn would free up time for the band 7 pharmacist. Another option is to develop the band 6 role into a specialist clinical role. Once agreed this will free up time to get the medicine reconciliation completed in a timely manner.

263/23 Potential Deviations from National Documentation

The report was taken as read. Fiona Osborne updated the surgery division brought a deviation of a NICE quality standard to the Quality Governance Group for check and challenge for emergency Endoscopic Retrograde Cholangio-Pancreatography **(**ERCP) procedure as they are not fully compliant. This is treating patients within 24hrs when they present and require emergency treatment as there is no 7 day on call service (Mon-Fri with 3 days a week MDT discussions).

Kate Wood noted it was good that the team are recognising where they fall short of the NICE guidance as we do not provide a 7-day service. It was queried what happens to patients outside of the service hours. It was recognised that we will not be compliant with this, however, we are going into a group structure with another organisation who do provide a 7-day ERCP service. Details of how the gap is being mitigated are needed as this doesn't show on the paper. Response was that discussion at the Quality Governance Group is that they do consultant to consultant referral to a tertiary centre out of hours for emergency cases. There is no documented evidence for this. This to be followed up with the division. Fiona Osborne echoed the need for the understanding of the impact on patients arriving on a Friday evening and waiting until Monday. Fiona Moore stated there was a research paper based on 48hr delay which showed an increase in 30 day mortality rates, length of stay and adverse effects for major organ failure. Kate Wood has

discussed this matter with the Executive team today and HUTH are happy to have conversations regarding setting up a clear pathway regardless of a patient's postcode.

The group approved the deviation but are not assured that the patients are getting the best outcome and further action needs to be taken.

ACTION: An update regarding the emergency ERCP procedure to be brought back to the group following further discussions with HUTH. It was noted if there isn't an improvement within 2 months, a paper will be requested. Fiona Moore to chase.

264/23 Patient Safety Incident Response Framework (PSIRF)

The report was taken as read. Fiona Moore updated good progress has been made with the PSIRF group and there is a draft policy and PSIRP almost completed. The plan is to be taken to the ICB for approval and final sign off on 10th October 2023. An implementation plan to then be created to allow the current SI's to be completed.

A successful transition across to the Learning From Patient Safety Event system (LFPSE) took place. Congratulations were given for moving at pace. It was noted that HUTH were an early adopter of PSIRF.

Kate Truscott queried who the Patient Safety Partners were. Response was there are 5/6 that work across the divisions.

ACTION: Fiona Moore to send an email detailing who the Patient Safety Partners are to the group.

Fiona Osborne queried if there were any concerns with group stakeholders. Response was there were no concerns but there were some inital challenges where certain divisions were not comfortable with the direction of travel. Support was given with a good outcome.

265/23 Learning from Deaths

The report was taken as read. The SHMI remains within the expected range. There is still the issue with palliative care diagnosis coding due to the lack of access to a palliative care consultant in Grimsby. Recruitment is ongoing for this post and will be going back to out to advert with an alternative back up plan of recruiting a specialist doctor should it not be successful. SJR's identified the overall care rating were either excellent, good or adequate. Adequate ratings were due to the end-of-life pathway being identified at an earlier point. Attention was drawn to the additional data in the appendix with pneumonia deaths. It was noted via the Mortality Improvement Group an increase in the rate of attendance of deaths with pneumonia patients. Access to data via CHKS was not provided, however, HUTH have provided some benchmarking data. This showed a rise nationally of influenza and pneumonia deaths in the winter period extending to early spring. The increased rate of attendances matches the increased rate of deaths. Hospital Standardised Mortality Ratio (HSMR) data shows we are within normal variance meaning the quality of care patients have been given is acceptable with no risk. Figures are less than pre-pandemic.

Kate Truscott queried regarding the mental capacity act and Deprivation of Liberty Safeguards (DoLS) issues on page 10 and the training. It was noted there has been an issue with capacity within the team. Response was the mental capacity DoLS team is solely David Wellburn. There has been progress recruiting a deputy post and they started this month which will help with pressures. A Mental Capacity Working Group has also been set up with divisional representation from ward managers and governance leads. They will ensure shared learning and key messages work on the 4 pilot wards. This is limited to the data access Trustwide but conscious there will be common themes. Individual areas are being encouraged to undertake their own quality improvement projects. The roll out of the resource folder (yellow) is now in place.

Sue Liburd asked if this comprehensive detail of work taking place could be included in the CQC report. This would then give a clearer picture of the significant amount of work being undertaken.

ACTION: Fiona Moore to pass on updating the CQC report with comprehensive details of all works being undertaken to Annabelle Baron-Medlam for next month's meeting.

Melanie Sharp updated regarding the training for the mental capacity act that it was acknowledged and the compliance and quality regarding the applications is needed. A quality improvement project has been identified to look at how we will increase compliance on a ward by ward basis. It was noted that education will be a focus.

Fiona Osborne noted this was the second time this report had been brought to the group in the new format. All agreed they were happy with the new format. The group gave their thanks to Fiona Moore for her hard work putting this report together.

Highlight reports

266/23 Quality Governance Group (QGG)

The report was taken as read.

267/23 Mortality Improvement Group (MIG)

No papers due to meeting being cancelled.

268/23 Patient Safety Champions Group (PSC)

No papers due to meeting being cancelled.

Items for information

269/23 Quality Governance Group (QGG) minutes

Distributed for information.

270/23 Mortality Improvement Group (MIG) minutes

No papers due to meeting being cancelled.

271/23 Patient Safety Champions group (PSC) minutes

No papers due to meeting being cancelled.

272/23 Any Other Business

Nothing raised.

273/23 Matters to Highlight to Trust Board or refer to QGG or other Board Sub-Committees

The Committee agreed to add the following points to the highlight report to the Trust Board.

Fiona Osborne advised from this month a new format of Highlight Report will go forward which will have more information than the previous reports. Fiona Osborne proposed to draft a highlight paper for circulation to Committee and Executive colleagues for review prior to submission. It was agreed the report should cover:

- PSIRF success
- Highlight there is an exit from Maternity special measures with a key thanks to the Maternity team
- Concern over Maternity vacancies but highlighting patients are safe
- Potential risks around the medicine reconciliation although this is being managed
- Concern over Pharmacy Vacancies although different approaches are being taken to keep patients safe
- Requests an Executive focus on the data gap in patient waits, wait bot, paediatric team, EoL collection.
- Key reports to be pulled out including the 15-step report
- Request for deviation from NICE guidance

274/23 Meeting review

- Nothing raised.

275/23 Date and Time of the Next Meeting:

The next meeting will take place as follows:
Date: 24th October 2023
Time: 13:30-16:00
Venue: Virtual via MS Teams

It was noted that Simon Parkes and Gill Ponder will be representing Sue Liburd and Kate Truscott at the next meeting.

The meeting closed at 16:00

QSC Annual attendance log

Name	Aug 2022	Sept 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	March 2023	April 2023	May 2023	June 2023	July 2023	Aug 2023	Sept 2023
Michael Proctor	✓													
Michael Whitworth														
Fiona Osborne	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	x	✓	✓
Maneesh Singh	x	✓												
Dr Kate Wood	✓	✓	✓	✓	✓	✓	✓	x	✓	✓	x	✓	✓	✓
Ellie Monkhouse	✓	x	✓	x	✓	✓	✓	x	✓	x	x	✓	✓	x
Dr Peter Reading	x	x	x	x	✓	✓	x	x	x	x				
Shaun Stacey	x	✓	✓	x	x	x	✓	x	x	x	✓	✓	✓	x
Susan Liburd			✓	✓	✓	x	x	✓	✓	✓	✓	✓	✓	✓
Kate Truscott			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Melanie Sharp														✓

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Jenny Hinchliffe, Deputy Chief Nurse Melanie Sharp, Deputy Chief Nurse
Title of the Report	**Nursing & Midwifery Assurance Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Board is asked to note the content of the report. CHPPD (Care Hours per Patient Day) was 8.6 in September. Two wards, C2 and Amethyst, had CHPPD below 6. The overall fill rate has been below 95% for the past three months. No patient safety concerns have been raised during this time period for wards with fill rates below 85% (Neonatal Intensive Care Unit, Grimsby, Laurel, Ward 26, Blueberry/Holly, Disney and Intensive Therapy Unit Grimsby). All these areas have high vacancy rates and sickness rates in September, however have robust processes in place to manage capacity and demand with senior oversight and timely internal escalation where required. The midwife to birth ratio for the Trust in September was 1:22.8 (Grimsby – 1:24.6, Scunthorpe – 1:21.6) which is better than the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios. There is a total of 209.91 WTE (Whole Time Equivalent) (10.84%) RN/RMW (Registered Nurse/Registered Midwife) vacancies and 108.95 WTE (10.68%) unregistered vacancies across the Trust. The increase in registered and unregistered vacancies can be attributed to an increase in establishments as part of the bed modelling. Focus remains on recruitment of newly qualified nurses and midwives, external domestic nurses and internationally educated nurses and midwives, all of which have healthy pipelines. With the current pipeline there is a forecast vacancy of 34.26 WTE Band 5 RN by March 2024. **It is anticipated that by December there will be approximately 40 WTE HCA (Health Care Assistant) vacancies to fill (assuming an operational zero of 13.85 WTE).** The overall vacancy rate for nursing in Community and Therapies has decreased slightly and remains low. In the acute setting 24 nurse staffing incidents and 38 red flags incidents were reported, with 9 of the staffing incidents being reported on Maternity Grimsby. Fourteen red flags were due to less than 50% substantive staff on a shift, this is closely monitored at Matron level, staff are moved across Directorates when required to increase substantive staff to mitigate the risk. Red flags have increased from last month however there has been no impact on patient safety reported.

	In community the total red flag incidents was 11 which is lower than the previous month. Seven of these relate to shortages across the community nursing networks. There has been a slight decrease in the total number of reported in-patient falls. The number of acute pressure ulcer incidents reported has increased whilst community pressure ulcer incidents reported in have slightly decreased. New formal complaint numbers increased to 28, representing a 39% increase on the previous month. September saw 83% (24) of closed complaints managed in timescale in comparison to 84% (31) for August, with performance maintained. September FFT (Friends and Family Test) data submission saw an increase to 824 from the previous month and further improvements in response rates should improve once the full implementation of the new provider system is in place. Six 15 Steps Challenge visits were completed within the acute and community schedules. There has been significant increase of cases regionally and nationally of alert organisms. The Trust is performing well and is below national average on all. However, there has in the last few months been an upward trend in MSSA (Methicillin-susceptible Staphylococcus aureus) Bacteraemia hospital acquired cases which appear to be associated to peripheral cannula care – further investigation and action plan in progress. 678 Nurses, Midwives and AHPs (Allied Health Professions) have accessed QI (Quality Improvement) training to date, in addition 46 QI projects have been initiated and progressing in the past 12 months.
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.
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 & Midwifery Assurance Report November 2023 (Sept 2023 Data)

1.0 Introduction

This is a routine report in accordance with the requirements of the updated National Quality Board 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, midwifery, and safe staffing. The changes to ward configurations and use of escalation beds have made it challenging to make comparisons and benchmark, and for this reason we continue to review individual metrics and apply professional judgement. Quality impact assessments are undertaken with final sign-off by the Chief Nurse prior to additional wards being opened.

The Chief Nurse chairs the Nursing Metrics Review Panel which 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 CHPPD (Care Hours per Patient Day)

The information presented shows data on inpatient wards only.

DPOW – Diana, Princess of Wales Hospital Grimsby
GDH – Goole & District Hospital
SGH – Scunthorpe General Hospital

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.

Ward C2 and Amethyst had CHPPD of 5.9 in September. Both wards had a high sickness level and also have higher vacancy rates.

The latest model hospital data for August 2023 indicates a provider value of 8.8 (quartile 3 mid to high 25%) against a peer median of 8.5 and provider median of 8.4.

DPOW – Diana, Princess of Wales Hospital Grimsby
GDH – Goole & District Hospital
SGH – Scunthorpe General Hospital

The overall fill rate has reduced below 95% for the past three months. Fill rates for individual wards vary from 109.8% to 64.9% (**Appendix 1**) and are outlined in ward dashboards (**Appendix 2**).

Wards with fill rates over 100% are B2, C3 and ward 3. C3 Short Stay and B2 IAAU (Integrated Acute Assessment Unit) have continued to have an increased number of beds open in September in line with the recent bed modelling, this has resulted in the requirement for additional staff to manage this increase which has now been incorporated into establishments.

Ward 3 required several nurse escort shifts and had additional 1-1 supportive care requirements. A pathway is being developed to consider utilising the portable MRI/CT (Magnetic Resonance Imaging/Computed Tomography) scanners at Goole Hospital for patients that are less urgent and ambulatory to help to reduce the need for additional staffing to escort patients off site.

Wards with fill rates below 85% are NICU (Neonatal Intensive Care Unit) Grimsby, Laurel, Ward 26, Blueberry/Holly, Disney and ITU (Intensive Therapy Unit) Grimsby. All of these areas have high vacancy rates and the vacancy rate increased on NICU Grimsby, Laurel and Ward 26 in September. All areas also had high sickness rates. Disney had a low bed occupancy rate of 57.8%, as had Ward 26 (48.3%) and NICU Grimsby (69.4%) which helped with maintaining patient safety. No patient safety concerns have been raised during this time period.

All of these are areas have robust processes in place to manage capacity and demand with senior oversight and timely internal escalation where required.

RNMW Ratio by Site

Latest Month	Site	Result	Variance to Previous	Previous Month	Trend
Sep 2023	DPoW	59.9%	1.1%	58.8%	
Sep 2023	GDH	54.1%	0.3%	53.8%	
Sep 2023	SGH	63.7%	0.8%	62.8%	

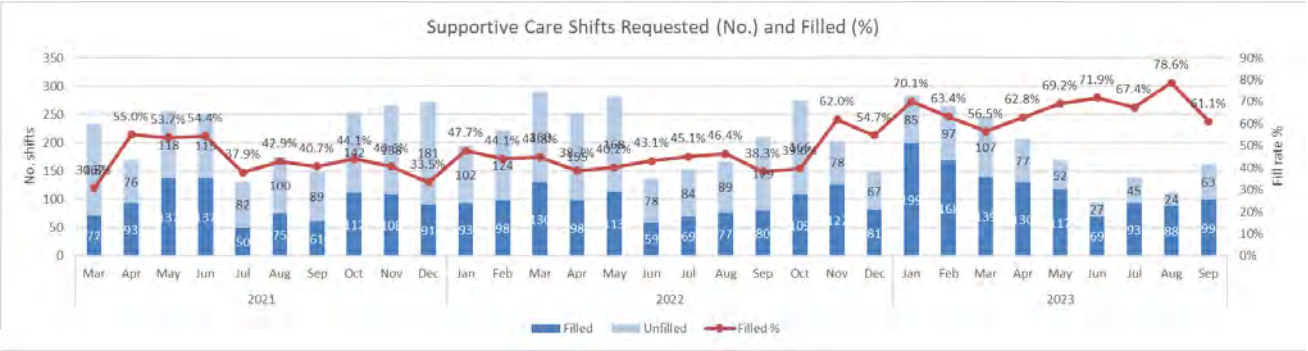
RNMW Ratio by Division

Latest Month	Division	Result	Variance to Previous	Previous Month	Trend
Sep 2023	Medicine	55.2%	0.1%	55.2%	
Sep 2023	Surgery & Critical Care	69.7%	3.3%	66.4%	
Sep 2023	Women & Children's	67.7%	0.6%	67.1%	

DPOW – Diana, Princess of Wales Hospital Grimsby
GDH – Goole & District Hospital
SGH – Scunthorpe General Hospital

A mix split of 60:40 is aimed for, with a higher skill mix in midwifery. RN (Registered Nurse) RM (Registered Midwife) to HCA (Health Care Assistant ratio for the Trust has been above 60% for the last two years. Medicine remains the lowest RN ratio in September at 55.2%, this has remained relatively static for the past 6 months. Surgery & Critical Care has the highest RN ratio and is reflective of the number of level 2 and 3 beds within the division.

2.2 Supportive Care – September 2023



Seven areas in Grimsby used supportive care shifts in September: A1, Amethyst, B3, C1G, C2, C3, Stroke. The fill rates varied from 60% to 100%.

Three areas in Scunthorpe used supportive care shifts: Disney, ward 27 and ward 29. The fill rates varied from 50% to 64.6%. Ward 3 in Goole used supportive care shifts with a fill rate of 31%. The overall fill rate for the Trust was 61.1%.

Robust process are in place with Matron oversight to ensure patient safety can be maintained whilst minimising the need for this additional resource. This is achieved by cohorting patients and by redeploying substantive staff from other areas to support any shortfall in unfilled supportive care shifts.

A process to capture more detail relating to the use of supportive care shifts is being piloted and it is hoped to include the number of shifts requested on the dashboards in the future.

2.3 Escalation Beds

Bed modelling has been completed by the Operations Directorate indicating an additional 8 medical beds were required at Grimsby and 4 extra beds at Scunthorpe. Surgery required an additional 9 beds at Scunthorpe. To date these beds have been used as escalation beds and staffed with bank and agency staff. Establishments have been adjusted from September 2023 to support recruitment of substantive staff to cover the increased bed numbers. Recruitment has commenced however it will be a few months before an impact on the use of temporary staffing is seen.

2.4 Overnight Patient Moves

Ward transfers between 22.00 and 06.00 hours are captured on the ward dashboards (**Appendix 2**) and continue to show high numbers of transfers during this period across all areas.

Within Medicine the number of out of hour patient moves continues to be monitored. It was previously noted that the Grimsby site undertakes more patient moves between 22:00 and 06:00 than the Scunthorpe site. These differences are more noticeable within the IAAUs (Integrated Acute Assessment Units) and Short Stay areas indicating that they are linked to bed availability and challenges with capacity. Due to these differences, a QI (Quality Improvement) project is underway looking at short stay and the process linked to identification, management, and placement of patients with an identified short stay need. In September the number of bed moves was at a similar level at both sites.

2.5 Staffing Indicators

2.5.1 Vacancies

The information presented below shows data on **inpatient wards** only.

DPOW – Diana, Princess of Wales Hospital Grimsby
GDH – Goole & District Hospital
SGH – Scunthorpe General Hospital

There is a total of 209.91 WTE (Whole Time Equivalent) (10.84%) RN/RMW (Registered Nurse/Registered Midwife) vacancies and 108.95 WTE (10.68%) unregistered vacancies across the Trust in September. Some of the increase in registered and unregistered vacancies can be attributed to an increase in establishments following the bed modelling undertaken.

The following newly qualified nurses, midwives and ODPs (Operating Department Practitioners) have been offered posts and have either commenced employment or will do so over the coming months:

	Newly Qualified Adult Registered Nurse	Newly Qualified Paediatric Registered Nurse	Newly Qualified ODP	Newly Qualified Midwives
Started/due to start Oct	36.65	7.8	2	13.96
Due to start Nov/Dec	10.8	2.72	2	1.08
Due to start Jan/Feb 2024	30.6			
Total	**78.05**	**10.52**	**4**	**15.04**

Registration with professional bodies can take several weeks therefore a delay is often seen in the corresponding reduction in vacancies.

Additionally, 51.35 WTE (Whole Time Equivalent) nurses and midwives have been attracted and recruitment from the domestic market and are going through recruitment checks

External domestic RN/RM (Registered Nurse/Registered Midwife recruitment:

Division	WTE (Whole Time Equivalent)
Medicine	10.02
Surgery & Critical Care	20.61
Family Services	9.42
Community & Therapy	9.34
Maternity	1.96
Total	**51.35**

Seven IEMWs (Internationally Educated Midwives) have joined the Trust and have their NMC (Nursing & Midwifery Council) registration, an additional four IEMWs will join the Trust in December.

The Trust has a memorandum of agreement in place with NHS England to appoint 90 IENs (Internationally Educated Nurses) by November 2023, however, has agreement to delay the last cohort until January 2024 due to our ability to safely support them in the clinical areas. IEN recruitment plans are as follows:

Month	Planned arrivals	Actual arrivals
May 2023	18	12
July 2023	23	23
September 2023	17	17
November 2023	18	(Revised plan = 20)
January 2024	16	(Revised plan = 20)
Totals	92 (90 + 2 c/f from 22/23)	52

An additional 20 IENs will be appointed in March 2024 in line with the plans agreed with the ICB (Integrated Care Board). The IENs who have joined the Trust continue to progress through their OSCE (Observed Structured Clinical Examination) preparation and induction programme with a 99.7% OSCE pass rate. Nationally between January - March 2023, a total of 10613 applicants took the new OSCE and overall, 76% achieved a pass.

HCA (Health Care Assistant) recruitment continues through the pool and through divisional specific recruitment campaigns. With those with start dates or having been allocated to clinical areas and undergoing recruitment checks, it is anticipated that by December there will be approximately 40 WTE (Whole Time Equivalent) HCA vacancies to fill (assuming an operational zero of 13.85 WTE).

2.5.2 Nursing Apprenticeships

The table shows an overview of the current apprenticeship programme, with additional detail in the retention section.

Start date	Course	Starters	Break in learning/ left programme	Anticipated end date	Anticipated no. of registrants	Actual no. of registrants
Sep 2022	Assistant Practitioner Nursing (APiN) conversion to RN (Registered Nurse)	1	-	Sept 2024	1	
Jan 2023	Nursing Associate (NA) conversion to RN*	5	-	Aug 2024	5	
Jan 2023	Trainee NA (15 places/year)	9	2 paediatric trainees (left programme) 1 due to maternity leave	Feb 2025	6	
Sep 2023	APiN conversion to RN*	4	1 (deferred)	Sept 2025	3	
Sep 2023	RNDA (15 places/year) Registered Nurse Degree Apprenticeship	10	-	Sept 2026	10	
Jan 2024	Nursing Associate (NA) conversion to RN*	2 offers		Feb 2026	2	
Sept 2024	APiN conversion to RN*	8 offers		Sept 2026	8	
Total		**39**	**4**	**-**	**35** (+2 deferred/break)	

**10 places per year for conversion programme*

2.5.3 Nursing Recruitment and Retention Work

Recruitment initiatives include:

- Working with workforce colleagues to diversify the IN (International Nursing) pipeline and ensure adequate support for ambitions. Participating in work with the Integrated Care Board to develop links with educational institutions in Kerala and Karnataka to support our current and future pipelines for Nurses and Allied Health Professionals. A visit to Kerala is planned for November.
- Widening Access Project (NHSE funding for 12 months) – to date 17 Healthcare Support Workers from diverse backgrounds have been offered posts. The target is 20 Healthcare Assistants by 31st March 2024.
- Targeted divisional support worker recruitment along with Trust mass recruitment days.
- Collaborative work with further and higher education establishments to deliver T-Level clinical placements:
    - Grimsby Institute – 13 learners on cohort 2. Of the 4 students hosted on the **G**ynaecology Paediat**R**ics M**A**ternity **C**ommunity Breast Car**E** (GRACE) work experience programme last year, all have gone on to university to study in Midwifery/Healthcare. Of the students taken on generalist placements last year, 80% of them now work for the Trust.
    - Franklin College – 3 intakes per year with 10 learners in each intake plus 10-15 summer internship placements offered.
    - Selby College – 4 T-level students offered placements.
    - North Lindsay College – 4 places offered on the GRACE project with a further 4 generalist placements offered.

Retention initiatives includes:

- Ongoing delivery of career clinics and promotion of the internal transfer process
- Continued development of the nursing career framework to improve accessibility
- Flexible working team rostering pilot progressing with rollout to further wards planned
- 54 HCA (Health Care Assistant) buddies trained across the Trust with plans to continue rollout

- Proposal being progressed to develop the Healthcare Assistant Council into a Shared Decision-Making Council
- Continue to train PNAs (Professional Nurse Advocates) with 45 qualified and 14 in training against a trajectory of 91 qualified PNAs by March 2024 (1 PNA:20 RNs (Registered Nurses)). Nationally there have been delays with procurement and allocation of the level 7 PNA programme. It is anticipated that by August 2024 the Trust will have 59 qualified PNAs (1 PNA:30 RNs). A recent evaluation of the programme has been undertaken (**Appendix 7**).
- Next cohort of trainee ACPs (Advanced Clinical Practitioners) commencing September 2023 & January 2024 (acute medicine – 3, urology – 1)
- Recruitment has commenced for the next cohorts of Nursing Apprenticeships to support career progression opportunities.
- International recruitment 'stay and thrive' work is ongoing.

2.5.4 Staffing incidents & Red Flags

Twenty-four nurse staffing incidents and 38 red flags incidents were reported in September. Nine of the staffing incidents were reported on Maternity Ward 26 Grimsby, 6 of these were due to below safe staffing levels after escalation, two due to a lack of suitably trained staff with no impact of patient care and one due to insufficient skill mix. Fourteen Safecare red flags were due to less than 50% substantive staff on a shift, this is closely monitored at Matron level, staff are moved across Directorates when required to increase substantive staff to mitigate the risk.

Safe staffing red flags have been reviewed and updated by the Safe Staffing and Effective Rostering Group to ensure they remain appropriate and are for approval by Nursing, Midwifery & AHP Board in December 2023.

3 Non-Inpatient Ward Areas & Emergency Departments

The non-inpatient ward dashboard can be found in **Appendix 3** and the ED (Emergency Departments) dashboards can be found in **Appendix 4**.

Grimsby ED registered nursing vacancies are an improving picture for September with 2.4 WTE (Whole Time Equivalent) less vacancies than in August, however the unregistered staff vacancy rate has increased by 4.7 WTE. Four Band 3 new HCAs (Health Care Assistants) will commence in post from December 2023. There are six Band 2 vacancies however this is due to three staff being appointed into the Band 3 vacancies. Adverts for the Band 2 HCA are live and interviews are being planned.

Hand hygiene for Grimsby ED for September is at 72.5% which is a 4.5% increase from the last data set, work is underway to improve this level. Hand hygiene at Scunthorpe ED has decreased slightly to 83.8%. The Medical division continue to challenge at the point of being identified and are sharing this information to the many different divisions that attend ED. Medicine have introduced a weekly audit check and hand hygiene is included in this to ensure 100% compliance is achieved.

Scunthorpe ED registered nursing vacancies has improved for September with 5.4 WTE less vacancies than August, however, there has been a slight increase in unregistered vacancies of 0.3 WTE.

4 Maternity

4.1 Midwife to birth ratio

The Maternity dashboard can be found in **Appendix 5**. The midwife to birth ratio for the Trust in September was 1:22.8 (Grimsby – 1:24.6, Scunthorpe – 1:21.6) which is better than the acceptable ratio of 1:28. Although the vacancy factor is high, the ability to cover shifts shows positively in the ratios.

4.2 Maternity Fill Rates and CHPPD (Care Hour per Patient Day)

Maternity Wards Fill Rates and CHPPD Sep 2023

Ward name	Fill Rate %	Change	Substantive Fill Rate %	Change	CHPPD	Change
Blueberry/Holly DPoW	**77.2%**	**▼ -17.2%**	**62.0%**	**▼ -18.3%**	**9.0**	**▼ -5.89**
Registered Nurses and Midwives	72.5%	▼ -17.9%	58.5%	▼ -15.7%	5.6	▼ -3.47
Care Staff	86.4%	▼ -14.9%	68.9%	▼ -22.2%	3.4	▼ -2.42
Central Delivery Suite	**92.5%**	**▲ 5.4%**	**64.2%**	**▲ 7.6%**	**31.7**	**▼ -0.39**
Registered Nurses and Midwives	94.1%	▲ 5.2%	63.5%	▲ 10.8%	25.9	▼ -0.42
Care Staff	86.2%	▲ 6.4%	67.0%	▼ -5.6%	5.8	▲ 0.03
Jasmine & Honeysuckle	**86.9%**	**▼ -3.6%**	**74.0%**	**▼ -1.0%**	**14.1**	**▲ 2.67**
Registered Nurses and Midwives	80.2%	▼ -3.1%	67.2%	▼ -0.8%	8.7	▲ 1.68
Care Staff	100.9%	▼ -4.8%	87.9%	▼ -1.5%	5.3	▲ 0.99
Ward 26 SGH	**80.7%**	**▲ 2.5%**	**47.8%**	**▲ 0.6%**	**7.3**	**▲ 0.31**
Registered Nurses and Midwives	77.8%	▲ 4.7%	43.4%	▲ 7.4%	5.1	▲ 0.36
Care Staff	88.4%	▼ -3.4%	59.9%	▼ -18.0%	2.1	▼ -0.06
Total	**83.9%**	**▼ -4.3%**	**62.6%**	**▼ -3.7%**	**11.6**	**▼ -0.95**

Maternity Wards RNMW Ratio

Ward name	RNMW Ratio %	Change
Blueberry/Holly DPoW	62.4%	▲ 1.4%
Central Delivery Suite	81.8%	▼ -0.3%
Jasmine & Honeysuckle	62.0%	▲ 0.2%
Ward 26 SGH	70.5%	▲ 2.1%
Total	**68.7%**	**▲ 1.3%**

The shift fill rates in maternity remain below 95% in all areas with staffing shortfalls seen across both hospital sites and in the community. Escalation processes and plans are in place to manage capacity and demand with daily senior oversight and escalation of any risks that can't be mitigated.

Maternity and neonatal services are discussed in detail in the separate Maternity and Neonatal Oversight Report.

5 Community Nursing

The Community Nursing dashboard can be found in **Appendix 6**.

5.1 Community Nursing Workforce

The overall vacancy rate for nursing in Community and Therapies has decreased slightly in September 2023 with the largest number of vacancies being Registered Nurse posts in the Community Nursing Networks.

There is ongoing work to recruit to vacancies and retain new and existing staff to improve staffing capacity. Once all the newly recruited band 5 nurses and the September cohort of newly qualified nurses are in post working as Registered Nurses, there will be minimal band 5 vacancy in the Community Nursing Networks. The current over establishment of HCAs (Health Care Assistants) is because of the Newly Qualified Nurses working in unregistered posts until they have their NMC (Nursing & Midwifery Council) registration.

The Macmillan Healthcare team vacancies are in the recruitment pipeline.

Vacancies by Team Sep 2023

Team	Vacancies - Qualified	Vacancies - Unqualified	Total
East Network	3.5	-0.8	2.8
South Network	3.2	-1.5	1.8
Macmillan Health Care Team		1.8	1.8
Palliative Care	1.2		1.2
Intermediate Care Services (ICS) + Core Therapy	1.7	-0.6	1.1
Tissue Viability Team	0.0	1.0	1.0
Evening / Night Service	0.5	0.5	0.9
Specialist Palliative Care Nurses (SPC)	0.5		0.5
West Network	2.1	-1.6	0.5
Single Point of Access (SPA)	1.3	-0.9	0.4
Unscheduled Care Team (UCT) (incl rapid response)	1.3E-15	0.2	0.2
Continence Team	0.0	0.0	0.0
DN Students	0.0		0.0
Chronic Wound Team	0.6	-0.7	-0.1
Locality Co-ordinators	-0.2	0.0	-0.2
Long Term Conditions / Complex Care Matrons (Comm Matrons)	-0.3		-0.3
Discharge Liaison Team		-1.0	-1.0
Total	**14.2**	**-3.6**	**10.6**

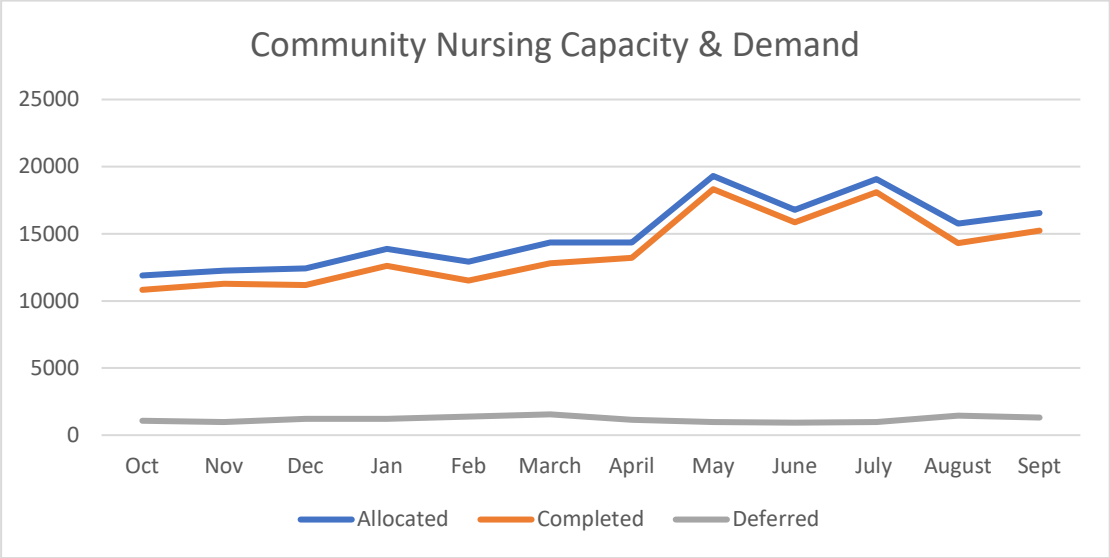
5.2 Community Red Flag incidents

The total red flag incidents for September 2023 are 11 which is slightly lower than the 15 reported in August 2023. Seven of these relate to shortages in staffing across the community nursing networks. Staff have been reminded in team meetings to report red flags which is why we have seen an increase as staffing challenges have not been significantly higher in September 2023.

5.3 Community Nursing Activity

There is limited activity information for September 2023 due to the ongoing issues with the data warehousing, this is evident in our Community Nursing dashboard. The following data has been pulled manually from Civica the electronic scheduling system used in Community Nursing. Work is ongoing on the reporting of data so it should be treated with some caution.

Visits Allocated Sept 23 (Completed + Deferred)	Visits Completed Sept 23 (Visits Activity Report)	Visits Deferred / Cancelled - Moved TO Sept 23 (Moved Visits Report)
16,549	15,233 (Average 507 per day) 91.4%	1316 moved 8.6%



5.3.1 Activity delivered/not delivered

- The data shows that the activity continues to be higher in month than was seen in 2022-2023 and there has been a further slight increase seen in September 2023.
- Despite the increase in the total number of visits, 91.4% of visits were completed and only 8.6% were deferred, this was a slight deterioration from previous months.
- Further work has been undertaken to understand this increase in demand and what kind of activity. The breakdown of activity is as below with the highest proportion of visits being for administration of insulin and wound care. The delegation of insulin QI project should reduce some demand for diabetic care. There needs to be a focus on projects for wound care.

	Aug-23		Sep-23
DIABETIC	37%		35%
PALLIATIVE	8%		7%
CATHETER/BOWEL	6%		6%
WOUND CARE	36%		42%
INJECTIONS	2%		3%
ASSESSMENT	8%		4%
EYE DROPS	1%		1%
BP	1%		1%
OTHER	1%		1%

- Capacity and demand are reviewed at a weekly safe staffing meeting, visits are looked at proactively and staffing moved between networks to cover any shortfalls.

- Capacity and demand are also reviewed on a daily basis and any visits that need to be deferred because of capacity are prioritised using the Essential Visit Guidance for Community Network Teams.
- Patients who are receiving care that is considered essential are ticked on the Civica electronic allocation system as requiring a ‘critical intervention’ so these visits are not deferred.
- The caseload holders (District Nurses) have oversight of deferred visits for their patients.
- Initial data collection for the Community Nursing Safter Staffing Tool (CNSST) has been completed in May 2023 with the second data collection scheduled for November 2023. This information will be used to undertake a nurse staffing establishment review.

6 Non-Medical Education Tariff (NMET)

Successful work continues to support the growing number of undergraduate students through expansion of student placements leading to increased tariff income.

The DHSC (Department of Health and Social Care) introduced tariffs for clinical placements on 1st April 2013. The clinical tariff payment is intended to provide an annual contribution to the funding of placement coordination and practice-based learning for all eligible clinical professions. The tariff funding should be used to support all professions for which it has been allocated. Work is ongoing to understand the cost of placement delivery and where the tariff is spent.

Practice Assessment Record & Evaluation (PARE) quarterly student practice placement feedback report (Jul-Sept 2023) identifies the nursing average evaluation rating is 91.1% positive. Midwifery placement ratings are now 95% positive (second significant improvement in a row). Targeted work and support being undertaken in the small number of areas where improvements can be made.

7 Advanced Practice

Three trainee ACP (Advanced Clinical Practitioner) apprentices in acute medicine and one trainee ACP in urology commenced on the ACP programme in September. 15 qualified and 10 trainees are now in post. Work will commence with Divisions to determine the need for future advanced level practitioner and medical associate professions roles in 2024 to meet service need.

8 Quality

8.1 Reported Falls Incidents (in-patient wards)

Falls - Total by Site

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2023	DPOW	43	1	42	
Sep 2023	GDH	2	-5	7	
Sep 2023	SGH	30	2	28	

Falls - Total by Division

Latest Month	Indicator	Result	Variance to Previous	Previous Month	Trend
Sep 2023	Community & Therapies	2	-5	7	
Sep 2023	Family Services	1	1		
Sep 2023	Medicine	56	-6	62	
Sep 2023	Surgery	16	8	8	

DPOW – Diana, Princess of Wales Hospital Grimsby
GDH – Goole & District Hospital
SGH – Scunthorpe General Hospital

There has been a slight decrease in the total number of reported in-patient falls in September 2023.

There was one in-patient falls reported with major harm in September 2023. The fall occurred on Amethyst Ward at the Grimsby site and resulted in the patient sustaining a femoral fracture. No lapses in care were identified at the huddle which was completed within one working day of the incident occurring. All appropriate risk reduction measures were in place and the patient had full mental capacity.

8.1.1 Emergency Departments

Falls within Departments decreased for September with no recorded falls with harm.

8.1.2 Wards with Highest Incidence of Falls

Highest Reporting Wards with Falls Incidents **Sep 2023**

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	7	▲ 3	1	▲ 1	0	0	0	0	8	▲ 4
DPOW - Amethyst	6	▲ 1	0	0	0	0	1	▲ 1	7	▲ 2
DPOW - C2	7	0	0	▼ -4	0	0	0	0	7	▼ -4
SGH - Ward 25	2	▼ -1	3	▲ 2	0	0	0	0	5	▲ 1
SGH - Ward 27	4	▲ 2	1	▲ 1	0	0	0	0	5	▲ 3

DPOW – Diana, Princess of Wales Hospital Grimsby
SGH – Scunthorpe General Hospital

C2 has triggered as a higher reporting ward for the third consecutive month with a decrease in the number of falls reported in September 2023. Amethyst has triggered as a higher reporting ward for the second consecutive month. None of the other higher reporting wards are demonstrating any concerning trends at this time.

8.2 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.

The number of pressure ulcer incidents reported in September 2023 has increased.

All moderate harm incidents reported in September 2023 have been reviewed at the weekly scrutiny meeting.

Two incidents which occurred on Ward 17 at Scunthorpe and the Emergency Department at Grimsby have been reported as serious incidents due to lapses in care. No new root causes were identified during the review process and local actions are in place to share the learning.

8.2.1 Wards with the Highest Incidence

Highest Reporting Wards with PU Incidents — Sep 2023

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	6	▲ 3	1	▲ 1	0	0	0	0	7	▲ 4
SGH - Ward 17	6	▲ 6	0	0	0	0	1	0	7	▲ 6
DPOW - C2	6	▲ 5	0	0	0	0	0	0	6	▲ 5
SGH - Ward 27	4	▲ 1	1	▲ 1	0	0	1	▲ 1	6	▲ 3
SGH - Ward 22	5	▲ 3	0	0	0	0	0	0	5	▲ 3

DPOW – Diana, Princess of Wales Hospital Grimsby
SGH – Scunthorpe General Hospital

None of the higher reporting wards are currently demonstrating any concerning trends.

No staffing concerns have been highlighted on any of the higher reporting areas.

The areas identified above will be discussed in more detail at the Nursing Metrics Panel alongside other indicators.

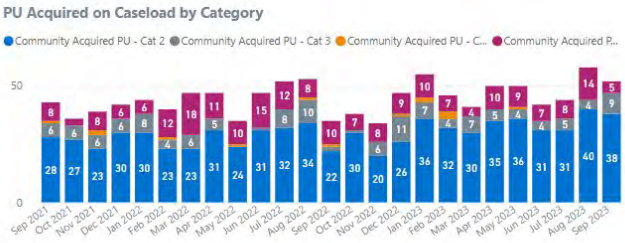
8.3 Community (Acquired on Caseload) Pressure Ulcer Incidents

The data includes pressure ulcers acquired on community caseload at North Lincs, this includes category 2,3,4 and unstageable pressure ulcers.

Data changes from month to month due to ongoing validation and these figures may contain un-validated pressure ulcers.

Community (Acquired on Caseload) PU Incidents — Sep 2023

PU - Total	PU - Cat 2	PU - Cat 3	PU - Cat 4	PU - Unstageable
52 ▼ -6	38 ▼ -2	9 ▲ 5	0	5 ▼ -9



PU Acquired on Caseload by Team — Sep 2023

Team	Community Acquired PU - Cat 2	Community Acquired PU - Cat 3	Community Acquired PU - Cat 4	Community Acquired PU - Unstageable	Total
South Network	15	5	0	4	24
West Network	11	2			13
East Network	5	2	0	1	8
Intermediate Care Services (ICS) + Core Therapy	6	0	0	0	6
Tissue Viability Team	1	0	0	0	1
Total	**38**	**9**	**0**	**5**	**52**

The number of pressure ulcer incidents reported in September 2023 have slightly decreased. South Network have reported the highest number of incidents followed by West Network and then East Network. This is reflective of the caseload sizes.

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.

There has been an increase in the number of category 3 pressure ulcers and a slight decrease in unstageable pressure ulcers. There have been no category 4 pressure ulcers.

All moderate harm incidents reported in September 2023 have been reviewed at the Community and Therapy Weekly Pressure Ulcer Scrutiny Meeting.

Lapses in care were identified in none of the incidents reviewed for September 2023.

A review of the networks and place of residence for patients who developed a category 2,3,4 or unstageable pressure ulcer for September is as below. 37 of the incidents occurred in care homes and 22 in patients' own homes. The information will be used to guide the ongoing education and training provided by the React to Red team to care homes.

Pressure Ulcer	**Developed in patients own home/network**	**Developed in residential/care home setting (name if known)**
Category 2	**8 South Network** **6 West Network** **3 East Network**	**7 South Network** 2 Bridgewater Park Care Home 1 Ashby Meadows 2 Balmoral House Residential Home 1 Gresham Lodge Residential Home 1 Blenheim Court Residential Home **5 West Network** 1 Ascot House 3 St Mary's Nursing and Residential Home 1 Randolph House Care Home **2 East Network** 2 Beech House Residential Home **1 Tissue Viability** 1 Carseld Residential Home in East Network **6 Intermediate Care Services** 4 Sir John Mason House 2 The Grange Residential Home
Category 3	**1 South Network** **1 West Network**	**4 South Network** 3 The Valleys Care Home 1 Gresham Lodge Residential Home **1 West Network** 1 St Mary's Nursing and Residential Home **2 East Network** 1 Abbey Village Care Home 1 Eagle House Care
Category 4	**0**	**0**

Unstageable	**2 South Network** **1 East Network**	**2 South Network** 1 Edmund House Residential Home 1 Sycamore Lodge Care Home
Totals	**22**	**30**

Improvement plan

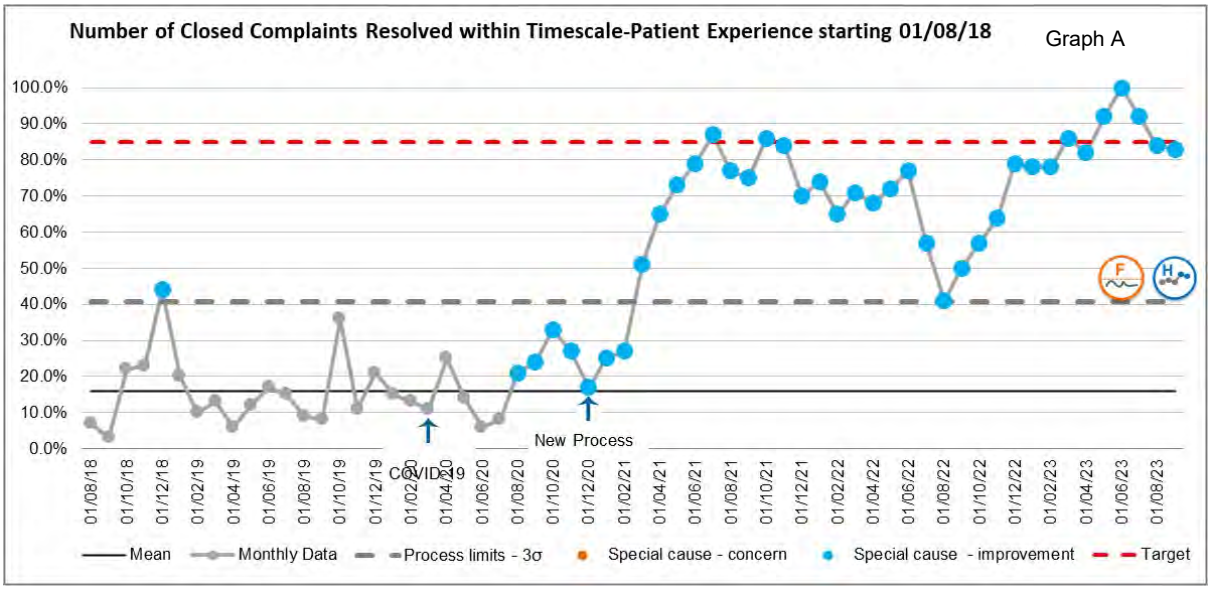
Areas for Improvement	Actions
Education and training	• Education and training with dates scheduled for 2023 • Tissue Viability training to be made mandatory every 2 years- to be approved • Weekly review of all moderate harm pressure ulcers leading to immediate actions being undertaken to reduce risk to patients • Tissue Viability education programme to be included in care home programme of training organised by Head of Nursing from the ICB (Integrated Care Board)
Staffing	• Weekly safe staffing, capacity, and demand review
Equipment	• Updated algorithm for equipment choice • Review procurement of wound care dressings due to ongoing delays with delivery of dressings from Pharmacies.
Risk assessments	• Introduce Purpose T across acute and community

9 Patient Experience

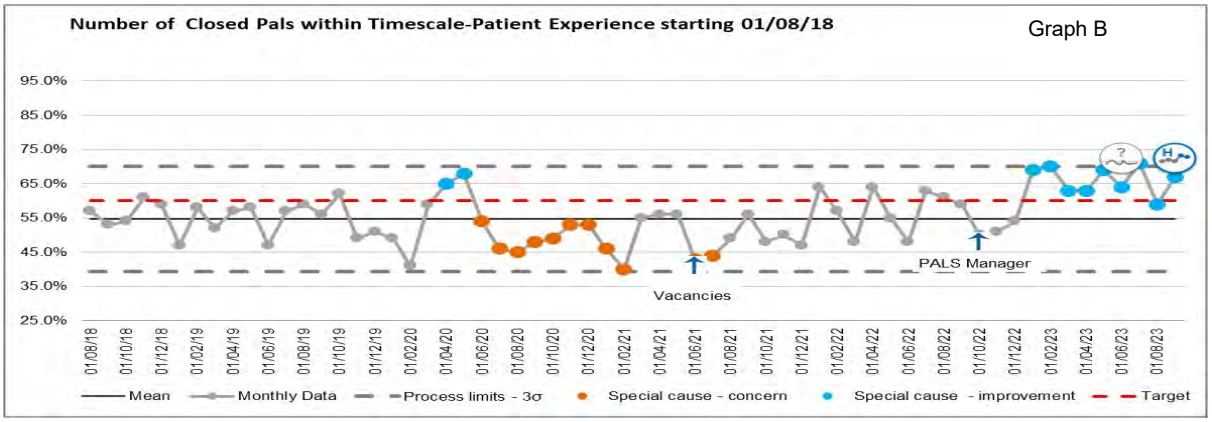
New formal complaint numbers significantly increased for September to 28, representing a 39% increase from the August (17) to September data. This increase will have an impact on, both, the central complaints teams, and divisions as they manage the increased numbers which continue to be complex.

Surgery & Critical Care and Medicine both received the highest number of new complaints with 10 per division; with a further breakdown to 5 for Orthopaedics, 5 for ECC (Emergency Care Centre) with the others divided across speciality services. Weekly meetings have been established to ensure oversight on their position due to increased timescales and some Lead Investigator challenges. Of the five closed complaints out of timescale in September, four of these reside under Family Services and one under Surgery and Critical Care. The Complaints Manager continues to monitor any delays and provides feedback monthly to each Division.

September saw 83% (24) of closed complaints managed in timescale in comparison to 84% (31) for August, with performance maintained (Graph A).



158 new PALS (Patient Advice and Liaison Service) concerns were logged in September. There was an increase in the number of closed concerns, with 109 closed in timescale, as seen in graph B below.



September saw 45 compliments logged through Ulysses, down from August (55). Continued work is required to review the process and engage managers and team members, current logged data remains under reported on positive feedback; engaging

everyone to report this type of feedback is essential at this time to gain a more balanced perspective.

The Volunteering Team has reached out to other Trusts to explore the practicalities of implementing a Youth Volunteer Programme, to provide further support to the links formed with HUTH (Hull University Teaching Hospitals). There has been some interest on the Trust's NLaG Facebook Group from our own staff's children so there does appear to be an appetite for our local youngsters to become involved within our volunteering teams. Hull Council for Volunteer Services has approached the Trust with some concept projects using volunteers sourced and managed by them to support discharge, these offers are being explored and shared with discharge leads. Volunteer recruitment is now live on Trac which should release volunteer administration time considerably and provide access to recruitment statistics, and ultimately widen volunteer opportunities through the digital recruitment process.

A draft of the proposed Visiting Framework, which includes embracing the role of Care Partners, was presented at the Nursing, Midwifery & AHP (Allied Health Professionals) Conference. This presentation was endorsed by Sarah, Carol's daughter, as the core principles within it embrace Carol's Campaign. Sarah shared an emotional address which was positively received, and this will support the next steps in implementing the framework, following Executive approval.

September FFT (Friends and Family Test) data submission saw an increase to 824 from the previous month (704); response rates should improve once the full implementation of the new provider system is in place. Interim paper response cards are available in all areas and the Patient Experience Team are managing these internally via a Microsoft Form platform. Healthcare Communications and the Trust digital team are working towards having Emergency Department text feedback in place during November, rollout for Maternity will then be the next speciality. However there still remains delays in the full implementation due to the ongoing digital priorities. This has a secondary impact as the temporary Patient Experience Manager role, which is leading the project implementation and imbedding of the new process across the organisation, which is only cost pressure funded until December 2023. This poses a significant risk to the success of this development, as highlighted previously.

10 Mixed Sex Breaches

In September the Trust declared one mixed sex breach which involved two patients who were not fit for the ward. One action plan was commenced which contained the actions for all patients affected.

Site	Speciality	Date	Sex	No. that occurred	Reason
Scunthorpe	Intensive Therapy Unit	03.10.23	M	1	Patient flow- unable to support step down- escalated at the time
Scunthorpe	Intensive Therapy Unit	04.10.23	F	0	Patient flow- unable to support step down- escalated at the time
Scunthorpe	Intensive Therapy Unit	04.10.23	F	0	Patient flow- unable to support step down- escalated at the time

11 15 Steps Challenge

Six 15 Steps Challenge visits were completed within the acute and community schedules during September 2023, Two at DPOW (Diana Princess of Wales Hospital, Grimsby) and four at SGH (Scunthorpe General Hospital). Two visits were rescheduled due to doctor strikes, week commencing the 11 September 2023, and one visit was rescheduled due to Infection control concerns on the department.

Supportive visits completed regularly on Disney Ward to gain further assurance on actions within their Improvement plan and to support a maintained rating of good.

Acute 15 Steps Challenge Visits				
Date	**Area**	**Previous Rating**	**Previous Rating**	**Most Recent Rating**
05/09/2023	Jasmine and Honeysuckle, DPOW	20/09/2021	07/09/2022	05/03/2023
05/09/2023	Blueberry and Holly, DPOW	30/06/2021	07/07/2022	05/09/2023
06/09/2023	Emergency Department, SGH	01/02/2022	30/05/2023	06/09/2023
07/09/2023	Disney Ward, SGH	07/101/2021	05/10/2022	07/09/2023
27/09/2023	Ward 27, SGH **Revisit**	08/12/2022	08/03/2023	27/09/2023

Community 15 Steps Challenge Visits			
Date	**Area**	**Rating**	**Most Recent Rating**
05/09/2023	Discharge Coordinators, SGH	15/07/2022	05/09/2023

*Rating guidance

Outstanding	Good	Requires Improvement	Intensive Support	Supportive Visit – New area

12 Infection, Prevention & Control (IPC)

There has been significant increase of cases regionally and nationally of alert organisms. The Trust is performing well and is below national average on all. However, there has in the last few months been an upward trend in MSSA (methicillin-susceptible Staphylococcus aureus) Bacteraemia hospital acquired cases which appear to be associated to peripheral cannula care – further investigation and action plan in progress.

A patient with positive Monkeypox attended the Emergency Department at Grimsby. Contact tracing performed – both patients and staff deemed to meet category 1 based on risk assessment national criteria therefore public health actions not required. Relevant staff given advice and support by Occupational Health. National Education Information provided to ED (Emergency Department) staff on both Grimsby and Scunthorpe sites.

A National Point Prevalence Survey has been undertaken on all inpatient wards at Grimsby and Scunthorpe and data is currently being submitted. The Infection Prevention and Control Conference Bugs R Us 'After the Pandemic – Our New World' was held in October. External speakers included from NHS England, Public Health and HUTH. (Hull University Teaching Hospitals). The key focus was on antimicrobial resistance and Gram-negative bacteria. The day was well attended and has evaluated very well.

Winter Road Show and Ward Boards plans are in process.

The Infection, Prevention & Control Annual Report 2022 – 23 was approved by Quality and Safety Committee.

Infection, Prevention & Control Team – Band 7 WTE (Whole Time Equivalent) post advertised due to x2 Band 7 part time IPCNs retiring/retired. This together with Deputy DIPC (Director of Infection, Prevention & Control) on long term sick leave posing challenging 'On Call Rota'.

Mandatory Alert Organisms
Overview 2023/24 YTD
Healthcare-associated cases

Overview 2023/24 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

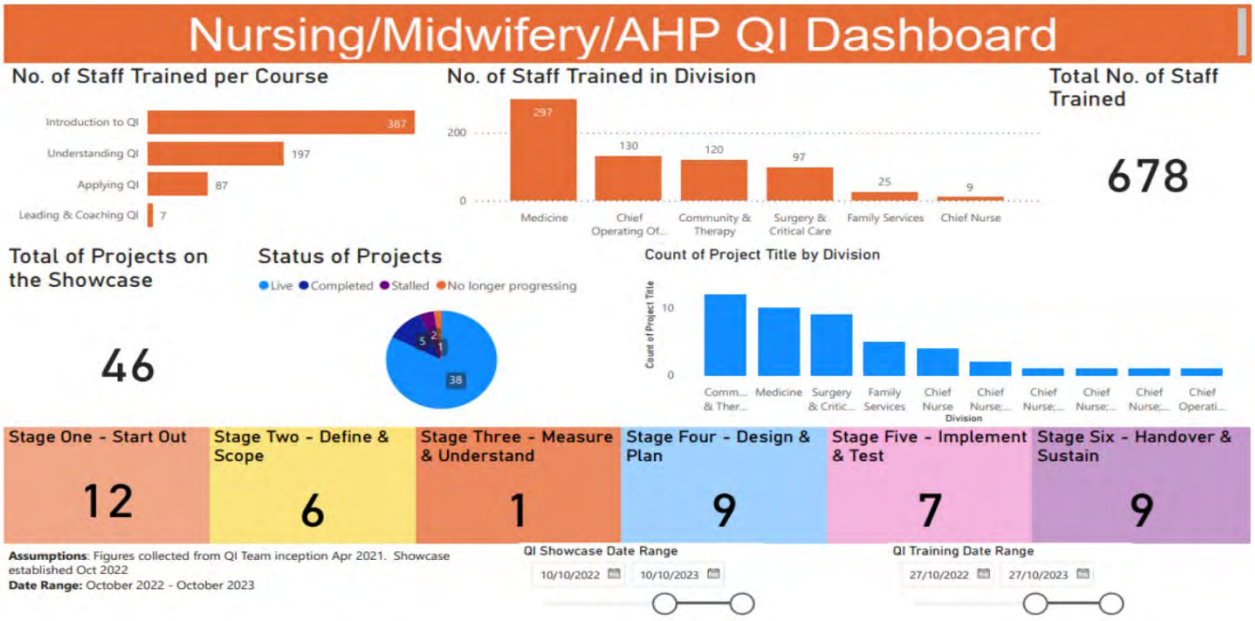
NHS Northern Lincolnshire and Goole NHS Foundation Trust

	PHE Trust-level Targets	Trust	DPOW	SGH	GDH
C. difficile	20	9	5	4	0
MRSA	No Target	1	0	1	0
MSSA	No Target	11	5	6	0
E. coli	46	27	14	8	5
Klebsiella spp.	22	13	6	5	2
P. aeruginosa	7	3	2	1	0

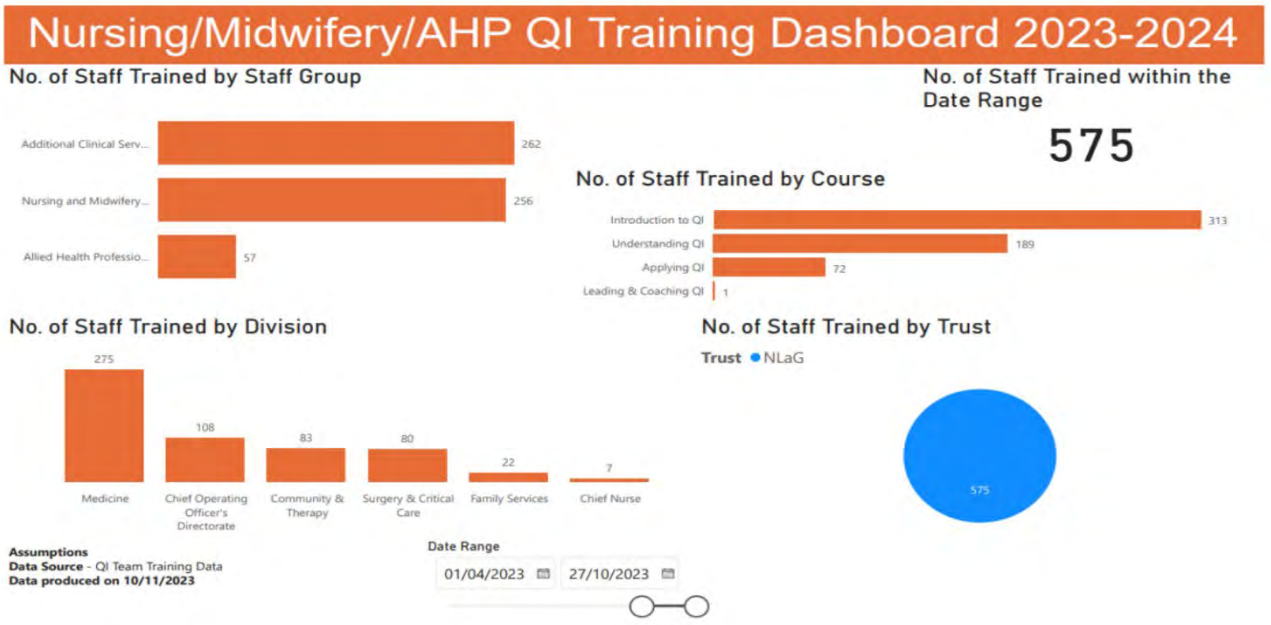
YTD	Year to date
C.difficle	Clostridium difficile
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-sensitive Staphylococcus aureus
E.coli	Escherichia coli

13 Quality Improvement (QI)

As part of the Trust Quality Improvement strategy to build QI capacity and capability across all levels of the organisation the below charts capture the number of Nurses, Midwives and AHP that have accessed QI training to date, split by division and the different levels of QI training completed in accordance with the QI educational dosing model, levels of training. To date 678 of this workforce have been trained at a level of QI, in addition 46 QI projects have been initiated and progressing in the past 12 months.



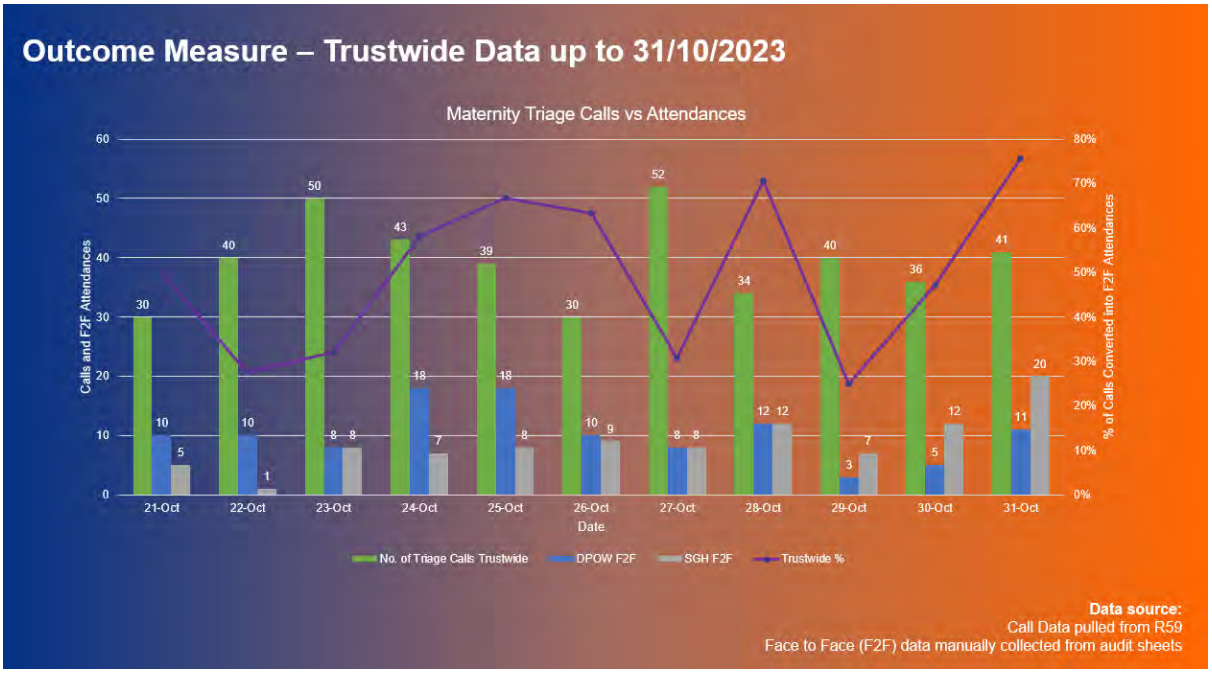
Of the 678 Nursing, Midwifery and AHP (Allied Health Professional) colleagues trained since Nov 2021, 575 of these have been trained since April 2023. The key contributor to this is through trust induction as well as focused delivery of “understanding QI” in ward and Emergency Department to support staff in understanding their role within QI within their daily work.



Work continues within our Maternity Services with the launch of the Maternity Triage services.

Aim statements:

To implement a fully operational maternity triage service across the whole of the Maternity Service, that utilises a Nationally recognised Triage model by October 2023.



14 Conclusion

Care hours per patient day (CHPPD) was 8.6 in September. Two wards, C2 and Amethyst, had CHPPD below 6. The overall fill rate has been below 95% for the past three months. No patient safety concerns have been raised during this time period for wards with fill rates below 85% (Neonatal Intensive Care Unit Grimsby, Laurel, Ward 26, Blueberry/Holly, Disney and Intensive Therapy Unit Grimsby). All these areas have high vacancy rates and sickness rates in September, however have robust processes in place to manage capacity and demand with senior oversight and timely internal escalation where required.

There is a total of 209.91 WTE (Whole Time Equivalent) (10.84%) Registered Nurse/Registered Midwife vacancies and 108.95 WTE (10.68%) unregistered vacancies across the Trust in September. The increase in registered and unregistered vacancies can be attributed to an increase in establishments following the bed modelling undertaken. Focus remains on recruitment of newly qualified nurses and midwives, external domestic registered nurses, and internationally educated nurses and midwives, all of which have healthy pipelines. With the current pipeline there is a forecast vacancy of 34.26 WTE Band 5 RN vacancies by March 2024. Healthcare Assistant recruitment continues through the pool and through divisional specific recruitment campaigns. With those with start dates or having been allocated to clinical areas and undergoing recruitment checks, it is anticipated that by December there will be approximately 40 WTE HCA (Health Care Assistant) vacancies to fill (assuming an operational zero of 13.85 WTE).

Collaborative work continues with local higher and further education establishments to deliver T-level placements with 80% of students support on generalist placements last year now working in the Trust and all four of the students hosted on the **G**ynaecology Paediat**R**ics M**A**ternity **C**ommunity Breast Car**E** (GRACE) work experience programme last year going on to university to study in Midwifery/Healthcare.

The overall vacancy rate for nursing in Community and Therapies has decreased, however work continued to recruit to all vacancies as well as retain new and existing staff. Retention work remains a priority. The successful HCA buddy scheme continues, with 54 buddies now trained across the Trust. The Trust continues to train the Professional Nurse Advocates with the support and restorative clinical supervision they provide evaluating well. Rollout of the flexible working team rostering pilot will remain a priority over the coming months.

Red flags continue to be reported with a reduction this month in the community setting. Thirty eight red flags incidents were reported on inpatient areas. Fourteen red flags were due to less than 50% substantive staff on a shift, this is closely monitored at Matron level, staff are moved across Directorates when required to increase substantive staff to mitigate the risk. There has been no impact on patient safety reported.

Within community, activity continues to be higher in month than was seen in 2022-2023 and there has been a further increase in September. 91.4% of visits were completed with 8.6% deferred which is a slight deterioration from previous months, however this is because of the significant increase in visits. Further work has been undertaken to understand the kind of activity relating to the increased visits and approximately 80% of visits related to wound care. Further work is being undertaken to break that down further.

There was one in-patient fall reported with major harm at Grimsby on Amethyst Ward. The falls huddle was completed within one working day and there were no lapses in care identified.

Two Pressure Ulcer incidents on Ward 17 at Scunthorpe and the Emergency Department at Grimsby have been reported as serious incidents due to lapses in care. No new root causes were identified during the weekly review process and local actions are in place to share the learning.

All moderate harm incidents reported for Community were reviewed at the Community and Therapy Weekly Pressure Ulcer Scrutiny Meeting and no lapses in care were identified.

Surgery & Critical Care and Medicine both received the highest number of new complaints. Weekly meetings have been established to ensure oversight on their position. Five closed complaints were out of timescale with four residing under Family Services and one Surgery and Critical Care. The Complaints Manager continues to monitor any delays and provides feedback monthly to each Division.

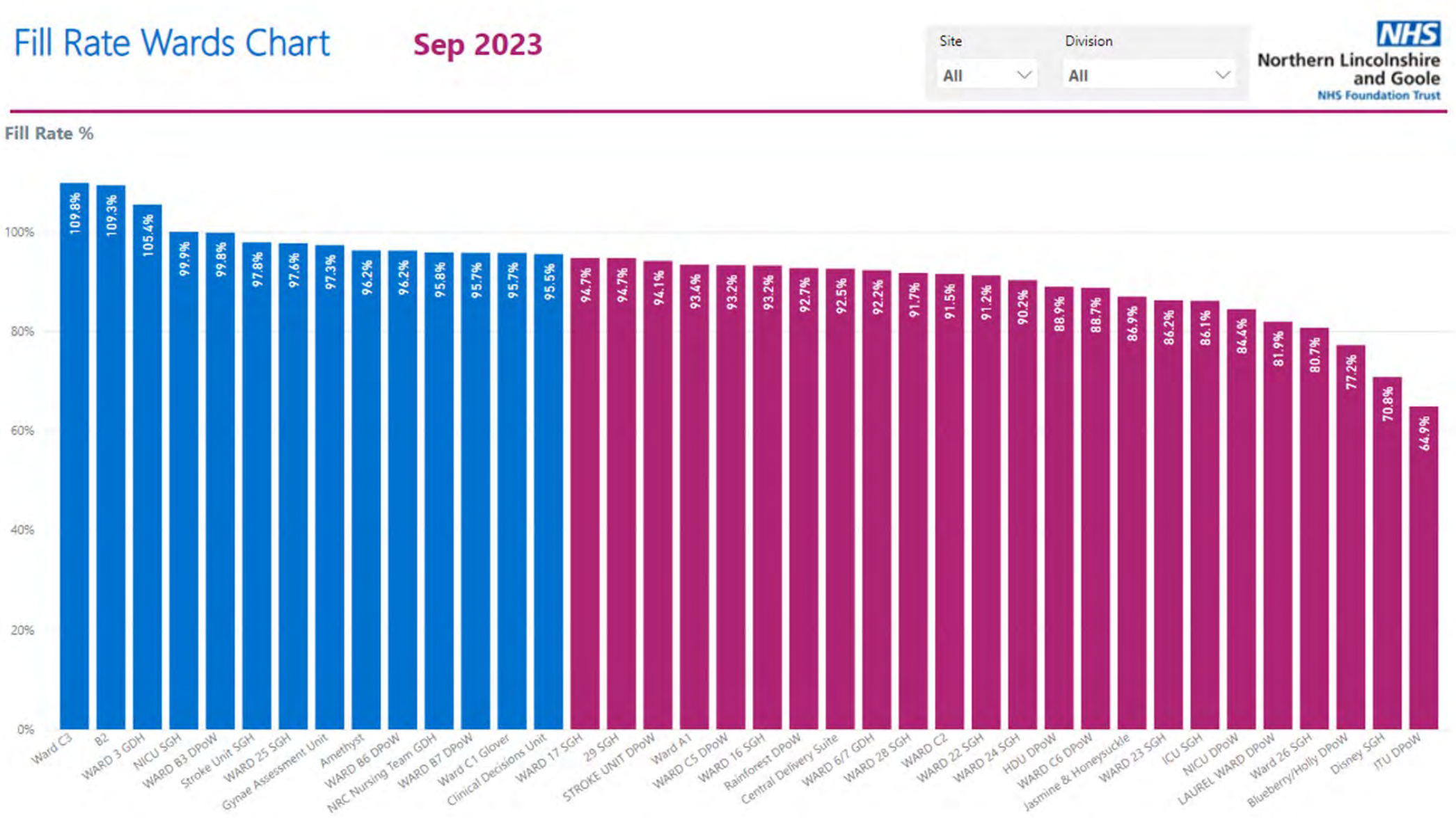
September saw 83% (24) of closed complaints managed in timescale in comparison to 84% (31) for August, with performance maintained. The Learning Log pilot phase is now completed, the Compliance Manager and Medicine Patient Experience Facilitator have met to review how the report works operationally. There is further work required by the pilot Division to establish clear oversight on action progression to ensure learning and closure. Therefore, a plan has been agreed to collaborate further and feedback progress in November, additional central team support has been offered.

A total of 158 new PALS (Patient Advice and Liaison Service) concerns were logged in September. There was an increase in the number of closed concerns, with 109 closed in timescale. With the temporary Patient Experience Manager's having returned from their period of leave it is thought this has directly impacted on our improved position, due to their daily oversight and involvement of PALS management. This post remains on the Chief Nurse directorate risk register as there is no current permanent funding stream secured.

Whilst there has been significant increase of cases regionally and nationally of alert organisms the Trust is performing well and is below national average on all. The Winter IPC (Infection, Prevention & Control) Plan has been formulated and linked into Trust Winter Planning Group. Currently Influenza and COVID-19 inpatients low. Childrens Services experiencing high acuity with RSV cases high which is the norm for the time of year.

The IPC Link Champions Network has been reviewed with a plan for quarterly education sessions. The first session is planned for the end of November on all 3 sites and at Global House for Community staff. An IPC workbook is in progress.

Appendix 1 – Fill Rate Wards Chart



Appendix 2 – DPOW (Diana, Princess of Wales Hospital, Grimsby) Ward Assurance Dashboard

DPOW Ward Assurance Dashboard

Sep 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
DPOW - A1	99.8	14.0	93.4	9.8	0.0	3.0	6.4	100.0	3.0	5.6	7.0	13.0	0.0	1.0	91.1	100.0	84.3
DPOW - Amethyst	99.9	26.0	96.2	5.9	0.0	2.0	4.1	83.3	7.0	10.2	0.0	0.0	0.0		100.0	100.0	85.6
DPOW - B2 Assessment Unit	81.3	416.0	109.3	9.1	0.0	1.0	12.5		8.0	10.3	0.0	0.0	0.0		86.1	100.0	86.3
DPOW - B3	94.4	78.0	99.8	7.5	0.0	0.0	3.2	60.0	4.0	5.2	4.0	5.2	0.0		92.9	100.0	89.1
DPOW - B4		0.0			0.0	0.0			0.0		0.0		0.0				
DPOW - B6	97.4	35.0	96.2	7.5	0.0	1.0	2.9		1.0	1.6	4.0	6.2	0.0		94.9	100.0	94.6
DPOW - B7	77.6	13.0	95.7	8.1	0.0	1.0	4.6		2.0	3.9	3.0	5.9	0.0	1.0	94.4	97.9	98.4
DPOW - C1 Glover	99.4	29.0	95.7	6.3	0.0	1.0	3.1	81.8	2.0	2.6	4.0	5.2	0.0	1.0	90.9	100.0	85.8
DPOW - C2	95.8	40.0	91.5	5.9	0.0	1.0	4.5	100.0	7.0	9.0	6.0	7.7	0.0	1.0	97.1		74.4
DPOW - C3 Short Stay	88.1	89.0	109.8	6.9	0.0	3.0	10.9	75.0	3.0	3.2	4.0	4.3	0.0	1.0	81.4		83.2
DPOW - C5	111.5	35.0	93.2	6.6	0.0	2.0	5.2		3.0	4.1	1.0	1.4	0.0		92.3	100.0	86.2
DPOW - C6	100.3	10.0	88.7	6.7	0.0	0.0	0.8		0.0	0.0	0.0	0.0	0.0		76.6	100.0	84.4
DPOW - HDU	88.6	35.0	88.9	18.3	0.0	0.0	1.0		1.0	5.4	2.0	10.8	0.0		93.1		
DPOW - HOBS DPW															100.0		
DPOW - ITU	90.6	25.0	64.9	26.4	0.0	0.0	6.7		0.0	0.0	3.0	18.4	0.0	3.0	89.7		
DPOW - Laurel	108.9	30.0	81.9	11.7	0.0	2.0	3.3		1.0	5.1	0.0	0.0	0.0		100.0	100.0	95.4
DPOW - Maternity		89.0	81.7	11.0	4.0	0.0	-14.8		0.0	0.0	0.0	0.0	0.0	1.0	100.0		
DPOW - NICU DPW	69.4	36.0	84.4	11.8	2.0	0.0	6.5		0.0	0.0	0.0	0.0	0.0	2.0	100.0	100.0	
DPOW - Rainforest	52.5	164.0	92.7	11.8	1.0	2.0	3.0		0.0	0.0	0.0	0.0	0.0		71.8	100.0	
DPOW - Stroke DPW	98.9	29.0	94.1	6.1	0.0	1.0	2.0	85.7	1.0	1.4	1.0	1.4	0.0	3.0	98.3		92.2

Appendix 2 – SGH (Scunthorpe General Hospital) Ward Assurance Dashboard

SGH Ward Assurance Dashboard

Sep 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
SGH - CDS	41.1	73.0	92.5	31.7	2.0	1.0	1.5		0.0	0.0	0.0	0.0	0.0				
SGH - CDU															100.0		
SGH - Disney	57.8	111.0	70.8	12.5	0.0	0.0	0.9	57.1	0.0	0.0	0.0	0.0	0.0		100.0		
SGH - Gynae Assessment	39.1	21.0	97.3	21.7	0.0	0.0	0.6		0.0	0.0	0.0	0.0	0.0		100.0	100.0	98.9
SGH - ICU	76.7	13.0	86.1	27.5	0.0	1.0	2.3		0.0	0.0	2.0	10.9	0.0		97.2		
SGH - NICU SGH	89.3	37.0	99.9	12.9	3.0	0.0	-0.7		0.0	0.0	0.0	0.0	0.0		100.0		
SGH - Stroke SGH	160.3	41.0	97.8	10.1	0.0	0.0	6.9		3.0	6.2	1.0	2.1	0.0		100.0	100.0	94.9
SGH - Ward 16	93.2	19.0	93.2	7.4	0.0	0.0	5.3		1.0	1.6	1.0	1.6	0.0		100.0	100.0	91.4
SGH - Ward 17	555.8	44.0	94.7	8.2	0.0	1.0	9.2		2.0	3.0	7.0	10.5	0.0		100.0	100.0	88.4
SGH - Ward 18	1.3	4.0		0.0	0.0	0.0			1.0	500.0	0.0	0.0	0.0			100.0	97.3
SGH - Ward 19					0.0	0.0	-2.0		0.0		0.0		0.0				
SGH - Ward 22	98.3	28.0	91.2	6.3	0.0	1.0	7.7		3.0	3.8	5.0	6.3	0.0	2.0	100.0	100.0	87.6
SGH - Ward 23 Short Stay	117.0	32.0	86.2	7.2	0.0	3.0	7.8		1.0	1.3	1.0	1.3	0.0	1.0	100.0	96.4	93.7
SGH - Ward 24 Assessment Unit	91.8	369.0	90.2	8.1	0.0	0.0	17.8		2.0	2.5	0.0	0.0	0.0	1.0	92.2	100.0	93.7
SGH - Ward 25	99.8	9.0	97.6	6.9	1.0	3.0	2.9		5.0	11.9	2.0	4.8	0.0		100.0	100.0	94.0
SGH - Ward 26	48.3	135.0	80.7	7.3	9.0	1.0	4.9		0.0	0.0	0.0	0.0	0.0		100.0		
SGH - Ward 27		45.0			1.0	3.0		64.6	5.0	7.4	6.0	8.8	0.0		100.0	94.1	90.6
SGH - Ward 28	70.1	59.0	91.7	9.2	0.0	0.0	1.9		1.0	1.7	4.0	6.8	0.0		75.0	90.5	98.0
SGH - Ward 29	98.1	85.0	94.7	6.7	0.0	0.0	7.3	50.0	2.0	2.7	4.0	5.4	0.0		94.8	100.0	95.9
SGH - Ward 5	99.4	26.0	95.5	7.4	0.0	0.0	3.3		4.0	6.1	3.0	4.6	0.0			100.0	97.8

Appendix 2 – GSH (Goole District Hospital) Ward Assurance Dashboard

GDH Ward Assurance Dashboard

Sep 2023

Division: All | Ward: All

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator Category	Occupancy		Staffing						Safety & Quality						Infection Control	Friends & Family	NEWS
Site - Ward	Occupied Bed Days %	Ward Transfers 22:00 to 06:00	Fill Rate %	CHPPD - Total	Staffing Incidents	Red Flags	Vacancies - Total	1:1 Supportive Care Shifts Filled %	Falls - Total	Falls per 1000 Bed Days	Hospital Acquired PU - Total	Hospital Acquired PU per 1000 Bed Days	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
GDH - GNRC	91.4	2.0	95.8	8.9	1.0	3.0	4.3		1.0	2.6	2.0	5.2	0.0		88.9		91.0
GDH - Ward 3	90.2	5.0	105.4	7.2	0.0	0.0	2.2	31.0	1.0	2.5	0.0	0.0	0.0	1.0	100.0	100.0	91.2
GDH - Ward 6	46.7	6.0	92.2	13.2	0.0	1.0	0.8		0.0	0.0	1.0	4.8	0.0	1.0	100.0	100.0	96.8

Appendix 3

Non-Inpatient Ward Assurance Dashboard

Showing Data: Sep 2023 Available Data: Apr 2019 to Sep 2023

NHS Northern Lincolnshire and Goole NHS Foundation Trust

A summary of some key staffing and quality indicators for the non-inpatient wards in the latest month.

	Indicator Category	Occupancy	Staffing					Safety & Quality					Infection Control	Friends & Family	NEWS
Site	Ward	Ward Transfers 22:00 to 06:00	Staffing Incidents	Red Flags	Vacancies - Qualified	Vacancies - Unqualified	Vacancies - Total	Falls - Total	Serious Incidents	Hospital Acquired PU - Total	Complaints	Administration Errors - Total	Hand Hygiene %	Recommendation rate %	Observations completed in time %
DPOW	Amethyst Day Case Unit		0.0	0.0	0.3	1.0 ↘	1.4 ↘	0.0	0.0	0.0	0.0		100.0		
	CDCU		0.0	0.0	1.0 ↗	0.5	1.4 ↗	0.0	0.0	0.0	0.0		100.0	100.0	
	Discharge Lounge DPW	0.0 ↘	0.0	0.0				0.0 ↘	0.0	0.0	0.0	1.0			150.0 ↘
	DIU		0.0	0.0	0.5	0.7	1.3	0.0 ↘	0.0	0.0	0.0		100.0	85.7	
	DSU DPW		0.0	0.0	-0.9 ↘	1.2	0.2 ↘	0.0	0.0	0.0	0.0		100.0		
	ECC DPW		9.0 ↗	4.0 ↗	8.9 ↘	7.7 ↗	16.6 ↗	2.0 ↘	0.0	2.0 ↗	0.0	3.0	72.5	50.0 ↘	99.4 ↗
	SDEC DPW	103.0 ↗	0.0	0.0	4.1	0.1	4.1	1.0 ↗	0.0	0.0	0.0		100.0 ↗	100.0	97.0 ↘
	UCS DPW		0.0	0.0				0.0	0.0	0.0	0.0				
SGH	Discharge Lounge SGH	1.0	0.0	0.0	2.3	-0.1	2.2	0.0	0.0	0.0	0.0	1.0 ↘			0.0 ↘
	DSU SGH		0.0	0.0	-0.8 ↘	2.2 ↗	1.4 ↘	0.0	0.0	0.0	0.0		100.0	200.0 ↗	
	ECC SGH		0.0 ↘	0.0	23.1 ↘	7.5 ↗	30.7 ↘	1.0 ↘	0.0	4.0 ↗	0.0	5.0 ↗	83.8 ↘	100.0 ↗	99.5 ↘
	PIU		0.0	0.0	1.2	0.3	1.5	0.0	0.0	0.0	0.0		100.0		99.7 ↘
	SDEC SGH	6.0 ↘	0.0	0.0	0.6 ↘	0.0	0.6 ↘	0.0	0.0	0.0	0.0		100.0		
	UCS SGH		0.0	0.0				0.0	0.0	0.0	0.0				
	Stroke Assessment Area														

Appendix 4 ECC (Emergency Care Centre) Assurance Dashboards

DPOW ECC Assurance Dashboard

Showing Data: Sep 2022 to Sep 2023 Available Data: Apr 2019 to Sep 2023

A summary of some key staffing and quality indicators for ECC.

Indicator Category	Indicator	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023
Staffing	Fill Rate %	123.9	151.3	94.1	100.9	148.7	106.2	103.2	106.9	106.3	104.6	103.3	101.4	101.4
	Staffing Incidents	0.0	0.0	2.0	2.0	1.0	0.0	1.0	1.0	0.0	1.0	1.0	1.0	9.0
	Red Flags	0.0	0.0	0.0	2.0	0.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	4.0
	Vacancies - Qualified	8.5	15.1	12.9	24.9	17.8	15.2	13.2	14.6	13.2	11.1	12.1	11.3	8.9
	Vacancies - Unqualified	-0.6	9.1	9.1	7.1	9.9	9.3	6.9	4.3	3.9	1.9	2.5	3.0	7.7
	Vacancies - Total	7.9	24.2	22.1	32.0	27.7	24.5	20.1	18.9	17.0	13.0	14.6	14.2	16.6
	ED Paediatric Emergency Fill Rate %													
Safety & Quality	Falls - Total	3.0	4.0	4.0	5.0	5.0	3.0	3.0	5.0	1.0	5.0	5.0	7.0	2.0
	Serious Incidents	0.0	0.0	0.0	0.0	2.0	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0
	Hospital Acquired PU - Total	0.0	2.0	0.0	2.0	5.0	0.0	0.0	1.0	3.0	0.0	1.0	0.0	2.0
	Complaints	0.0	4.0	3.0	3.0	3.0	3.0	2.0	2.0	3.0	1.0	2.0	0.0	0.0
	Administration Errors - Total	5.0	1.0	1.0	6.0	9.0	2.0	4.0	2.0	5.0	2.0	2.0	3.0	3.0
	ED 12hr Trolley Waits	351.0	361.0	346.0	559.0	457.0	451.0	439.0	210.0	360.0	387.0	290.0	228.0	401.0
	ED Mental Health Incidents	2.0	3.0	4.0	4.0	8.0	6.0	3.0	6.0	7.0	2.0	6.0	1.0	5.0
	ED Paediatric Incidents	10.0	10.0	13.0	12.0	10.0	9.0	13.0	15.0	13.0	8.0	7.0	11.0	14.0
	ED Red Flags	4.0	2.0	2.0	7.0	6.0	3.0	7.0	3.0	1.0	3.0	3.0	6.0	7.0
Infection Control	Hand Hygiene %	100.0			52.9	77.7	74.7	70.6	72.4	70.9		68.0		72.5
Friends & Family	Recommendation rate %	68.1	74.5	76.0	66.9	78.4	76.6	60.8	71.1	82.7	82.3	100.0	75.0	50.0
NEWS	Observations completed in time %	98.0	98.9	97.8	98.9	98.9	99.0	98.5	98.7	98.9	98.4	99.4	98.7	99.4

SGH ECC Assurance Dashboard

Showing Data: Sep 2022 to Sep 2023 Available Data: Apr 2019 to Sep 2023

A summary of some key staffing and quality indicators for ECC.

Indicator Category	Indicator	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023
Staffing	Fill Rate %	109.6	108.6	73.0	53.3	81.8	82.0	90.9	97.0	100.2	98.0	99.3	98.4	99.3
	Staffing Incidents	0.0	1.0	0.0	0.0	1.0	0.0	0.0	0.0	0.0	1.0	0.0	1.0	0.0
	Red Flags	0.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Vacancies - Qualified	16.1	16.5	12.8	13.0	8.8	7.7	7.8	28.0	28.3	27.3	27.5	28.5	23.1
	Vacancies - Unqualified	6.9	2.4	2.6	3.6	1.6	-2.4	-6.5	13.6	13.6	10.5	8.9	7.2	7.5
	Vacancies - Total	23.0	18.9	15.3	16.6	10.4	5.4	1.3	41.5	41.9	37.8	36.4	35.7	30.7
	ED Paediatric Emergency Fill Rate %													
Safety & Quality	Falls - Total	4.0	6.0	3.0	2.0	7.0	4.0	1.0	4.0	7.0	2.0	1.0	3.0	1.0
	Serious Incidents	0.0	0.0	0.0	1.0	1.0	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0
	Hospital Acquired PU - Total	1.0	0.0	1.0	1.0	0.0	0.0	0.0	3.0	0.0	1.0	0.0	2.0	4.0
	Complaints	1.0	1.0	2.0	2.0	1.0	4.0	2.0	3.0	3.0	4.0	1.0	0.0	0.0
	Administration Errors - Total	5.0	0.0	0.0	0.0	2.0	2.0	2.0	1.0	2.0	1.0	0.0	1.0	5.0
	ED 12hr Trolley Waits	357.0	257.0	190.0	401.0	345.0	329.0	415.0	244.0	313.0	241.0	252.0	288.0	224.0
	ED Mental Health Incidents	0.0	2.0	5.0	4.0	6.0	6.0	2.0	8.0	13.0	1.0	5.0	8.0	2.0
	ED Paediatric Incidents	4.0	7.0	9.0	12.0	5.0	5.0	7.0	13.0	8.0	16.0	5.0	9.0	14.0
	ED Red Flags	9.0	1.0	1.0	8.0	2.0	1.0	3.0	3.0	2.0	6.0	3.0	4.0	2.0
Infection Control	Hand Hygiene %	100.0	100.0	93.8	100.0	78.3	80.4	87.5	77.5	77.3	82.6	94.4	84.6	83.8
Friends & Family	Recommendation rate %	68.4	71.1	72.0	60.5	74.5	75.0	63.2	77.6	71.6	80.1	63.6	80.0	100.0
NEWS	Observations completed in time %	99.5	99.7	99.5	99.7	99.2	99.4	99.7	99.7	99.6	99.4	99.5	99.8	99.5

Appendix 5

Trustwide Maternity Dashboard

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Indicator	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Apr 2023	May 2023	Jun 2023	Jul 2023	Aug 2023	Sep 2023
Midwife to Birth Ratio	24.8	22.9	24.2	23.7	23.4	22.2	22.4	22.3	23.0	23.1	23.3	22.8
Red Flags	17.0	11.0	20.0	3.0	1.0	4.0	6.0	15.0	25.0	2.0	7.0	14.0
(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)	0.0	0.0	0.0	0.0	0.0	0.0	0.0	2.0	2.0	0.0	0.0	3.0
(b) Missed or delayed care (e.g. delay of 60 minutes or more in washing and suturing)	1.0	0.0	3.0	1.0	0.0	3.0	2.0	3.0	0.0	0.0	3.0	3.0
(c) Missed medication during an admission to hospital	0.0	3.0	0.0	0.0	0.0	0.0	2.0	0.0	2.0	0.0	0.0	0.0
(d) Delay of more than 30 minutes in providing pain relief	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(e) Delay of 30 minutes or more between presentation onto the ward and being seen	0.0	0.0	1.0	0.0	0.0	0.0	1.0	1.0	0.0	0.0	1.0	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	5.0	3.0	9.0	1.0	1.0	1.0	1.0	3.0	5.0	0.0	1.0	1.0
(h) Delayed recognition of and action on abnormal vital signs (e.g. sepsis or urine output)	0.0	1.0	1.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.0
(i) Any occasion when 1 midwife is not able to provide continuous one-to-one care and support a woman during established labour.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
(j) Community staff have been called in to work on the unit.	11.0	4.0	6.0	1.0	0.0	0.0	0.0	6.0	16.0	2.0	2.0	5.0
Continuity of Carer %	14.0											
In Receipt of %	8.0											
CoC In Receipt of %	66.0											
Continuity Team Caseload	311.0											
Divert / Unit Closures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Actual v Planned Staffing %	89.0	96.2	91.0	93.1	92.3	97.2	97.8	98.2	94.8	94.2	92.8	94.5
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	100.0
1:1 Care in Labour %	100.0	100.0	100.0	100.0	99.5	100.0	100.0	100.0	100.0	100.0	100.0	99.5
Vacancies	41.6	41.1	40.4	42.2	41.7	34.4	16.0	10.5	14.5	14.9	15.5	15.4
Vacancies - Registered	39.8	34.4	34.4	36.0	37.3	30.5	17.6	13.9	18.0	17.6	19.1	15.9
Vacancies - Unregistered	1.8	6.7	6.0	6.1	4.4	3.9	-1.6	-3.4	-3.5	-2.7	-3.6	-0.4
Serious Incidents	0.0	0.0	2.0	0.0	0.0	0.0	1.0	1.0	1.0	1.0	0.0	0.0
Complaints	3.0	2.0	0.0	1.0	2.0	1.0	1.0	1.0	2.0	3.0	0.0	0.0
PALS	6.0	4.0	3.0	3.0	3.0	3.0	1.0	6.0	6.0	6.0	0.0	0.0
Sickness Absence (Division) %	6.5	5.0	6.7	5.6	5.5	5.9	6.0	5.7	5.2	5.5	5.7	

Appendix 6

Community Nursing Assurance Dashboard

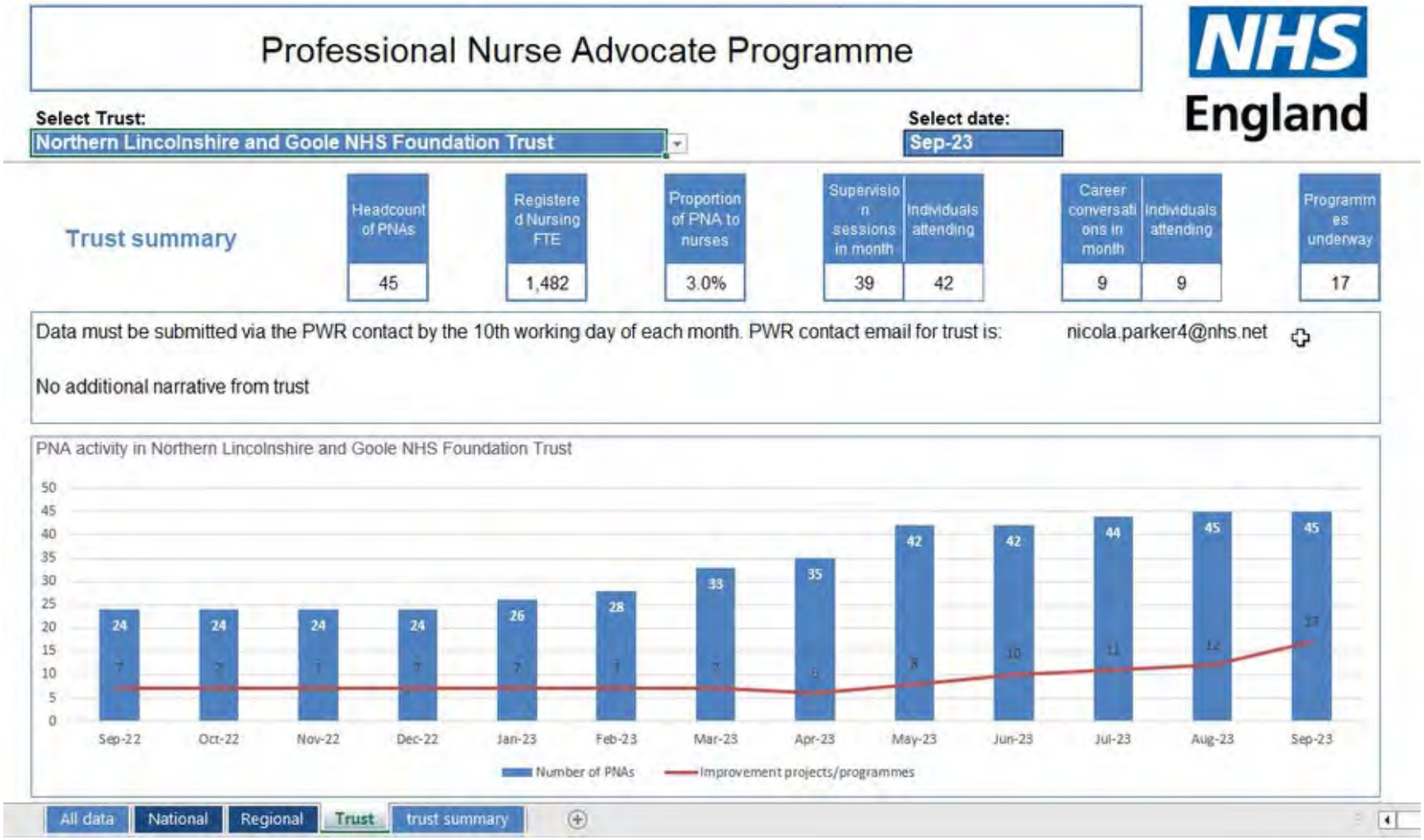
Sep 2023

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					0.0	13.0 ↘					0.5 ↘			
East Network					0.0	8.0 ↘					2.8 ↘			
South Network					0.0	24.0 ↗					1.8 ↘			
West, East & South Networks												97.8		
Unscheduled Care Team (UCT) (incl rapid response)					0.0	0.0					0.2			
Macmillan Health Care Team					0.0	0.0					1.8 ↘			
Specialist Palliative Care Nurses (SPC)					0.0	0.0					0.5 ↗			
Palliative Care					0.0	0.0					1.2 ↗			
Single Point of Access (SPA)					0.0	0.0					0.4 ↘			
Continence Team					0.0	0.0					0.0 ↘			
Tissue Viability Team					0.0	1.0 ↘					1.0			
Long Term Conditions / Complex Care Matrons (Comm Matrons)					0.0	0.0					-0.3			
Intermediate Care Services (ICS) + Core Therapy					1.0 ↗	6.0 ↘					1.1			
Discharge Liaison Team					0.0	0.0					-1.0			
Locality Co-ordinators					0.0	0.0					-0.2			
Evening / Night Service					0.0	0.0					0.9 ↗			
Chronic Wound Team					0.0	0.0					-0.1			
DN Students					0.0	0.0					0.0			
Community Nursing													83.3 ↘	48.7 ↗

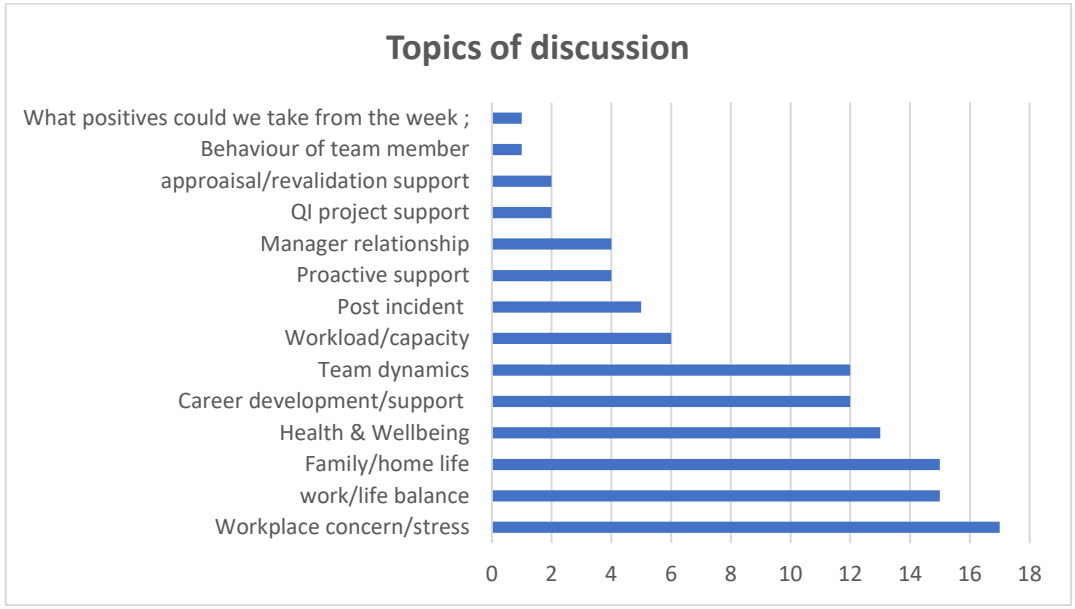
Activity data not currently available for the dashboard

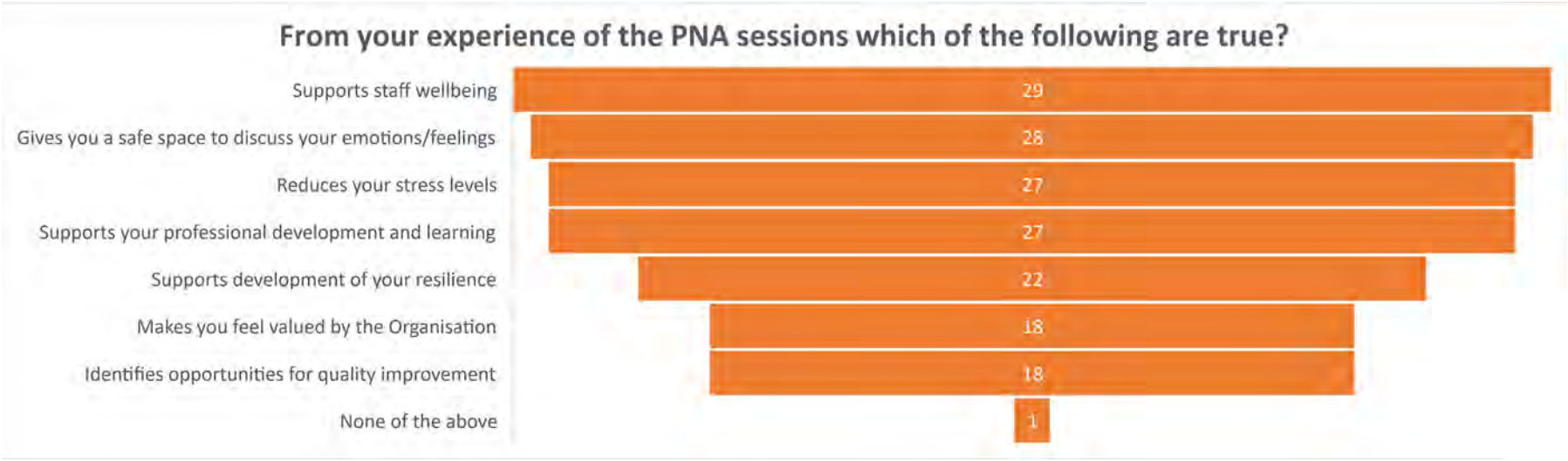
Appendix 7 Professional Nurse Advocate Programme



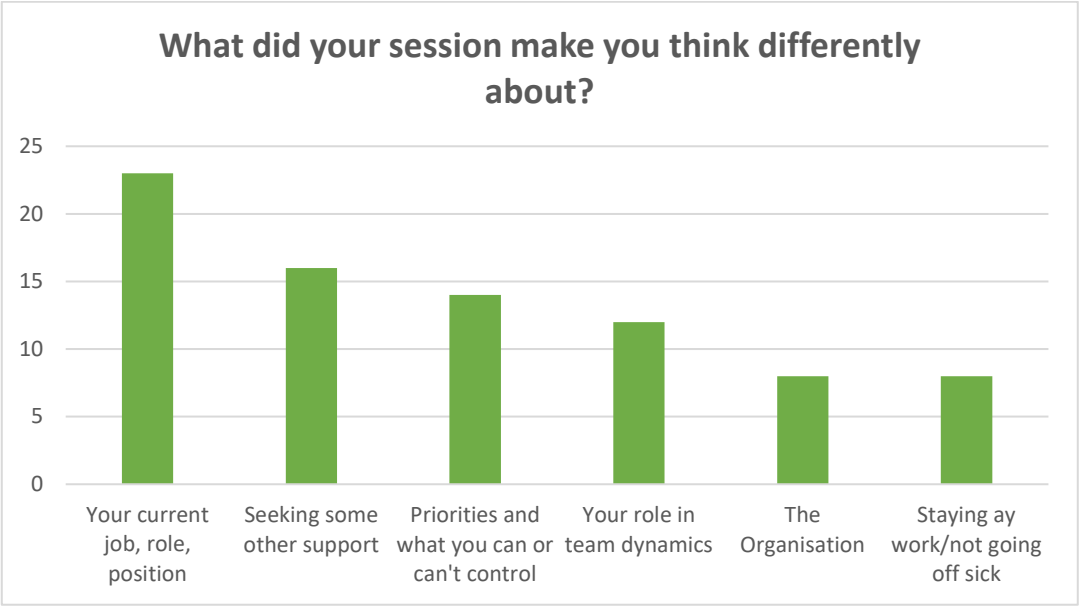
Restorative Clinical Supervision (RCS) - Supervisee Evaluation data

In Q2, 38 responses were received from supervisees who received RCS.





29/38 staff member felt that the RCS session supported their wellbeing which equates to 76%. 47% (18/38) of staff indicated that the PNA session ‘makes you feel valued by the organisation’.


What did your session make you think differently about?
25
20
15
10
5
0
Your current job, role, position
Seeking some other support
Priorities and what you can or can't control
Your role in team dynamics
The Organisation
Staying ay work/not going off sick

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Dr Kate Wood – Chief Medical Officer	
Contact Officers/Authors	Faculty of Medical Leadership & Management (FMLM) Dr Paul Evans – Medical Director Angus Waite – Head of Professional Services & Innovation	
Title of the Report	**Faculty of Medical Leadership & Management - Affiliated Organisation Report**	
Purpose of the Report and Executive Summary (to include recommendations)	The Faculty of Medical Leadership and Management (FMLM) undertook a site visit to North Lincolnshire and Goole NHS Trust (NLAG) on 27 – 28 September 2023. The visit comprised a series of meetings with both medical and non-medical leaders and managers within the trust, and tours of key departments across both the Grimsby and Scunthorpe sites.	
Background Information and/or Supporting Document(s) (if applicable)	Previous visit reports, already circulated	
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)	Not applicable	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Not applicable	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Faculty of
Medical Leadership
and Management

FMLM Affiliated Organisation Report

Northern Lincolnshire and Goole NHS Foundation Trust

Descriptions of a visit conducted on 27 – 28 September 2023

Dr Paul Evans CB OStJ SFFMLM
Mr Angus Waite BA FRSPH

Executive summary

The Faculty of Medical Leadership and Management (FMLM) Medical Director (Dr Paul Evans) and FMLM Head of Professional Services & Innovation (Mr Angus Waite) undertook a site visit to North Lincolnshire and Goole NHS Trust (NLAG) on 27 – 28 September 2023.

The visit comprised a series of meetings with both medical and non-medical leaders and managers within the trust, and tours of key departments across both the Grimsby and Scunthorpe sites. Both had the opportunity to meet the new group Chief Executive Officer (CEO), Mr Jonathan Lofthouse, the Chief Medical Officer, Kate Wood, and other stakeholders both from within the trust and outside. Many were at various career stages and included non-medical managers, nurses and administrators.

The positive atmosphere across both sites was notable and stood in stark contrast to the atmosphere experienced two years ago at the beginning of NLAG's focus with FMLM on medical and clinical leadership. This was FMLM's fourth visit to both sites, and there has been a notable and gradual improvement over this period due to the efforts of the medical directorate and other key leaders. Of particular note is the clear team cohesion we observed across many areas of the trust, including during 'impromptu' visits to certain departments. This is clearly contributing to the effectiveness of the trust executive in delivering improvement in key departments and will be invaluable as the trust embarks on a significant change programme.

There is an undoubted positive culture amongst staff. The partnership with FMLM has helped foster the role of strong clinical leadership in supporting change with a keenness at all career stages to embrace FMLM standards to optimise both team and organisational development.

FMLM visiting team

Dr Paul Evans, FMLM Medical Director

Mr Angus Waite, FMLM Head of Professional Services and Innovation

Background

FMLM Affiliation is a relationship between healthcare delivery organisations and FMLM that aims to support better medical leadership across the organisation. Organisational affiliation involves the adoption of the FMLM Leadership and Management Standards for Medical Professionals by the organisation for all medical staff. This includes the inclusion of the FMLM standards in terms of reference for all doctors employed by the trust with the inclusion of FMLM Fellowship as a desirable qualification for consultant level posts and above, assistance embedding an assessment of medical leadership and management capability as part of annual appraisals for medical leaders at consultant level and above, and on-site discussions annually between FMLM and a selection of doctors and medical leaders at different levels to provide education and identify areas for improvement and continued programmes of support.

Northern Lincolnshire and Goole NHS Foundation Trust began the process of adopting the FMLM standards for medical professionals in June 2021. Discussions with the medical director, senior medical team and appraisal leads were conducted throughout 2021 and onwards, including a visit by Dr Paul Evans, FMLM Medical Director, on 22 September 2021, by Dr Paul Evans and Angus Waite, FMLM Head of Professional Services, on 23 - 24 March 2022, and by Paul Evans on May 10 – 11 2023.

Ahead of the visit outlined below, meetings were arranged with key executive, medical staff and multidisciplinary teams from the Scunthorpe and Grimsby sites. These included individuals representing doctors within the trust who have been identified, whether by their career progression or continuing professional development (CPD) undertaken with the trust, as being potential future leaders or important stakeholders in NLAG's commitment to bring about better medical engagement and medical leadership to improve patient care. Emergency department teams from both sites were also included in the meetings arranged, as both departments had been identified early in the FMLM Affiliation as potentially benefiting significantly from the partnership, and had been the subject of interest and visits from FMLM previously. Maternity was also proposed as an important department to visit due to the potential for positive conversations to be held around team working. Both the Grimsby and Scunthorpe maternity units were visited as part of this series of meetings.

Itinerary and findings

North Lincolnshire and Goole NHS Trust (NLAG) is in its third year as an Affiliated Organisation of FMLM. The last visit to the Trust was in May 2023.

A full programme of departmental visits and meetings had been arranged by the Trust. This enabled FMLM to visit both the Grimsby and Scunthorpe hospital sites and meet many Trust employees at various grades and different workforce specialisms. The full timetable is attached as an appendix.

Findings

- Emergency Department visits - Grimsby and Scunthorpe

  The significant takeaway from both emergency department (ED) site visits was the very clear multidisciplinary team working that was benefitting patients. The newly constructed departments proved to be a major resource in terms of staff morale and self-confidence, in addition to the clear and obvious benefits for patients. Both departments shared key features in their new configuration, including large 'motherboard' style screens aiding patient flow and knowledge, and clear delineation of treatment zones that has considerably aided staff team cohesion. Dr Abdul Khan, the clinical lead, continues to impress with his quiet but knowledgeable and personable approach. He appears to have had a significant influence in supporting tight-knit teams to form. He has been empowered by the Executive after completing FMLM's emerging clinical lead training programme and has impressed many stakeholders with his step-up to greater responsibility. It is good to see that the consultant physician on-call was based within the ED which considerably helped patient assessment and flow and added to the learning opportunities.

- Radiology and endoscopy department visits

We visited the Endoscopy (Scunthorpe) and Radiology (Grimsby) departments to meet key medical leaders and the wider multidisciplinary team. Dr Ajay Dabra, Clinical Lead for Radiology, and Hayley Briggs, Assistant General Manager of Radiology were delighted to be embarking on their new journey with trainees as a designated department for specialist radiology training, the award of which represents a great achievement for all staff in the department. With endoscopy, we met Mr Ramana Kallam, Clinical Lead – General Surgery, Lisa Gadd - Endoscopy Manager and Hayley Briggs, Assistant General Manager to discuss team working and JAG accreditation (Joint Advisory Group on Gastrointestinal Endoscopy). Our discussions were positive and demonstrated a tight-knit senior leadership team within the departments.

- Maternity visits

Both maternity units at Scunthorpe and Grimsby were the subject of visits from the FMLM team. Shortly before our visit we were informed that two days prior, 'special measures' on maternity had been lifted, a great achievement for all staff in the current climate. We met a variety of staff members, including midwives, obstetrician and gynecologist (OG) consultants, and trainees. We were impressed with the obvious mutual respect displayed between doctor and midwife. An anecdote about a 'group hug' at the end of a tough shift demonstrated the clear bonds within the team and were a pleasing indication of supportive team working. Significant differences in the method of patient flow between the two sites were remarked upon by most senior staff, with some indicating a clearly 'preferred' option. This should be monitored and effort should be made to ensure that tribal identities around 'our way of working' do not get in the way of an objective view on methodology.

- Links with primary care

A meeting was arranged between key clinical staff at NLAG and leaders from the local primary care community, including GP partners and representatives from the new Integrated Care Board (ICB). A wide-ranging and frank discussion ensued around where responsibility for patient flow lay, what blockages there were in the system, and the lack of engagement

between primary and secondary care. We commend Dr Wood for instigating the meeting and in particular NLAG's efforts to reach out into the community and wider system. All at the meeting agreed that there needed to be more interaction between senior stakeholders within the integrated system. A combined leadership programme based on the existing FMLM programme at NLAG was discussed as a way to bring together emerging leaders within the system, this proposal was positively received by all parties.

- ## All cohort meeting with participants of FMLM medical leaders programme

A virtual meeting was held with all current and past participants of the FMLM emerging clinical lead programme, now in its third year. Participants displayed great enthusiasm for the programme, further demonstrated through the waiting list that the course now attracts. FMLM remarked on the fact that in most departments visited by the team, there were people in responsible leadership positions who had progressed out of the programme and were being utilized and given greater responsibility as a result. This was clearly a factor noticed by participants and commented upon by the alumni, who appeared to demonstrate a tight-knit community of medical leaders within the trust, a very gratifying and positive development.

CEO meeting

We were most grateful to Mr Jonathan Lofthouse for generously giving us an hour to discuss NLAG, their progress in clinical leadership and the wider group which he now heads. NLAG's journey of improvement, from a tough starting point three years ago, was remarked upon by all and the desire to spread this improvement methodology, centred on clinical leadership, across the group was a point of conversation. We made a commitment to touch-base once he had finalised his new executive team in November.

Acknowledgements

We would like to thank Dr Kate Wood, Mich Green, Executive Personal Assistant, and Raj Johal, Head of Business and Medical Engagement, for putting the programme together and to all the executives who supported the visit so effectively.

Key links

The FMLM Leadership and Management Standards for Medical Professionals

Background on FMLM Affiliated Organisations

The FMLM Fellowship

Leadership and leadership development in health care: the evidence base

Background on the Faculty of Medical Leadership and Management

NLAG hosting FMLM Affiliation Visit - Diana Princess of Wales Hospital - Scartho Rd, Grimsby DN33 2BA

DAY 1 TIMETABLE – Wednesday 27th September 2023, 08:00-17:00

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Time	FMLM (Dr Paul Evans) visiting/meeting with…	Location (plus, other details)	Focus being…
08:00 Dr Paul Evans and Angus Waite to arrive at DPoW and get set up/settled in the Executive Board Room (near Kate's office)			
08:00-09:00	Dr Kate Wood, *Chief Medical Officer*	In person – Executive Board Room	Pre-meet and go over the planned timetable for the 1.5 days
09:00-09:15 – Break and travel time to next appointment			
09:15-10:15	Dr Abdul Khan, *Clinical Lead (Emergency Care)* Other ED staff on department	In person – Emergency Department	Emergency Department site visit and dialogue with Clinical leaders and staff teams. Discuss progress since previous visits.
10:15-10:30 – Break and travel time to next appointment			
10:30-11:30	Mr Mohammed Abdullah, *Consultant, O&G Consultant and Clinical Lead* Nicky Foster, *Associate Chief Nurse - Midwifery*	In person – Maternity Unit	Maternity Unit site visit and dialogue with Clinical Leaders and staff teams.
11:45-13:00	Paul & Angus working lunch Drop-in session to include SAS/middle grade doctors	In person and via MS Teams – Executive Board Room with Teams dial in option	Drop-in session
13:00-13:15 – Break and travel time to next appointment			
13:15-14:15	Mr Ramana Kallam, *Clinical Lead – General Surgery* Lisa Gadd, *Endoscopy Manager* Hayley Briggs, *Assistant General Manager*	In person – Endoscopy Department	Endoscopy unit site visit and meet Dr Ramana Kallam, Lisa Gadd and Hayley Briggs and discuss JAG accreditation
14:15-14:30 – Break and travel time to next appointment			
14:30-16:00	Dr Peter Melton, *GP* Dr Naveen Samuel, *GP & Divisional Medical Director (Community & Therapies)* Dr Andrew Lee, *GP* All NLAG Divisional Medical Directors, CMO and Dep CMO	In person and via MS Teams – Executive Board Room with MS Teams dial in option	Introduction to the FMLM and how they support organisations like ours. Further discussion with a focus on how Primary and Secondary Care can bring their leadership together as a system to improve outcomes through team working.
16:00-17:00	FMLM – Medical Leaders Programme (Cohorts 1, 2 and 3 to be invited via teams)	Via MS Teams – Exec Board Room	Share your impact as a leader since completing the programme (Cohort 3 are part way through)
5pm FINISH			

NLAG hosting FMLM Affiliation Visit at Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH

DAY 2 TIMETABLE – Thursday 28th September 2023, 08:00-13:00

Time	FMLM (Dr Paul Evans) visiting/meeting with…	Location (plus, other details)	Focus being…
08:00 Dr Paul Evans (Medical Director) and Angus Waite (Head of Professional Services and Innovation) to arrive at SGH and get set up/settled in the Executive Meeting Room, Butterwick House			
08:00-09:00	Dr Kate Wood, *Chief Medical Officer*	In person – Executive Meeting Room	Pre-meet and day 1 reflections.
09:00-10:00	Miss Preeti Gandhi, *Consultant* Nicky Foster, *Associate Chief Nurse Midwifery*	In person – Maternity Unit	SGH Maternity visit
10:00-11:00	Dr Ajay Dabra, *Clinical Lead for Radiology at SGH* Hayley Briggs, *Assistant General Manager*	In person – SGH Radiology	SGH Radiology visit
11:00-12:00	Jonathan Lofthouse, *Group CEO*	In person – Executive Meeting Room or Jonathan's office	Introductory meeting between Dr Paul Evans – Medical Director of FMLM and Group CEO
12:00-13:00	Dr Abdul Khan, *Clinical Lead (Emergency Care)* Other ED staff on department	In person – Emergency Department	Emergency Department visit
1pm FINISH			

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Linda Barker – Head of Infection, Prevention & Control
Title of the Report	**Annual Infection Prevention Control Report**
Purpose of the Report and Executive Summary (to include recommendations)	This report is a record of activities relating to the prevention and control of healthcare associated infection in Northern Lincolnshire and Goole NHS Foundation Trust during the year April 2022 to March 2023. Priority for the IPC (Infection Prevention and Control Team) has been the highly complex IPC management of the continuation of SARS CoV-2 variants of concern, managing the surge caused by new variants, high prevalence of other respiratory viruses mainly Influenza and RSV, patients with dual viruses and the diarrhoea and vomiting virus Norovirus. The emergence of the Omicron variant and subsequent variants since December 2021, coupled with The United Kingdom (UK) vaccination programme, and COVID treatments, led to much milder forms of respiratory disease. During this period the NHS (National Health Service) was attempting to return to normal functioning to address the large backlogs of care and procedures. The effects of this meaning increased inpatients, elective procedures, diagnostic works, and more people throughout our hospitals than seen for the last 2 years. Flow of new guidance to transition to 'Living with COVID' was managed in a proactive robust manner with excellent engagement from clinical staff. The team continue to work closely with various colleagues such as operational teams, laboratory, hotel services, procurement, estates, and many other services to best manage. The winter months were a substantial challenge and significant strain on the IPC team compounded by a demanding on call rota. Despite this, business as usual continued with full completion of the audit and surveillance IPC programme with focus on continuing the work around nosocomial infections, invasive devices, and antimicrobial stewardship. Overall, there have been several achievements in the past twelve months, which include: **Performance** • The IPC Team worked closely with Operations to navigate The Trust through the COVID-19 pandemic, and during this report specific period, managed the relaxation of the COVID restrictions and allowing more normal hospital functioning. • Managed a particular long difficult winter period due to high numbers of cases and outbreaks of COVID-19, and unusually high numbers of other illnesses i.e., Influenza

	and Norovirus – ensuring patient safety and minimum bed losses. • Supported The Trust in achieving very good performance of alert organism case thresholds regionally and nationally. (at time of report despite there being a significant increase, the Trust is performing well and below the national average on all alert organisms) • 100% compliance with IPC Strategy • There were no lapses/care associated with C. difficile infection from cases reviewed • Gram negative blood stream infections which remain 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 (Peripheral Venous Catheters) and urinary catheters remains broadly the same • Antimicrobial IV (intravenous) usage is difficult to compare due to the pandemic response but progress being made and heading in the right direction • Continuation of the IPC newsletter produced **Areas for further improvement and support include:** • As part of the Estates strategy, future build projects/upgrade plans continue to take into consideration the IPC requirements including enhanced ventilation, oxygen demands and isolation capacity. This will help the Trust prepare for future infection challenges. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect staff and patients and not solely rely on the use of PPE (Personal Protective Equipment). This is critical within areas that are undertaking AGPs (Aerosol Generating Procedures) 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 (high-efficiency particulate absorbing) filtration units. However, the opening of the new Emergency Departments (ED's) at Scunthorpe General Hospital (SGH) and Diana Princess of Wales Hospital (DPOW) provides excellent ventilation, spacious waiting areas and isolation facilities. • 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 opening of ward 25, SGH which has 14 single rooms has helped address the imbalance. Redirooms are used to maximise isolation facilities.

	• There continues to be a lack of Consultant Medical Microbiologists onsite 5 days a week, with DPOW having no one on site. • A Lead for FIT Testing needs to be established • Historically the deep clean schedule has unfortunately been subjected to operational pressures and as such frequently cancelled. The setting up of a Deep Clean Compliance Group should enable significant improvement going forward • Currently there is no enhanced cleaning system used in the Trust, the purchasing/renting of a system i.e., UV needs to be addressed.	
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
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ✓ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

1.	**To give great care**

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

Northern Lincolnshire and Goole NHS
NHS Foundation Trust

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

2022-23

Written by

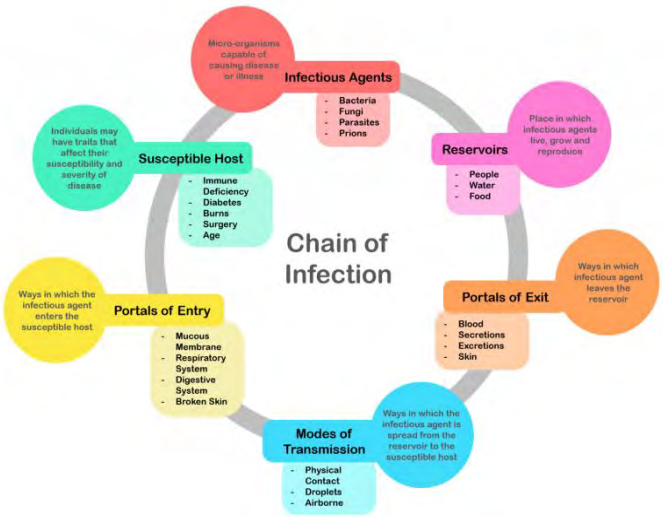
Linda Barker

Head of Infection Prevention & Control

on behalf of

The DIPC (Director of Infection Prevention & Control)

Ellie Monkhouse, Chief Nurse



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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 2022 to March 2023.

Priority for the IPC (Infection Prevention and Control) Team has been the highly complex IPC management of the continuation of SARS CoV-2 variants of concern, managing the surge caused by new variants, high prevalence of other respiratory viruses mainly Influenza and RSV, patients with dual viruses and the diarrhoea and vomiting virus Norovirus.

The emergence of the Omicron variant and subsequent variants since December 2021, coupled with The United Kingdom (UK) vaccination programme, and COVID treatments, led to much milder forms of respiratory disease. During this period the NHS (National Health Service) was attempting to return to normal functioning to address the large backlogs of care and procedures. The effects of this meaning increased inpatients, elective procedures, diagnostic works, and more people throughout our hospitals than seen for the last 2 years. Flow of new guidance to transition to 'Living with COVID' was managed in a proactive robust manner with excellent engagement from clinical staff. The team continue to work closely with various colleagues such as operational teams, laboratory, hotel services, procurement, estates, and many other services to best manage.

The winter months were a substantial challenge and significant strain on the IPC team compounded by a demanding on call rota.

Despite this, business as usual continued with full completion of the audit and surveillance IPC programme with focus on continuing the work around nosocomial infections, invasive devices, and antimicrobial stewardship.

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

Performance

- The IPC Team worked closely with Operations to navigate The Trust through the COVID-19 pandemic, and during this report specific period, managed the relaxation of the COVID restrictions and allowing more normal hospital functioning.
- Managed a particular long difficult winter period due to high numbers of cases and outbreaks of COVID-19, and unusually high numbers of other illnesses i.e., Influenza and Norovirus – ensuring patient safety and minimum bed losses.
- Supported The Trust in achieving very good performance of alert organism case thresholds regionally and nationally.
- 100% compliance with IPC Strategy
- There were no lapses/care associated with C. difficile infection from cases reviewed.
- Gram negative blood stream infections which remain 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 (Peripheral Venous Catheters) and urinary catheters remains broadly the same.
- Antimicrobial IV (intranvenous) usage is difficult to compare due to the pandemic response but progress being made and heading in the right direction.
- Continuation of the IPC newsletter produced.

Governance

- IPC data reviewed and challenged at the Nursing Metrics Board
- Continued use of systems using Power BI to feedback ward / dept performance against KPIs (Key Performance Indicators).
- 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 6 monthly.
- The Infection Prevention & Control committee continued to meet.

Areas for further improvement and support include:

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

As part of the Estates strategy, future build projects/upgrade plans continue to take into consideration the IPC requirements including enhanced ventilation, oxygen demands and isolation capacity. This will help the Trust prepare for future infection challenges. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect staff and patients and not solely rely on the use of PPE. This is critical within areas that are undertaking AGPs (Aerosol Generating Procedure) 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. However, the opening of the new EDs (Emergency Departments) at SGH (Scunthorpe General Hospital) and DPOW (Diana Princess of Wales Hospita) provides excellent ventilation, spacious waiting areas and isolation facilities.

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 opening of ward 25, SGH which has 14 single rooms has helped address the imbalance. Redirooms are used to maximise isolation facilities.

There is no HDU (High Dependency Unit) at SGH which causes issues when there needs to be escalation of respiratory patients, especially if no capacity on ICU (Intensive Care Unit) 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 again this year with surges of COVID-19, other respiratory illness, example Influenza as well as Norovirus. The physical layout of this unit is not conducive to segregate of staff.

There continues to be a lack of Consultant Medical Microbiologists on site 5 days a week, with DPOW having no one on site.

A Lead for FIT Testing needs to be established.

Historically the deep clean schedule has unfortunately been subjected to operational pressures and as such frequently cancelled. The setting up of a Deep Clean Compliance Group should enable significant improvement going forward.

Currently there is no enhanced cleaning system used in the Trust, the purchasing/renting of a system i.e., UV (ultraviolet) needs to be addressed.

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 2022 to March 2023. 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 3 years in managing the COVID-19 pandemic, the continuation of SARS CoV-2 variants of concern, managing the surge caused by new variants, high prevalence of other respiratory viruses mainly Influenza and RSV, patients with dual viruses and the diarrhoea and vomiting virus Norovirus.

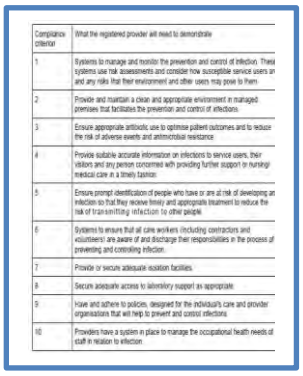
The purpose of this report is to inform patients, public, staff, the Trust Board of Directors, Council of Governors and Clinical Commissioning Groups (CCGs) of the infection prevention and control work undertaken in 2022-23 and provides assurance that the Trust remains compliant with the Health and Social 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 (Department of Health, 2015). This report is structured using the criteria in the Health and Social Care Act 2008 – Code of Practice for Health and Adult Social Care on the Prevention and Control of Infections and related guidance which sets out the criteria against which a registered provider's compliance with requirements relating to cleanliness and infection control will be assessed by the CQC (Care Quality Commission).

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 SARS CoV-2 variants of concern, increase in other viruses IPC activities have had to be prioritised yet again. However, 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

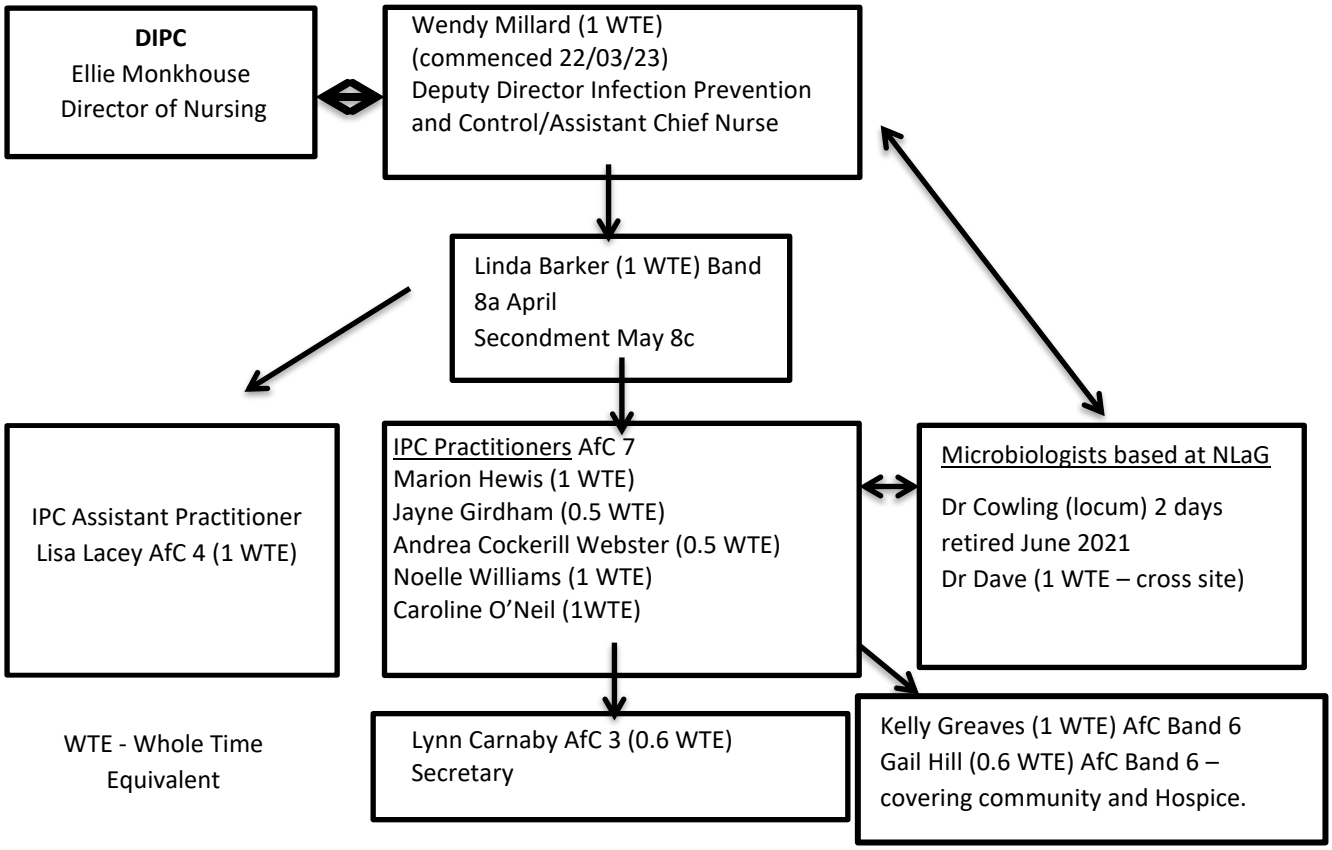
The Trust's arrangements for the prevention and control of infection are contained within the document, *Infection Prevention & Control Strategy: Overview of the Trust Approach and Arrangements for Infection Prevention & Control* [IC/SP3], which is held by the Directorate of Governance & Assurance/Trust 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 DIPC (Director of Infection Prevention and Control) 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. 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 on the SGH site which has been well received by colleagues.

Infection Prevention & Control Team at March 2023



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. An opportunity arose allowing review of the team structure and succession planning the overall team structure to be reviewed, culminating in the recruitment of a Band 4 Assistant Practitioner and plans for the recruitment of a Band 5 nurse. The team continues a service level agreement to provide cover to the local hospice unit in Scunthorpe.

Infection Prevention & Control (IPC) 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.

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, Clinical Commissioning Group (CCG) representatives, Estates / facilities, nominated deputy for medical director and others co-opted as required. The COVID-19 Incident Control Centre which facilitated the cascade of key messages and the many national updates disbanded as per national guidance (living with COVID).

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.

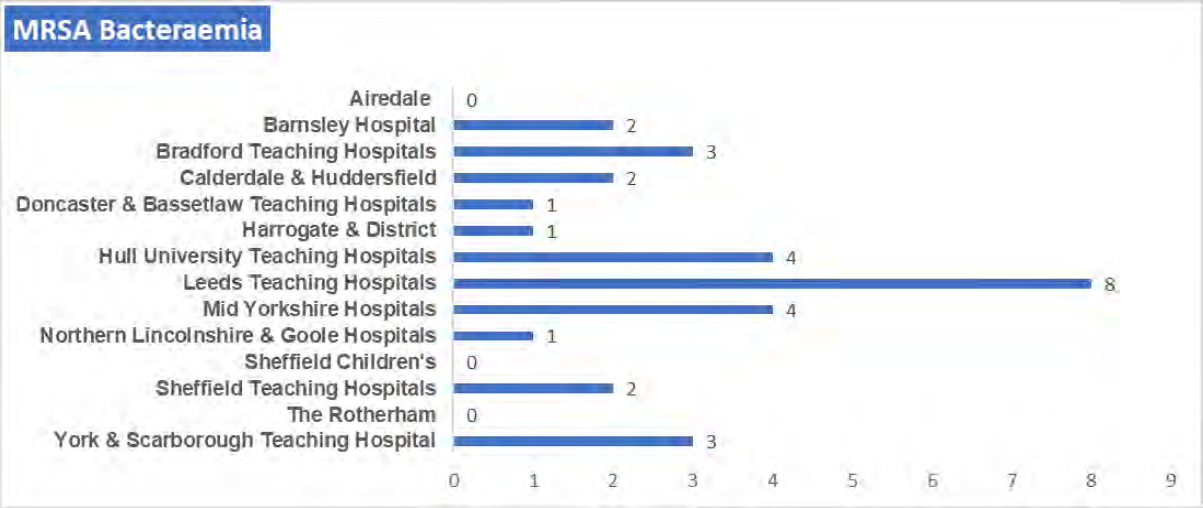
MRSA Bacteraemia

Nationally, there remains a zero tolerance for preventable MRSA bacteraemia cases. Thus, once again the Trust had a trajectory of zero avoidable hospital-acquired cases. Unfortunately, there has been a MRSA hospital acquired case at SGH – the first in the Trust for over 27 months. A rigorous Post Infection Review Process deemed the case preventable, with the root cause being peripheral cannula related. An action plan and learn lessons is in place.

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
2022-2023	1	1

FIGURE 1 TOTAL NUMBER OF MRSA BACTERAEMIA HOSPITAL ONSET YORKSHIRE & HUMBER UP TO MARCH 2023



Clostridioides difficile (formerly known as Clostridium difficile) Infections

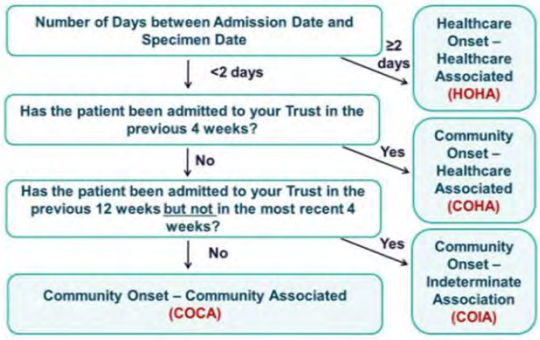
Clostridioides difficile infection (CDI) remains an unpleasant, and potentially severe or fatal infection that occurs mainly in elderly and other vulnerable patient groups especially those who have been exposed to antibiotic treatment. *Clostridioides difficile* is a bacterium that releases a toxin which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

The *C.difficile* objective guidance continued the use of lapse in care as a performance indicator. A lapse in care would be indicated by evidence that policies and procedures consistent with local guidance or best practice were not followed. There was also a change three years ago 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 2022/23 the Trust has been allocated a trajectory of no more than 21 cases combining the HOHA and COHA.

FIGURE 2 BREAKDOWN OF C.DIFFICILE CASES BY DIVISIONS

C. difficile cases by Site, Division and Ward

Financial Year	2022/23												Total
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	
DPOW	3	2	1	2	1	1	2	1	0	0	0	2	15	15
Family Services	0	1	0	0	0	0	0	0	0	0	0	0	1	1
Medicine	2	1	1	2	0	0	1	1	0	0	0	2	10	10
Surgery & Critical Care	1	0	0	0	1	1	1	0	0	0	0	0	4	4
SGH	0	0	3	0	1	0	1	1	0	0	1	1	8	8
Medicine	0	0	3	0	1	0	1	1	0	0	1	1	8	8
Total	3	2	4	2	2	1	3	2	0	0	1	3	23	23



The trust had a CDI objective of no more than 21 cases and ended the year on 23 reported cases. There were no significant lapses in practice / care detected from the Post Infection Reviews undertaken with the main issues around antimicrobial prescribing, and previous CDI.

The SGH site had 8 cases, Goole & District Hospital (GDH) 0 cases and DPOW 15 which is a significant turnaround from the previous year. 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 well compared to Yorkshire & Humber data for CDI rates in patients over 2 years of age for all England acute trusts based on 100,000 bed days 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.

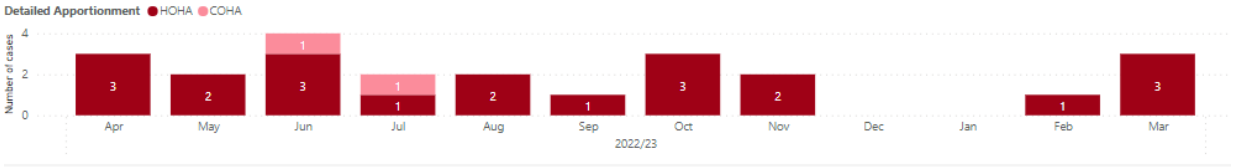
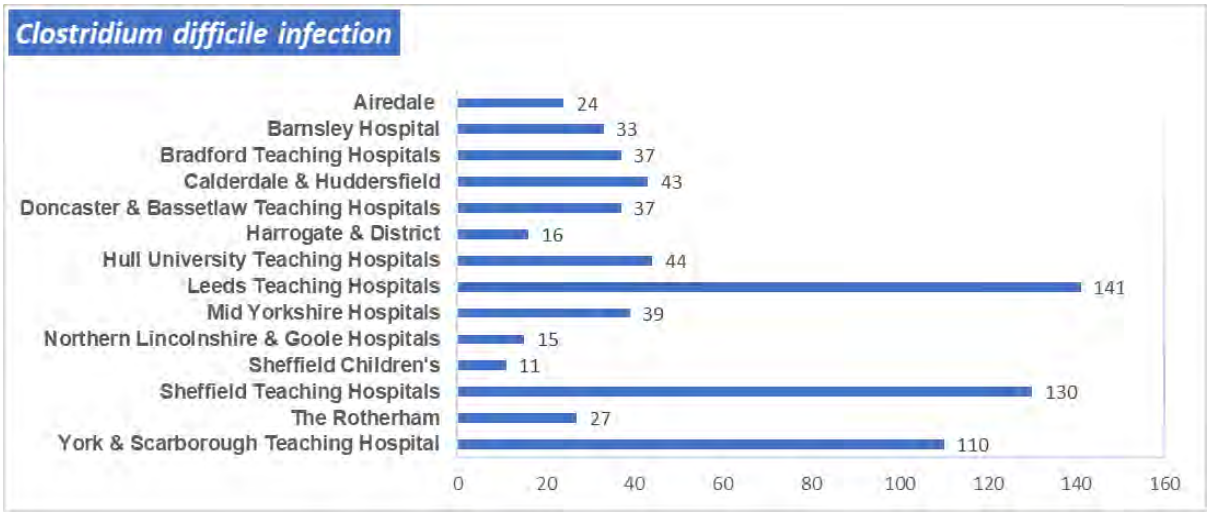


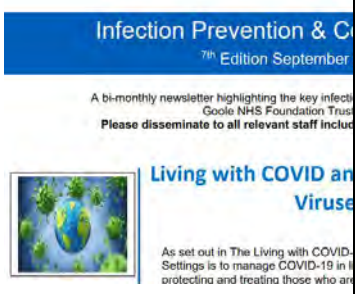
FIGURE 5 NUMBER OF HEALTHCARE ONSET CASES OF C. *DIFFICILE* JULY - MARCH 2023

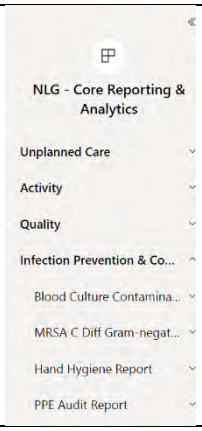
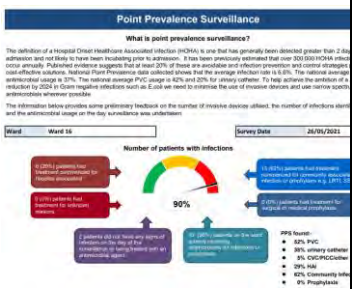


Post Infection Review

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. During 2022/23 a thorough review of each case was held and they were deemed no lapses in care.

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%207th%20edition.pdf
	The IPC Blog is regularly updated to provide bite sized information to staff https://ipc427.wordpress.com/

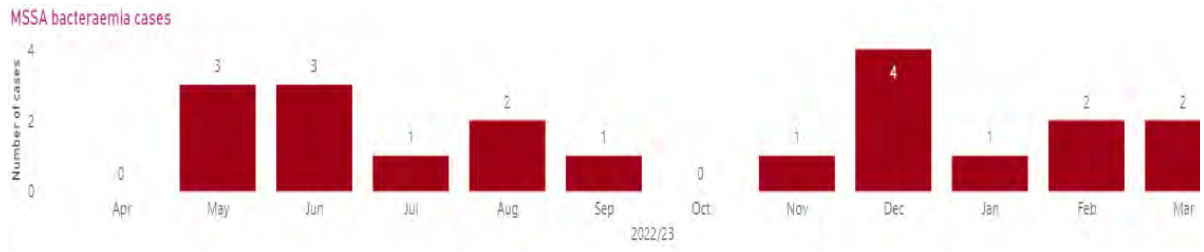
Hand Hygiene Roadshow 2022  	The Infection Prevention & Control Team visited all ward areas on all three sites for World Hand Hygiene Day on the 5th May 2022, with quizzes, and competitions.  
 	The implementation of bespoke audits to help ensure best practice was in place during the pandemic – including 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. NLG-Core Reporting and Analytics
 	Point prevalence surveillance continues to be undertaken 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. 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 MSSA (Meticillin Sensitive *Staphylococcus aureus)* 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

FIGURE 6 MSSA TRUST APPORTIONED CASES



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 including 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 3 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 56 to 65 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.

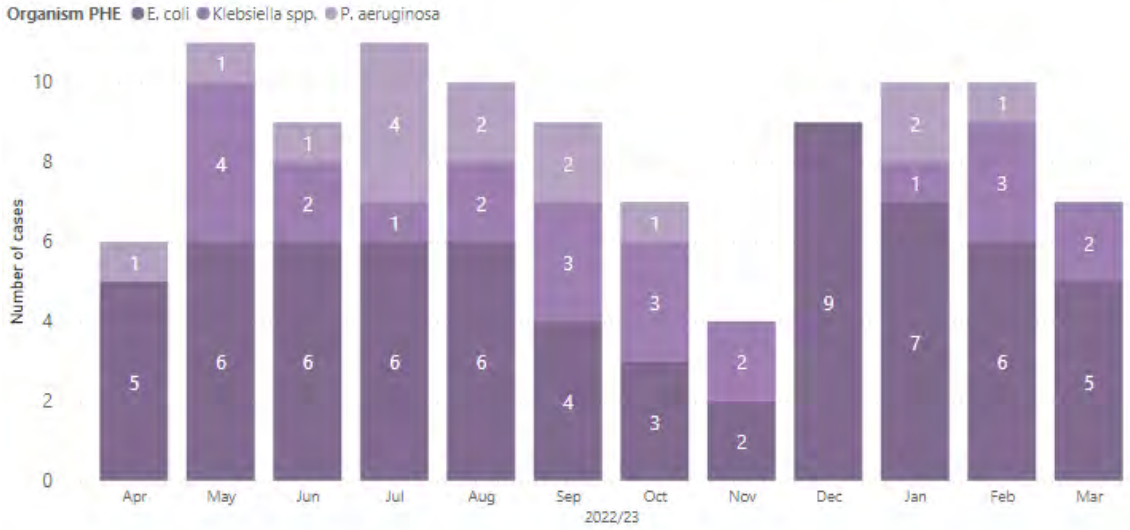
Due to the age profile of most cases a significant number will have numerous co-morbidities and risk factors e.g., dementia, increasing their risk of infection. Therefore, measures such as hydration, removal of urinary catheters, appropriate diagnosis and treatment of urinary tract infections and improved surgical management are some of the key priorities to tackle this burden.

TABLE 2 TRUST APPORTIONED GRAM-NEGATIVE CASES

Financial Year	2022/23												Total
Site	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total	
DPOW	2	4	2	3	3	1	3	0	4	4	4	2	32	32
Medicine	2	4	2	3	2	1	2	0	3	4	3	0	26	26
Surgery & Critical Care	0	0	0	0	1	0	1	0	1	0	1	2	6	6
GDH	0	1	2	1	0	0	0	0	2	0	0	0	6	6
Medicine	0	1	2	1	0	0	0	0	2	0	0	0	6	6
Surgery & Critical Care	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ward 5/6 GDH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
SGH	3	1	2	1	2	2	0	2	3	3	2	3	24	24
Medicine	3	1	2	1	2	2	0	2	3	2	2	2	22	22
A&E	2	1	1	0	1	2	0	0	1	1	0	0	9	9
Acute Assessment Unit - SGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Acute Assessment Unit B SGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ambulatory Care Unit SGH	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	5	6	6	5	5	3	3	2	9	7	6	5	62	62

DPOW - Diana, Princess of Wales Hospital, Grimsby
GDH - Goole & District Hospital
SGH - Scunthorpe General Hospital

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 dismilar to our local position.

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.

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

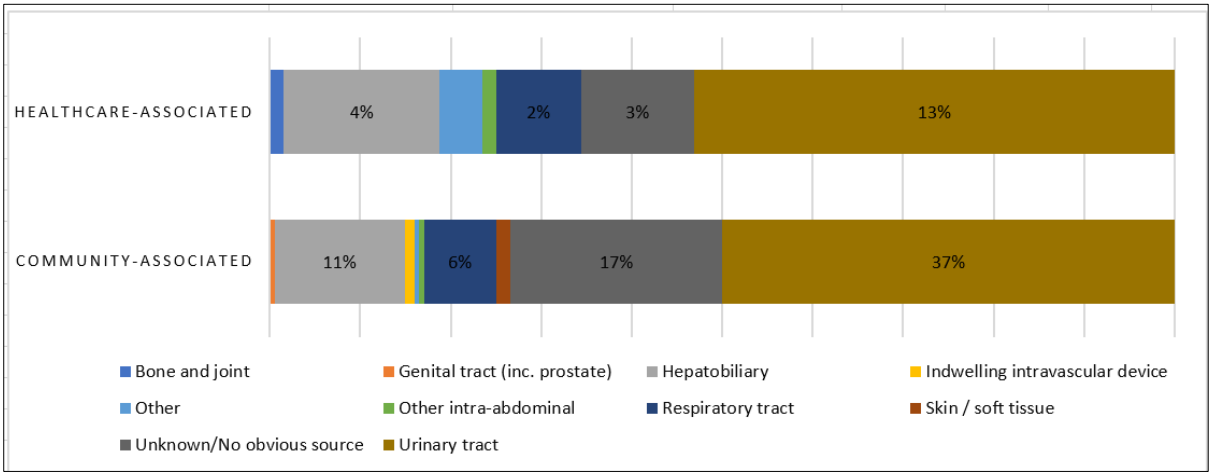
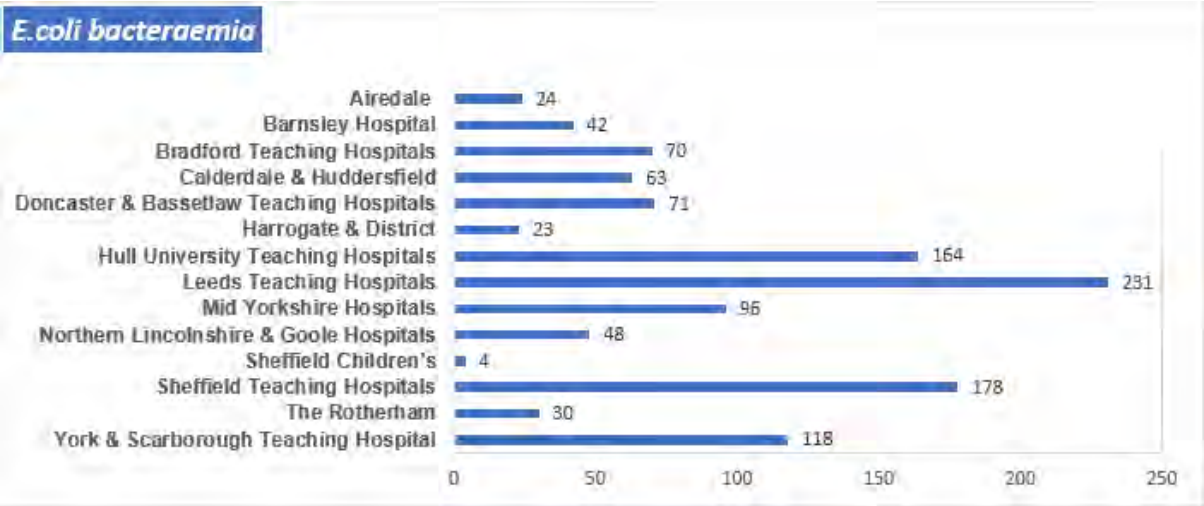


FIGURE 9 COMPARISON OF HEALTHCARE E.COLI BACTERAEMIA CASES REPORTED ACROSS THE REGION JULY - MARCH 2023



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 27 cases of Pseudomonas aeruginosa with 15 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 58 cases of Klebsiella with 23 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 THR (primary total hips) and TKR (primary total knee) at Grimsby and Goole hospital sites.

TABLE 3 ORTHOPAEDIC HIP AND KNEE REPLACEMENT INFECTION RATES - APRIL 2022 - MARCH 2023

	All Hospitals	**Grimsby**			**Goole**		
	National Rate	No. Operations	No. Infections	% Infection	No. Operations	No. Infections	% Infection
Hip Replacement	0.5%	197	1	0.5%	106	0	0.0%
Knee Replacement	0.4%	166	0	0.0%	217	0	0.0%

Overall, the infection rates remain within normal parameters, and again this year the Trust has not received an outlier letter from UKHS (UK Health Security Agency). 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 (Surgical Site Infection) 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 10 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

Influenza is a viral infection with an incubation period of 2 – 3 days usually but varying between 1 and 7 days. It usually presents as a non-specific febrile illness with headache, muscle pain and a dry cough but may even be asymptomatic. The two main Viruses that affect humans are Influenza A and Influenza B.

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 UPTAKE BY FRONTLINE WORKERS

StaffGroup	Flu Vaccine Received	Grand Total	Percentage of Staff who have received their Flu Vaccine
Medical and Dental	160	842	19.00%
Nursing and Midwifery Registered	669	2062	32.44%
Add Prof Scientific and Technic	54	117	46.15%
Allied Health Professionals	166	473	35.10%
Additional Clinical Services	470	2080	22.60%
Administrative and Clerical	166	409	40.59%
Estates and Ancillary	185	605	30.58%
Students	2	8	25.00%
Grand Total	**1872**	**6596**	**28.38%**

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 (Carapenemase producing Enterobacteriaceae). A Trust policy has been updated with the latest national framework and 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 Carbapeenem-resistant Enterobacteriaceae (CRE) or Carbapenem-Resistant Organism (CRO) cases, however this picture is likely to change as the framework now dictate an increased criteria for screening on admission.

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.

The overall hospital onset infection rate has risen to **9.8%** from 7.6 % last year and 7.1% pre pandemic in 2019, this is likely to be a reflection of the pandemic. At the time of compiling this report it is worth noting that there has been a significant increase of cases of alert organisms regionally and nationally. The Trust is currently performing well and is below the national average on all alert organisms. It was noted that the number of antimicrobials prescribed remains around **55%** 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 (Peripheral Venous Cannulas) not utilised for greater than 24 hours has decreased from **18% to 16%**. It was pleasing to note most of the PVC had an appropriate assessment and dressing was clean, intact, and secure.

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)

The revised National Standards for Healthcare Cleaning were shared in 2021 supported by engagement webinars to enable providers to adopt the updated standard. Led by Facilities Services including key Nursing and IPC engagement, the team developed detailed analysis documents indicating where our practices should adopt, and where investment to support enhanced auditing would be required. To our patients and staff, the new standard brought other industry recognised communication requirements for the cleaned environment based on “Star” ratings.

Six Functional Risks (FR) Ratings now guide the cleaning and auditing frequencies determined by the department operational function, FR1 being the highest possible rating reserved for areas such as operating theatre.

The Functional Risk Ratings also identified a significant increase in the number of audits required. Used to ensure compliance with the standard, but also to ensure reporting and escalation of the environment occurred, our resource required significant investment to achieve the programme. An informed business case took the risk forward into the annual business planning forum, approval for the appointment of 2 full time

team members on the Scunthorpe & Grimsby sites were approved. Goole would be delivered with existing resources. The teams work in conjunction with ward and department managers, Estates, and IPC to deliver the annual audit programme.

The Facilities team and Hospital Support Assistants have run ahead with the new standard and alongside the enhanced audits demonstrate a continued high standard of cleaning, recognised elsewhere within 15 step audits and the recent CQC (Care Quality Commission) inspection.

Our Capital Investment Programme 2021 – 22 and 2022 – 23 has also required significant cleaning support ensuring that cleaning remained a priority as the build environment changed. This was a challenging period; however, we are proud of how the new Emergency Care Centres have been established and maintain a "day one" cleaning standard for our patients and staff.

The facilities teams also supported the medical gas upgrades at Grimsby, this often-meant short notice deep cleans and rapid turnaround of wards and movement of patients, again often at a weekend and short notice overtime. This project completed successfully and the Facilities teams, including Deep Clean played a key role in its success.

Our deep clean teams fulfil a multitude of tasks which includes scheduled deep cleans (Programme Cleans) reactive cleans and infection cleans. It was recognised that to achieve these cleans and hand the ward back to clinical colleagues in a timely manner, the core hours which included a 06:00 start were not always conducive to the clinical environment. It was decided the core hours would be changed to support patient flow. Subsequently the Deep Clean teams are available on site to facilitate cleans and support the site activity.

The environment and pressures in which our teams operate has changed significantly over recent years, but our teams continue to remain professional and dedicated to their roles. They have worked through a pandemic, two new Emergency Care Centres opening, New Cleaning Standards being introduced and numerous projects which we were integral for completion.

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 WAT (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 11 IPC ENVIRONMENTAL AUDIT TOOL FEEDBACK FORM

Infection Prevention and Control Environmental Audit

Northern Lincolnshire and Goole NHS Foundation Trust

Site:	DPOW
Location:	DPOW - Cardiology Day Case Unit
Date:	03/02/2023
Observer / Auditor:	Andrea Webster-cockrill

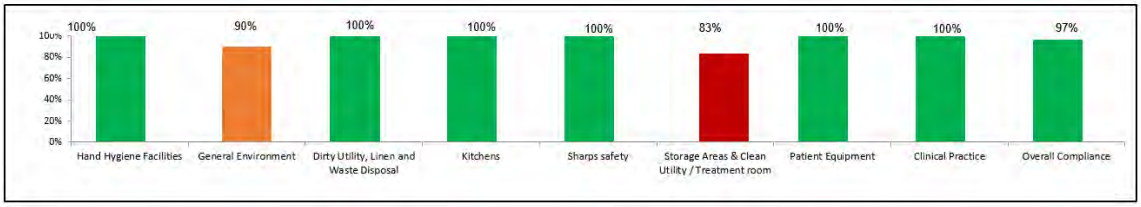


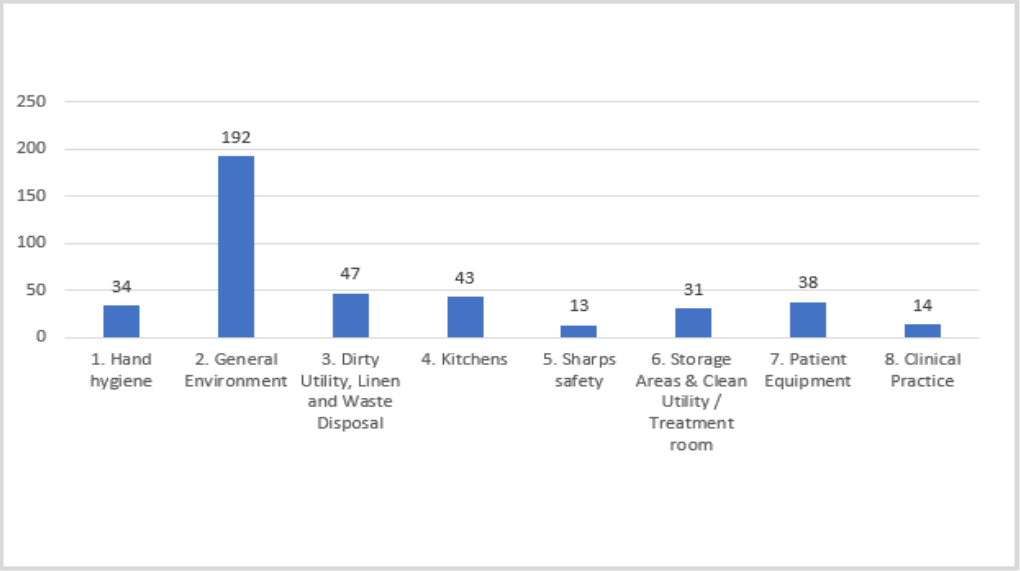
TABLE 5 ENVIRONMENTAL AUDIT SCORES

Compliance by Ward and Division

	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
2022/23	**91%**	**74%**	**83%**	**77%**	**91%**	**77%**	**76%**	**88%**	**82%**
Community	**89%**	**62%**	**82%**	**59%**	**91%**	**64%**	**66%**	**93%**	**76%**
DPOW	**93%**	**88%**	**89%**	**86%**	**89%**	**82%**	**84%**	**83%**	**87%**
Medicine	95%	91%	92%	83%	93%	93%	88%	83%	90%
Surgery & Critical Care	90%	91%	92%	88%	78%	83%	96%	92%	89%
Family Services	93%	82%	81%	89%	93%	62%	66%	76%	80%
GDH	**100%**	**80%**	**83%**	**90%**	**96%**	**91%**	**76%**	**88%**	**88%**
Medicine	100%	82%	86%	100%	100%	100%	87%	100%	94%
Surgery & Critical Care	100%	72%	87%	83%	89%	76%	65%	67%	80%
Family Services	100%	91%	100%	67%	100%	100%	75%	100%	92%
Chief Operating	100%	91%	50%	100%	100%	100%	80%	100%	90%
SGH	**89%**	**72%**	**76%**	**78%**	**91%**	**84%**	**82%**	**86%**	**82%**
Medicine	90%	61%	78%	79%	91%	86%	78%	74%	80%
Surgery & Critical Care	94%	88%	83%	88%	96%	82%	90%	94%	89%
Family Services	90%	84%	74%	78%	87%	97%	89%	100%	87%
Chief Operating	50%	40%	33%	0%	N/A	0%	50%	100%	39%

DPOW - Diana, Princess of Wales Hospital, Grimsby
GDH - Goole District Hospital
SGH - Scunthorpe General Hospital

FIGURE 12 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 (Hospital Sterilisation and Decontamination Unit). 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)

Antimicrobial Stewardship

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 (National Institute for Health and Care Excellence) 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 (electronic prescribing medication and administration) 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 2022/23 and activities related to antimicrobial stewardship

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary. Education and training is facilitated both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate durations of prescriptions for antimicrobials and optimise treatment for patients through an effective stewardship programme. The pharmacist staffing levels continue to be challenging. The Trust has been exploring all options to improve capacity including a recruitment drive, use of locum agencies, relocation packages offered, Star Chamber and shared working with HUTH (Hull University Teaching Hospitals) is being explored.

Activities undertaken:

Guidelines

- Path links paediatric antimicrobial guidelines reviewed. The plan is for them to be available on Microguide in 2023/24,
- Adult antimicrobial guidelines published on Microguide.

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
- Immunisation training
- Penicillin allergy training
- Teaching at post graduate institute

Audit and surveillance of antimicrobial use

There have been challenges with collating data each quarter due to staffing and capacity issues. The Trust have found a way round this so that the data is collected every quarter and fedback to the audit and quality team each quarter to be included as part of the Trust quality priority data. Two of these standards were included in the quality priorities namely the percentage of patients prescribed an antibiotic and the number of patients that have a review date documented. The following targets were agreed for the 2022/23:

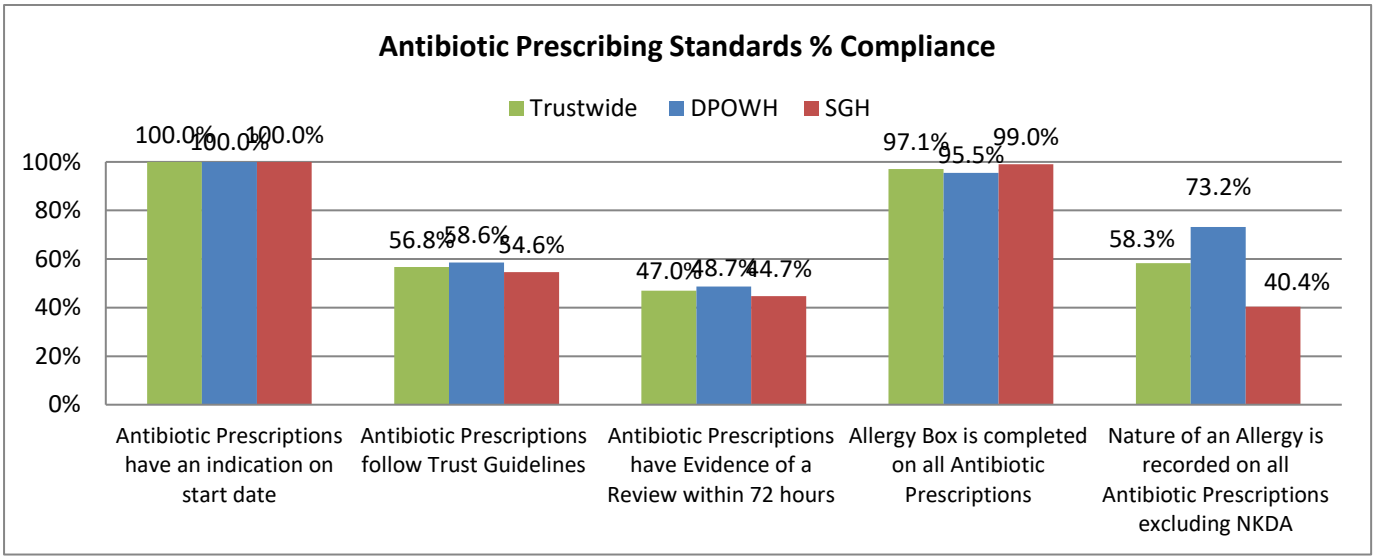
- Reduction in patients prescribed an antibiotic – target reduction to 50%
- Antibiotic prescriptions have evidence of a review within 72 hours – target 70%

Due to challenges with data collection for QI (Quarter 1) to Q3 – the data should not be relied upon to draw any conclusions. Data for Quarter 4 shows the desired targets and thresholds were not achieved and specific actions will be implemented to improve this for the next financial year.

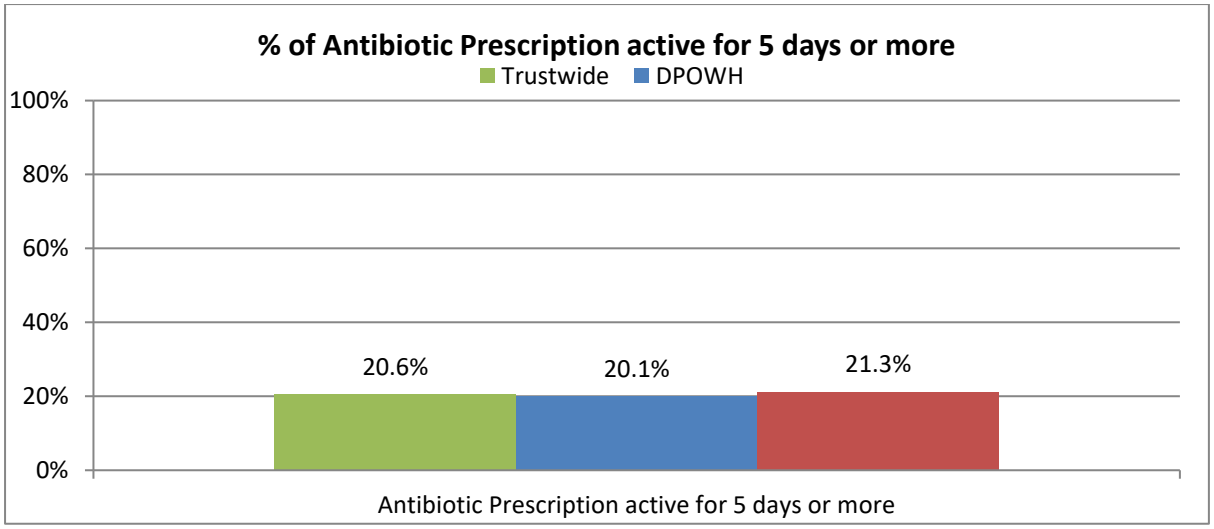
	2022/23 Q1	2022/23 Q2	2022/23 Q3	2022/23 Q4
% of Patients prescribed an Antibiotic Trustwide	42.3%	Not Available	45.2%	65.6%
% of Patients prescribed an Antibiotic DPOW	39.9%	Not Available	39.0%	64.4%
% of Patients prescribed an Antibiotic SGH	120.0%	59.7%	53.5%	67.1%

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

	Trustwide			DPOWH			SGH		
Audit Prescribing Standards	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	450	450	100.0%	243	243	100.0%	207	207	100.0%
Antibiotic Prescriptions follow Trust Guidelines	451	256	56.8%	244	143	58.6%	207	113	54.6%
Antibiotic Prescriptions have Evidence of a Review within 72 hours	279	131	47.0%	156	76	48.7%	123	55	44.7%
Allergy Box is completed on all Antibiotic Prescriptions	451	438	97.1%	244	233	95.5%	207	205	99.0%
Nature of an Allergy is recorded on all Antibiotic Prescriptions excluding NKDA	103	60	58.3%	56	41	73.2%	47	19	40.4%



	Trustwide			DPOWH			SGH		
Audit Prescribing Standards	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	451	93	20.6%	244	49	20.1%	207	44	21.3%

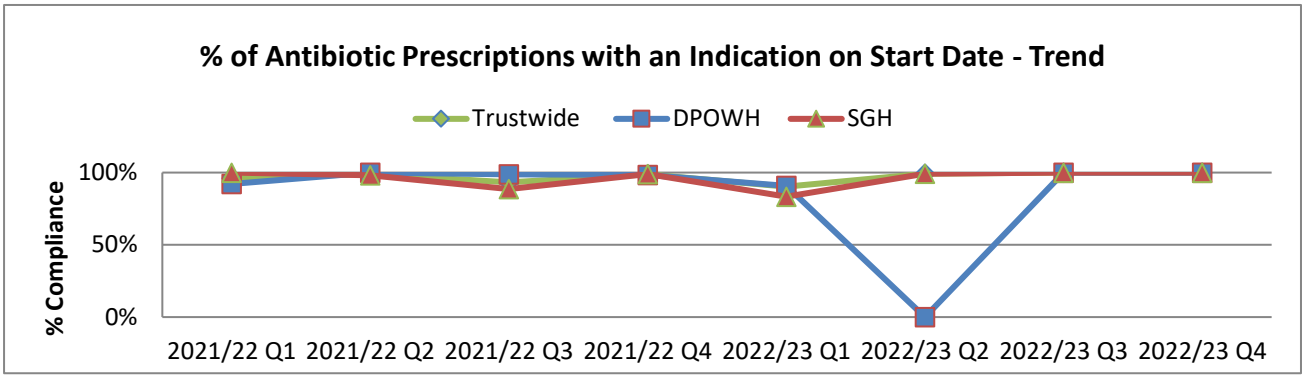


72 Hour Review Decision	Trustwide	DPOWH	SGH
Antibiotic was stopped	**6.8%**	**11.5%**	**0.8%**
Route changed e.g. IV to PO with no review / stop date	**1.1%**	**1.3%**	**0.8%**
Route changed e.g. IV to PO with review / stop date given	**3.9%**	**3.8%**	**4.1%**
Antibiotic was switched with no review / stop date	**3.2%**	**5.1%**	**0.8%**
Antibiotic was switched with review / stop date given	**4.7%**	**7.7%**	**0.8%**
No change to prescription and not re-written	**35.8%**	**26.9%**	**47.2%**
No change to prescription and re-written with no review / stop date	**31.5%**	**31.4%**	**31.7%**
No change to prescription and re-written with review / stop date given	**12.9%**	**3.8%**	**4.1%**

Prescribing Standard Trends

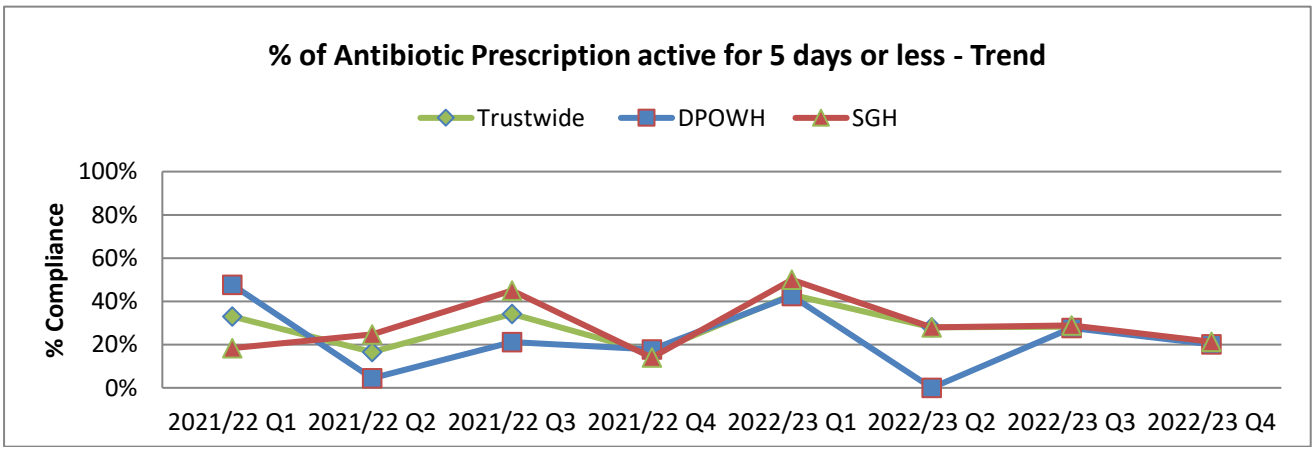
% of Antibiotic Prescriptions with an indication on start date

Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	96.1%	92.1%	100.0%
2021/22 Q2	98.9%	100.0%	98.2%
2021/22 Q3	93.3%	98.8%	88.6%
2021/22 Q4	98.7%	98.4%	99.0%
2022/23 Q1	90.3%	90.9%	83.3%
2022/23 Q2	99.2%	Not Available	99.2%
2022/23 Q3	100.0%	100.0%	100.0%
2022/23 Q4	100.0%	100.0%	100.0%



% of Antibiotic Prescription active for 5 days or more

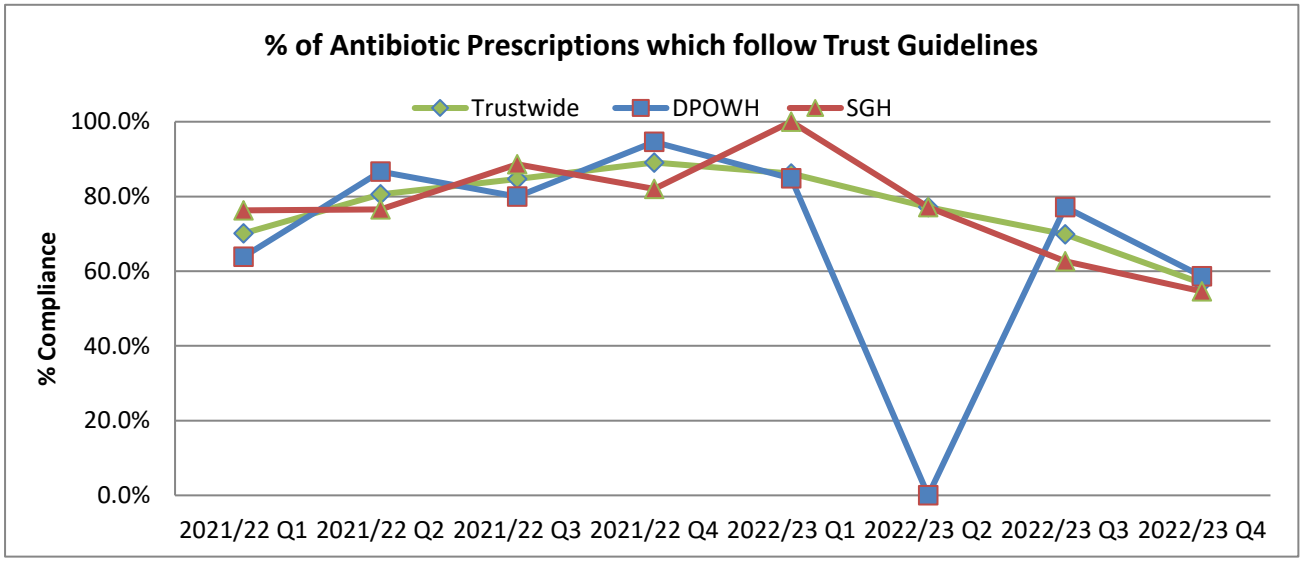
Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	33.1%	47.6%	18.4%
2021/22 Q2	16.5%	4.5%	24.7%
2021/22 Q3	34.1%	21.2%	45.0%
2021/22 Q4	16.2%	17.8%	14.0%
2022/23 Q1	43.1%	42.4%	50.0%
2022/23 Q2	28.0%	Not Available	28.0%
2022/23 Q3	28.3%	27.7%	28.9%
2022/23 Q4	20.6%	20.1%	21.3%



% of Antibiotic Prescriptions which follow Trust Guidelines

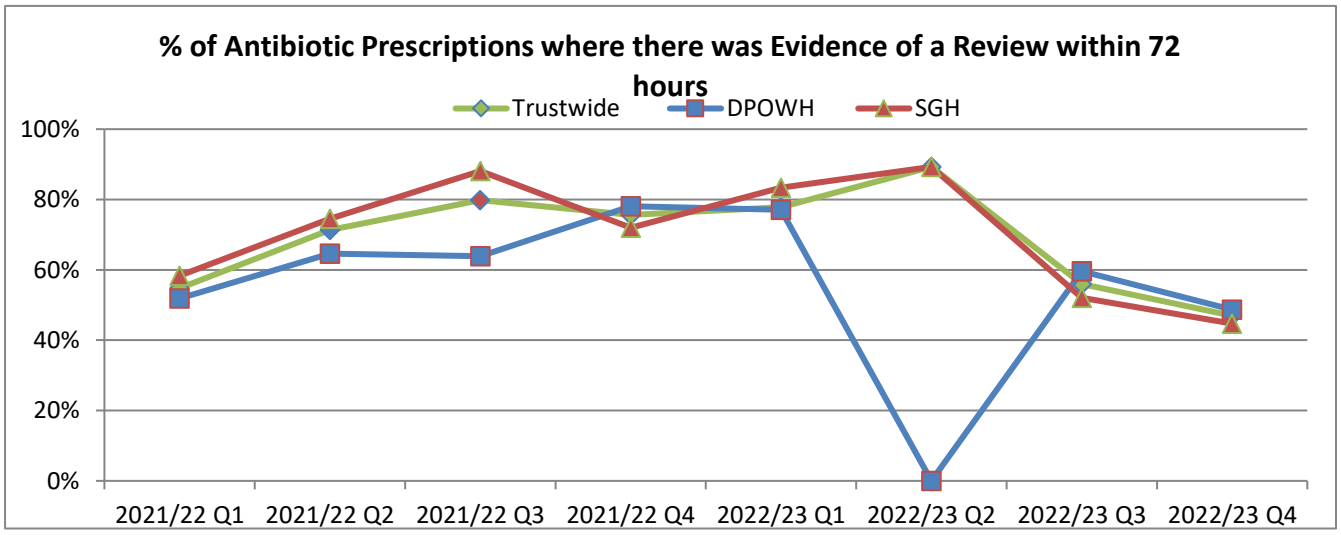
Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	70.1%	63.9%	76.3%
2021/22 Q2	80.6%	86.6%	76.5%
2021/22 Q3	84.7%	80.0%	88.6%
2021/22 Q4	89.1%	94.6%	82.0%
2022/23 Q1	86.1%	84.8%	100.0%
2022/23 Q2	77.1%	Not Available	77.1%

2022/23 Q3	69.9%	77.1%	62.7%
2022/23 Q4	56.8%	58.6%	54.6%



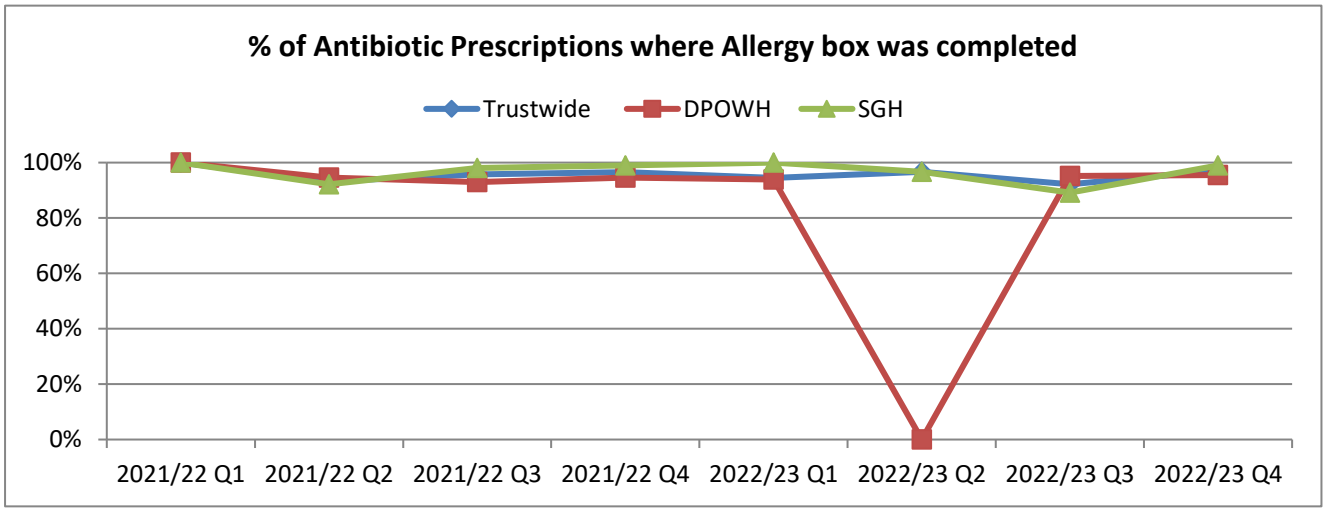
% of Antibiotic Prescriptions where there was Evidence of a Review within 72 hours

Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	54.8%	51.9%	58.3%
2021/22 Q2	71.3%	64.6%	74.5%
2021/22 Q3	79.8%	63.9%	88.1%
2021/22 Q4	75.6%	78.1%	72.0%
2022/23 Q1	77.8%	77.1%	83.3%
2022/23 Q2	89.3%	Not Available	89.3%
2022/23 Q3	56.0%	59.6%	52.1%
2022/23 Q4	47.0%	48.7%	44.7%



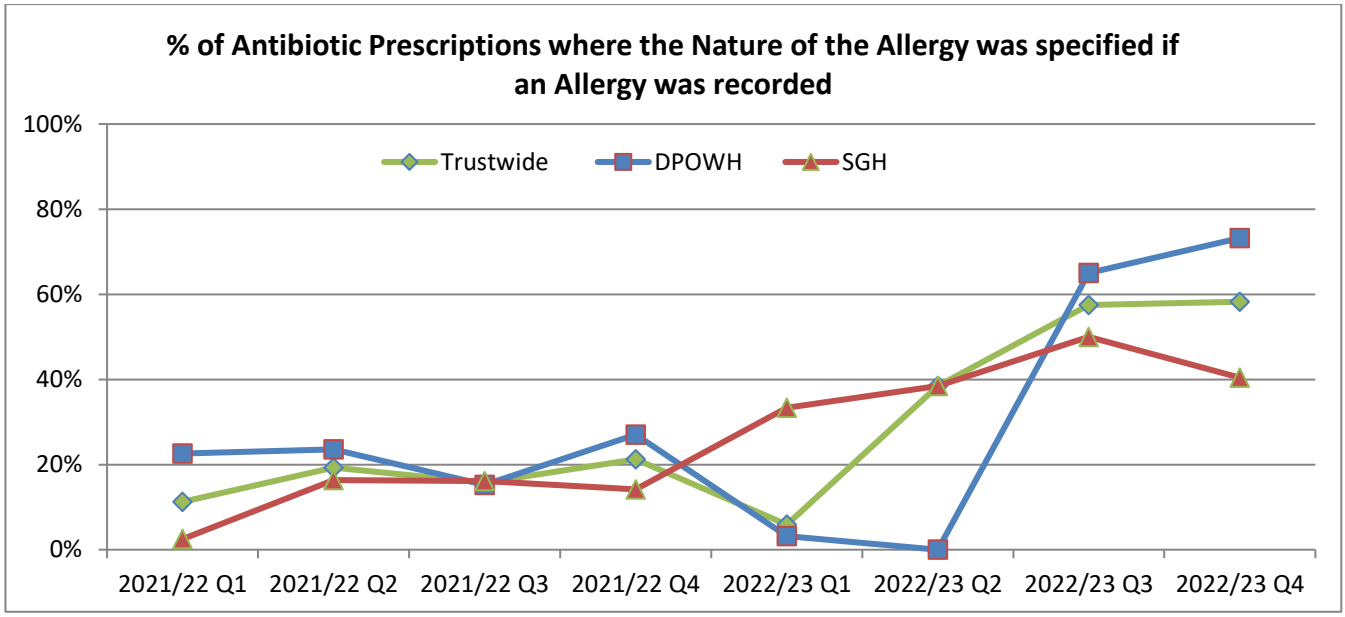
% of Antibiotic Prescriptions where the Allergy box was completed

Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	100.0%	100.0%	100.0%
2021/22 Q2	93.2%	94.6%	92.2%
2021/22 Q3	95.7%	92.9%	98.0%
2021/22 Q4	96.5%	94.6%	99.0%
2022/23 Q1	94.4%	93.9%	100.0%
2022/23 Q2	96.6%	Not Available	96.6%
2022/23 Q3	92.2%	95.2%	89.2%
2022/23 Q4	97.1%	95.5%	99.0%



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

Year & Quarter	Trustwide	DPOWH	SGH
2021/22 Q1	11.3%	22.6%	2.5%
2021/22 Q2	19.3%	23.6%	16.3%
2021/22 Q3	15.7%	15.2%	16.2%
2021/22 Q4	21.3%	27.0%	14.1%
2022/23 Q1	5.9%	3.2%	33.3%
2022/23 Q2	38.5%	Not Available	38.5%
2022/23 Q3	57.5%	65.0%	50.0%
2022/23 Q4	58.3%	73.2%	40.4%



National work

- Participation in TEACH study
- NHS benchmarking presentation
- World Antimicrobial Awareness Week
- Networking with organisations within the region
- Participation in national surveys

Other activities:

- NICE compliance
- Chair of regional Antimicrobial group
- Feedback quarterly to YCP group
- Raised the profile of antimicrobial stewardship
- Stewardship rounds
- Local UTI (Urinary Tract Infection) audit – results and actions fedback at relevant forums
- Continuing antimicrobial surveys – providing data on the prescribing of antimicrobials within the organisation
- Support the OPAT (Out patient antimicrobial therapy) pilot – this has been successful and the Trust are now looking at expanding the service

Investing in innovation, supply and access to tackle AMR

Action	Status
Continually assess suitability of new antimicrobials for inclusion on Trust formulary	Green
Introduction of Microguide to improve accessibility/compliance to Trust guidelines and improve stewardship	Green
Continue to support national research projects on new diagnostic or treatment strategies	Amber
Support the introduction of new laboratory technologies eg. MALDI-TOF to improve prompt and appropriate treatment, as and when this technology becomes accessible for routine clinical use.	Amber

Trust strategy and ambitions action progress:

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

Actions	Status
Continue to develop strategies to reduce overall consumption of broad-spectrum antibiotics in line with national targets where possible.	**Green**
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	**Green**
Continue to audit compliance against guidelines to ensure appropriate choice and dose prescribed. Feedback results to antimicrobial steering group, infection control committee and medicines and therapeutics quarterly	**Green**
Continue to use antimicrobial reduction and usage report to facilitate improvements in antimicrobial stewardship	**Green**
Reduce inappropriate duration of antimicrobials through effective stewardship programme.	**Green**
Reduce unnecessary prescriptions for antimicrobials through effective stewardship programme.	**Green**
Continued collaboration with regional antimicrobial pharmacists through regular network group meetings and email group to ensure shared good practice	**Green**
Regular review and implementation of national stewardship programmes and pathways for secondary care.	**Green**
Ensure electronic prescribing supports stewardship to track prescribing rates and guidance compliance	**Green**
Continue to review antimicrobial stock on clinical areas to ensure prompt administration of antibiotics for acute infections.	**Green**
Continue to monitor antimicrobial stock shortages and develop action plans to ensure optimal patient care when continuous supplies affected.	**Green**
Regular audit and feedback on 24-72 hour antibiotic review to reduce extended use of broad spectrum antibiotics.	**Green**
Regular review and implementation of national guidelines for specific infections e.g. treating uncomplicated urinary tract infections.	**Green**
Ensure data is submitted as required for the Antimicrobial related *CQUIN*. Progress to be reviewed at the Antimicrobial Stewardship Group meetings.	**Green**
Facilitate education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses	**Green**
Continue to support OPAT	**Green**

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 can be quickly printed off by staff as required as well as quick reference guidance on 'how to' manage patients with infections.

Preventing infection

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

These measures include:

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

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 3 years allowing early detection of COVID-19 cases and other pathogens.

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

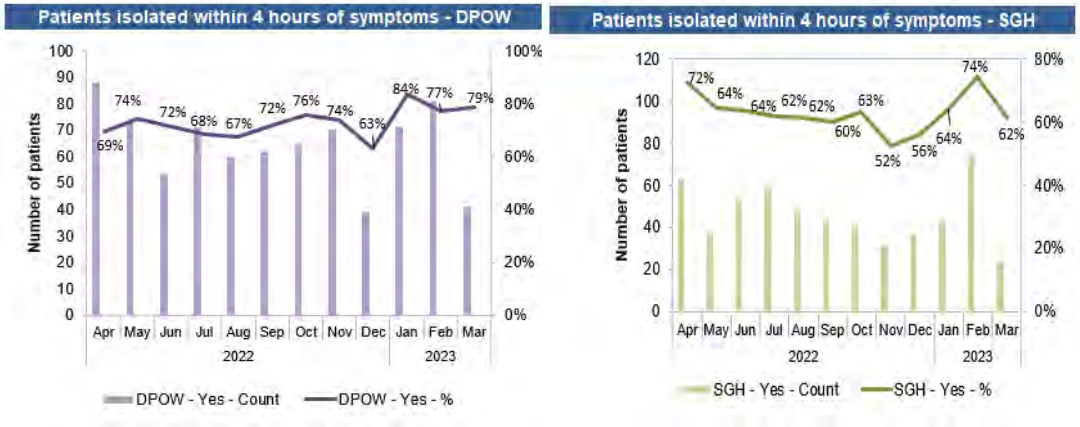
The bulk of MRSA isolates come from routine wound swabs and from swabs taken specifically to look for the presence of the organism (screening swabs). Most patients, from whom the organism is isolated, are not infected but rather merely colonised, i.e., harmlessly carrying the organism. Patients requiring 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. Once again with surges of COVID-19 and other respiratory viruses i.e., Influenza, RSV safe isolation of patients was challenging the adoption of the redirooms certainly allowed us to minimise the overall impact. By the deployment of the

redirooms for patients with suspected or known contact/droplet infections which allowed single rooms to be used as priority for patients with unexplained diarrhoea and/or vomiting.

FIGURE 13 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.

Norovirus

Norovirus used to be a predominant winter pathogen. It is extremely easily transmitted between people even with excellent IPC practice. UK Health Security Agency (UKHSA) surveillance data in February 2023 showed that laboratory reports of Norovirus were 77% higher than the 5-season average for the same period prior to the COVID -19 pandemic. Prevalence in the community was high during the winter of this report period which was reflected in Care Home outbreaks and number of inpatients/outbreaks in our hospitals.

Winter Picture 2022 -2023

As can be seen the number of COVID cases escalated again during the winter. Omicron variants such as BA 2L15 proved highly infectious which caused disruption not only with outbreaks but staff illness. However, since the vaccine programme has been introduced protection against severe illness has been maintained and we have seen fewer deaths and critical care admissions. 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.

As anticipated the 2022 – 2023 influenza season started early throughout the European region, mirroring the experience in the Southern Hemisphere. The combination of high inpatient numbers with influenza, COVID -19 and other respiratory viruses had a high impact on The Trust.

Improving air quality assists the prevention of outbreaks, opening windows to improve ventilation along with the use of HEPA filtration units is now common practice on the wards.

As part of the COVID strategy the use of the Redirooms were deployed to enhance the isolation capacity and continue to be utilised.

The use of fluid repellent surgical masks and FFP3 masks was encouraged for clinical staff managing COVID, affluenza 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 was supported by an external provider and clinical practice facilitator team and worked well helping to maintain the 2-year cycle of fit testing requirements.

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. The winter period brought outbreaks of all 3 viruses with numerous patients with dual viruses resulting in challenging management decisions.

FIGURE 14 WARDS AND BAYS CLOSED FOR OUTBREAKS OF CONFIRMED COVID-19, INFLUENZA, NOROVIRUS, D&V

FIGURE 15 NLAG COVID-19 OUTBREAK DATA

Measures implemented to assist with the management of Respiratory Viruses i.e., COVID-19, Influenza, RSV.

	As part of the ongoing surveillance the IPC team will continue to undertake monitoring to ensure staff were complying with best practice in PPE management.
	Throughout the year the team used carbon dioxide (CO_2) monitors to help identify poor ventilation, which increases the risk of transmission of infections from person to person. People breathe out CO_2 and if it builds-up in a space, it can show that ventilation needs improving. The amount of CO_2 in the air is measured in parts per million (ppm) and a consistent CO_2 value of below 800ppm indicates that an indoor space is well ventilated. Monitoring in areas such as large ward bays, clinic waiting areas allowed opportunities to advise on mitigating actions, examples: Recently, the team monitored the waiting room in SDEC at Grimsby, due to concerns regarding the high number of patients regularly sitting in the room. Readings were taken at different times of the day and showed a consistent value of over 800ppm – averaging over 1000ppm. Simple actions were put in place; a window was opened slightly and a HEPA filter (Air Purification Unit) was placed in the room. Regular monitoring of the area now shows values of between 410 and 600ppm. A five-bedded bay on a medical ward was also monitored and was consistently showing average values of 950ppm, despite a HEPA filter already in use. The outer filters were found to be very dusty – they were cleaned, and along with a window opened slightly, the regular values are now averaging 490ppm
	The Trust purchased a number of air filtration units during the pandemic, and these are in continuous use. These help to reduce the number 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.

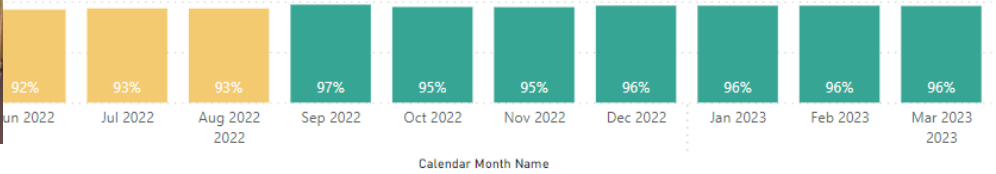
6. Ensure that all care workers are aware of their responsibilities in preventing and control of infection.

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.

Isolation Facilities



The infrastructure of the Trust continues to pose a challenge in the number of isolation facilities available. During the pandemic Redirooms were purchased and are still used to maximise isolation facilities. As part of the estate's strategy, future building projects/refurbishments continue to take into consideration IPC requirements including enhanced ventilation. This helps the Trust prepare for the IPC infection challenges including future waves of COVID – 19. Adequate mechanical ventilation is now seen as being essential to help mitigate the risk of airborne pathogens to help protect patients and staff. We do not have this functionality widespread within the Trust, as such we rely on the use of HEPA filtration units. The opening of Ward 25 at SGH with 14 ensuite rooms, followed by the new Emergency Departments (ED's) at DPOW and SGH has helped greatly – providing excellent ventilation, isolation facilities and within the ED's, spacious waiting areas. The plans for the new admission wards later in the year, early 2024 will also lower the transmission risk of pathogens by providing excellent ventilation and isolation facilities.

7. Secure adequate access to laboratory support as appropriate.

Microbiology Laboratory (report by Nick Duckworth Laboratory manager)

Overall activity levels as reported monthly appear stable but obscure the fact that the Covid-19 PCR work has fallen dramatically over the last 12 months to about 5% of 2021-22 figures by March 2022 following the national guidance for testing issued by DHSC at the end of March 2022 whilst business as usual work has rebounded considerably by about 9% against last year with acute and primary catching up on delayed activity and activity as a consequence of delayed interventions.

Lincolnshire TB Service and NLAG Respiratory Teams have had significant backlogs of patients requiring TB serology as a result of Covid-19 and the former, major screening of industrial and community locations, leading to an increase of 15% in QuantiFERON TB testing against 2021-22. This in turn with a positivity rate of 12-15% means an increase in mycobacterial microscopy and culture investigations with 25% increase over 2021-22 but only 2% over pre-pandemic activity, but this is expected to increase as a result of national and local socio-economic pressures as well as a consequence of poor health post-Covid-19 infection and delayed intervention. This does point to a need for some in-house rapid molecular testing availability for TB to assist management, as well as drug-resistance Polymerase Chain Reaction (PCR) testing as we have a significant population in Lincolnshire who are a risk for multi-drug resistant TB (MDT TB).

Other areas showing significant increase are urine microbiology, Helicobacter faecal antigen and fungal culture, the latter due mainly to the reimplementation of the superficial mycology service by the directorate to users, but also increased systemic fungal infections, already on the rise pre-pandemic but being driven by patients post-Covid infection, and is why the directorate has been asked by the Microbiology Consultants to try and bring fungal marker testing in-house to reduce delays to results enabling them to support patient management and antimicrobial prescribing more effectively.

Teicoplanin assay requests have continued to increase since an attempt to repatriate this assay 3 years ago and have doubled making this another objective for the coming year both in terms of supporting current testing levels, and future predicted increases in prescribing if we are able to improve the turnaround time.

Activity from the sepsis pathway is expected to rise as trust are required to implement the national guidance for blood culture collection to laboratory receipt, reporting times and monitoring of blood fill. This has delayed the blood culture tender as these additional requirements need to be discussed and included. The sepsis pathway also requires rapid antimicrobial susceptibility testing to support rapid identification, Matrix -associated laser desorption ionization (MALDI) and rapid meningitis PCR testing so these will form part of the new directorate objectives – fungal marker testing is also an element of the sepsis pathway, so that the directorate can work towards the trust sepsis objective on several inter-related but manageable projects.

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

Reference	TITLE OF DOCUMENT	REVIEWED
IC/OP/Pol/015	Additional Precautions	19/04/2022
IC/OP/Pol/016	Decontamination of Medical Equipment Prior to Inspection, Service or Repair	19/04/2022
IC/OP/Pol/038	Viral Gastroenteritis	19/04/2022
IC/OP/Pol/046	Cleaning of Wards Following Closure due to an Outbreak of Infection	19/04/2022
IC/OP/Pol/052	Standard Universal Precautions	19/04/2022
IC/OP/Pol/005	Surveillance Policy	29/06/2022
IC/OP/Pol/012	Control of Varicella Zoster Virus	25/08/2022
IC/OP/Pol/034	Hand Decontamination Policy	25/08/2022
IC/OP/Pol/004	Isolation Policy	26/08/2022
IC/OP/Pol/005a	Notification of Infectious Diseases - metro button on IC Hub Main Front Page	01/09/2022
IC/OP/Pol/005b	How to Notify CCDC - linked from metro button on IC Hub Main Front Page	01/09/2022
IC/OP-SI017	IC Summary Information - Dealing with Waste at Ward/Department Level	21/02/2023

6. 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 the 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

Almost 9000 members of staff have undertaken some form of IPC training which is a significant increase from last year.

TABLE 7 TRAINING UNDERTAKEN

Aug 2023	Column Labels			
Row Labels	**No**	**Yes**	**Grand Total**	
208|LOCAL|Antimicrobial Stewardship|	183	2088	2271	92%
NHS|CSTF|Infection Prevention and Control - Level 1 - 3 Years|	22	861	883	98%
NHS|CSTF|Infection Prevention and Control - Level 1 - No Specified Renewal|	17	1455	1472	99%
NHS|CSTF|Infection Prevention and Control - Level 2 - 1 Year|	626	3672	4298	85%
Grand Total	**848**	**8076**	**8924**	**90%**

Community & Therapies Services Infection Prevention and Control Annual Report 2022-2023

Information provided by Mandy Hill IPCN

Overview

2022/2023 has seen so many changes coming back to normality from Covid 19. We stopped completing BAF (Board Assurance Frameworks) in May 2022 which feels like a lifetime away. The taking down of the Covid 19 Swabbing tents in the grounds of the car park near Global House and changes to 'when to take' covid swabs has constantly changed throughout the period of the annual report. National Guidance has been followed regarding advice on mask wearing, and at times (based on local and regional Covid figures) gone above and beyond to protect staff and patients.

Community staff have excelled at facing the challenges in the community, as staff shortages, and staff covid clusters/outbreaks has added to the extreme pressure to make our patients safe and well cared for.

Major changes have occurred to the Community Infection Prevention & Control (IPC) team during this period April 2022-March 2023.

Our Senior Nurse/Deputy Director of Infection Prevention and Control retired May 2022 and the Infection Prevention lead at the time stepped up to cover his role, she has provided excellent support and advice to the Acute and Community teams. Subsequently, we have a new Deputy, Director of Infection Prevention & Control in post who commenced her position in March 2023.

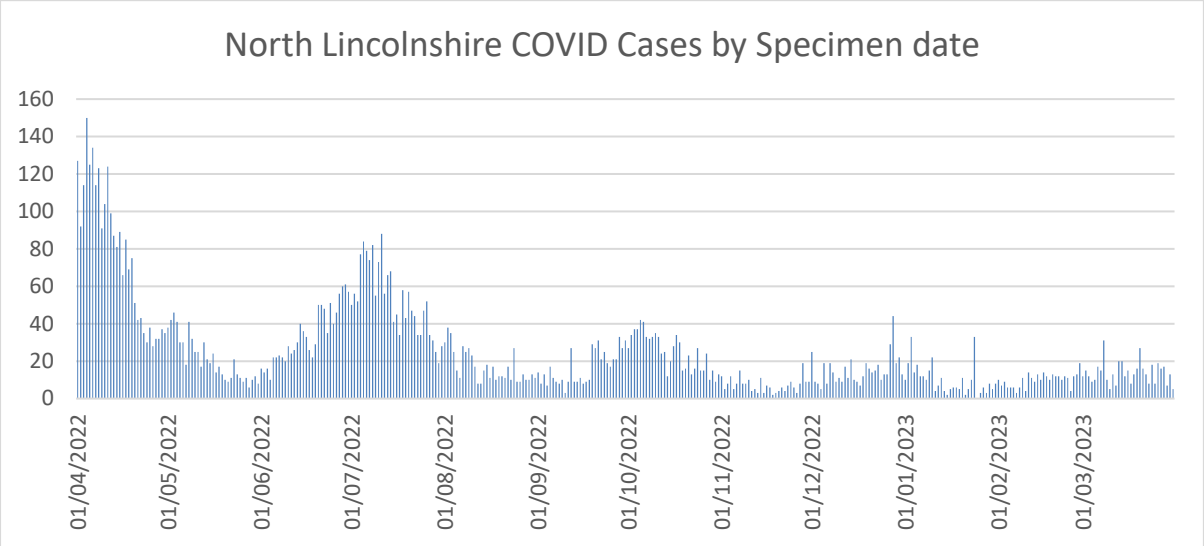
At the start of 2022-2023 the Community IPC Team consisted of a 0.6 wte Band 6 Community staff nurse and a 0.8 wte Band 3 AHCA. Since September 2022 the staffing reduced to a 0.6 wte Band 6 IPC Community staff nurse due to a team member leaving her post. To mitigate the short fall in community staffing, Goole Hospital is now covered by the NLaG Acute team since October 2022.

Lindsey lodge remains part of the Community IPC Team.

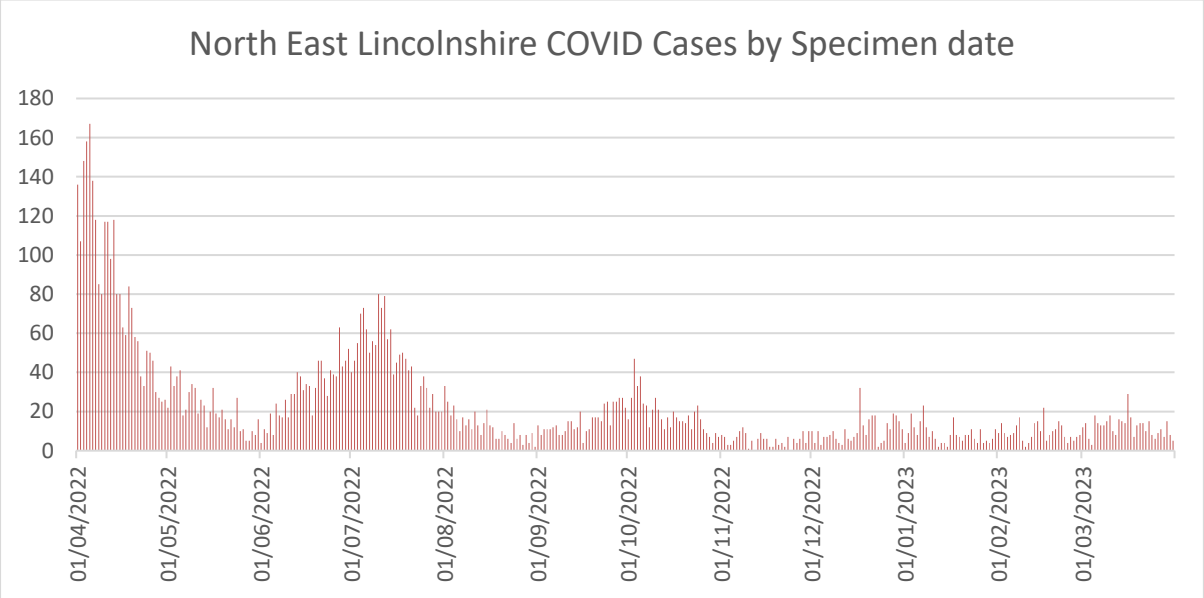
The community IPC team and NLaG acute team work closely together and additional administration and searches are undertaken, and cover provided at times to the acute service when needed to ensure patient safety is not compromised.

In our region the Covid 19 positive figures fluctuated throughout the year. Please see below the monthly covid positive cases throughout the period from April 2022 – April 2023 which shows where the peaks and troughs and spikes in numbers occurred.

Cases in North Lincolnshire



Cases in North East Lincolnshire



As of May 2022, Covid 19 became another respiratory disease and 'learning to live' with Covid commenced. Due to the vaccine those who contracted covid were provided with antibodies to help fight against covid, thus reducing the severity of the virus. Those with comorbidities and multi-morbidities including those immunocompromised remained vulnerable.

Staff were undertaking LFT tests twice weekly, and reporting the results via the Government Web site to help reduce the transmission of the virus, as some positive cases had no symptoms at all. The Contact Tracing App was alerting those in the wider Community to possible risk of contracting the virus.

National Guidance information from the Government changed throughout the pandemic based on current scientific information at the one given time, thus numerous amendments and advice changes have been made throughout the year regarding PPE, Isolation, duration advice, 'shielding' of extremely vulnerable patients, and home working.

Staff were encouraged to book Covid19 booster jabs and Flu jabs in October 2022, as vaccination remained the primary protection measure against Covid 19 and Flu. Mask wearing was reviewed every few weeks and the decisions based on local Covid 19 figures.

Surveillance organisms

Table below shows Alert Organism figures for the period April 2022- March 2023. The arrows indicate if increase or decrease from the previous year. There are no target figures set for MSSA at present.

Comparison of North Lincolnshire performance against CAI surveillance organisms for 3 years

Organism	2020/21	2021/22	**Target for 2022-2023**	**2022/23**
	Performance	Performance	Target	Performance
MRSA	0 ↓	2 ↑	**0**	**0** 2↓
C.difficile	10 ↓	6 ↓	**22**	**21 0** →
E.coli	125↓	48 ↓	**115**	**128 4**↑
MSSA	31↓	10 ↑	**No target set**	**27** 15↓
P. Aeruginosa	7	12 ↑	**13**	**9 10**↓
Klebsiella spp.	30	9 ↑	**31**	**33 6**↓

Audits and findings

Board Assurance Framework (BAF) Covid risk assessments ceased in May 2022

Hand hygiene (HH) observations continued to be recorded electronically through Web V. Staff were asked to undertake 10 observations per month, if possible, in their areas. However, it is recognised that staff with one or two staff within their teams are unable to undertake this.

The data from HH audits are inputted through Web V and exported through Power BI via the dashboards. The audits are required to provide assurance that HH is being undertaken with correct technique and BBE compliance.

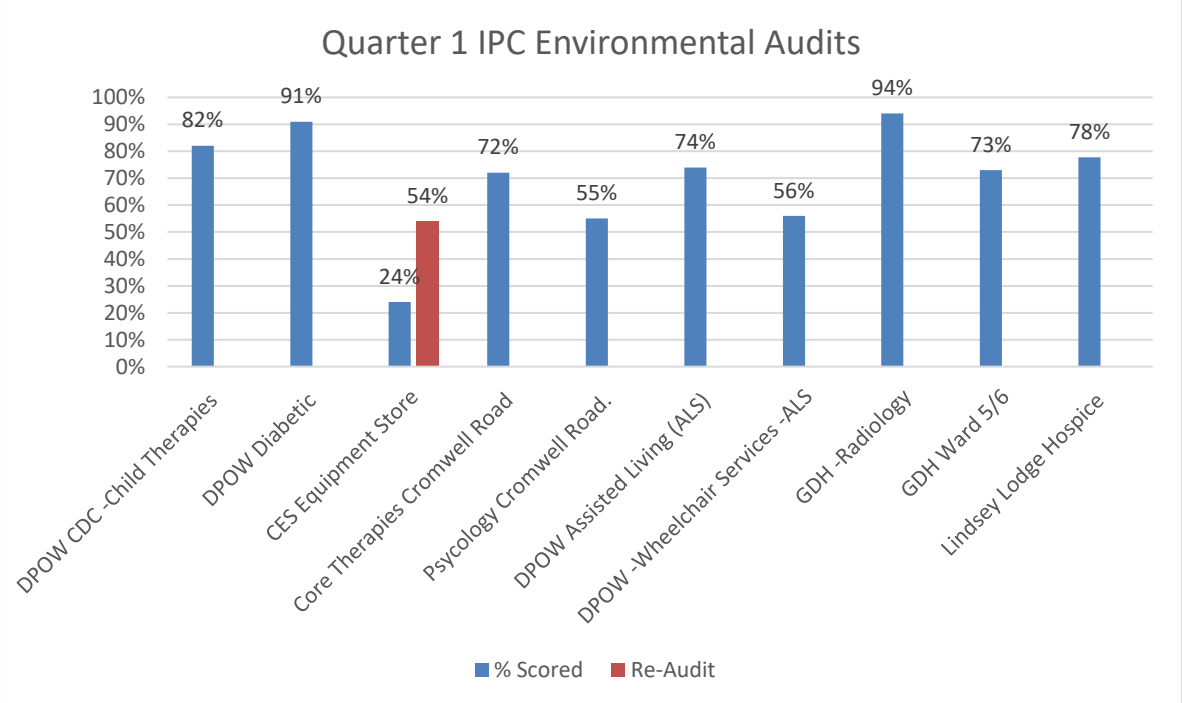
Infection Prevention & Control (IPC) Environmental Audits

The community IPC Team undertook 45 IPC Environmental Audits throughout 2022-2023 which is broken down into quarters, and 2 reviews of premises.

RAG Rating Key (as per Audit tool)
Green 92 - 100%
Amber 82 - 91.9%
Red 0 - 81.9%

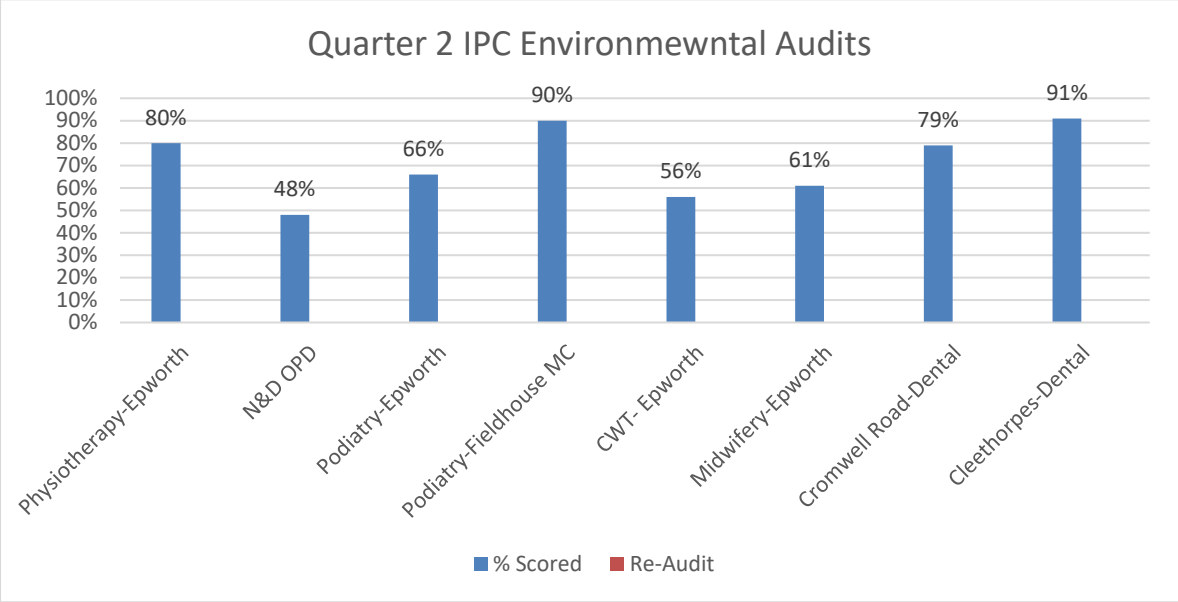
Quarter 1 April – June 2022

10 IPC Environmental Audits were undertaken, 1 re-audit, and a review of Global House. Goole Hospital was part of the Community IPN's remit during this period and Lindsey Lodge Hospice.



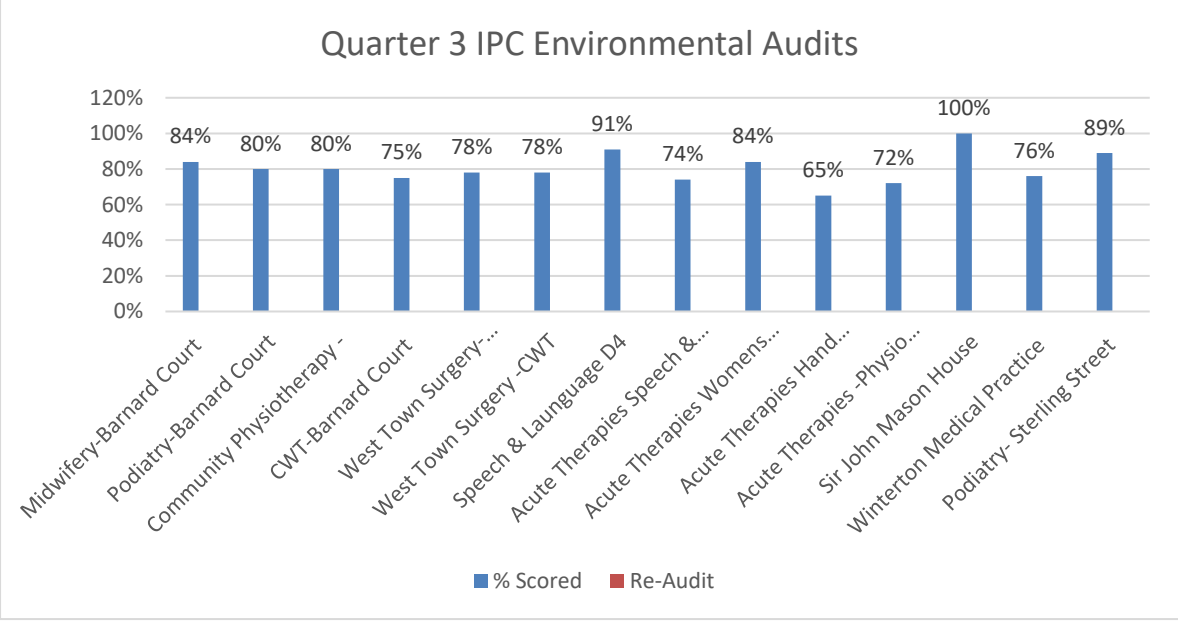
Quarter 2 July- September 2022

8 IPC Environmental Audits undertaken.



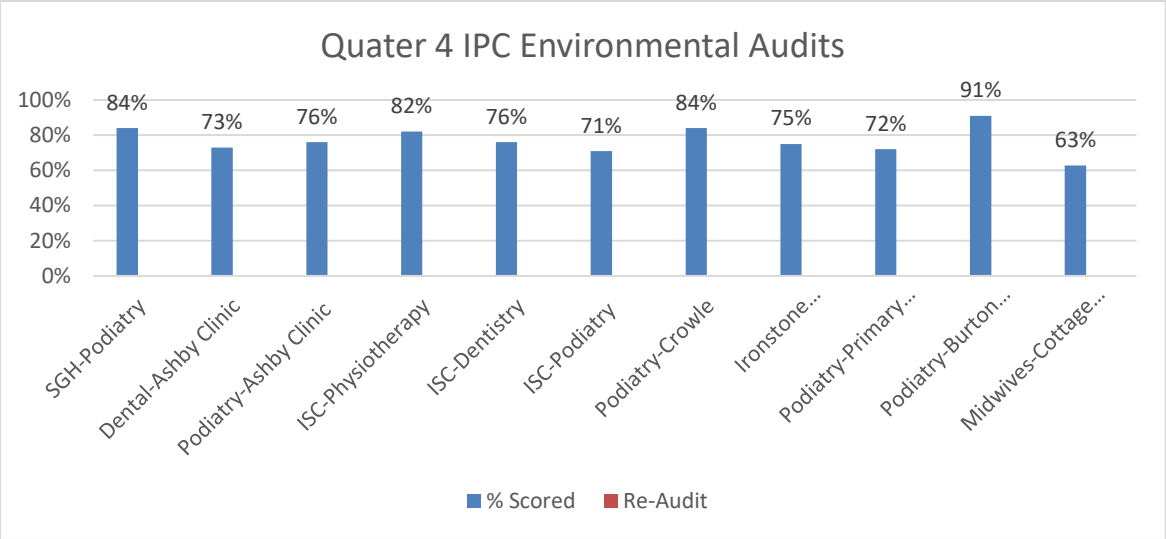
Quarter 3 October-December 2022

14 IPC Environmental Audits undertaken and 1 review on a temporary premises at Water's Edge Visitors Centre, Barton.



Quarter 4 January -March 2023

12 IPC Environmental Audits were undertaken. However, the graph will show 11 as CWT and the Continence Service audits were amalgamated as they use the same rooms and the findings sent out to both services.



Themes from the audits

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

- Environmental issues with walls damaged, flooring stained and the skirting coming away from the wall, ceiling tiles stained and require repair.
- Dust – high and low dust found on visits. (Bases of couches dusty)
- Boxes/items stored on the floor.
- Missed opportunities of Hand washing
- Staff not compliant with Bare below the elbows.
- Inappropriate items on the sink, soap not in brackets on the wall and some soap out of date.
- Areas needed decluttering (and general tiding) making cleaning areas more accessible.
- Blinds not made od impervious material.
- Inappropriate items kept under the sink, mugs, food items.
- Disposable curtains out of date/no date.
- Temporary closure mechanism not utilised on Sharps contains/bins.
- Rust on some patient equipment. i.e., trolleys.
- Rusty and broken on pedal bins.
- No Blood spillage poster in the area.
- Ceiling tiles damaged.

It has been recognised that IPC environmental audit has flaws and a bias to the community areas, as it is the same audit criteria which applies to the Acute setting within the hospitals. Plans to review the community audit is proposed based on this finding.

Areas of Concern/Improvement

Central Equipment store

The Central Equipment store (CES) has been identified as not fit for purpose, as the decontamination area is not enclosed; this is an historical issue believed to be on the Risk register. Although this is an area of concern, improvements have been made.

Barnard Court Facilities

This is a Rotherham Doncaster and South Humber (RDaSH) building. The patient and staff toilets at Barnard Court, Brigg are in a shocking state and require attention. It has been escalated through NLaG to RDaSH property services.

The Chronic Wound Team share the same room as the Midwives which is not recommended by IPC; it is mitigated by essential cleaning of the room after each service use. Plaster was missing from the wall in this room, which posed as additional infection risk, but pleased to report this issue has been rectified. The outside waste was not in a secure area on a previous audit: it is now fully secure, and no public access can be gained.

Midwives at Cottage Beck

The building has had some environmental improvements in the rooms. There was an issue with rats which has now been resolved.

The Acute Therapies SGH

Major improvements have been seen to the walls and kitchen area within the department.

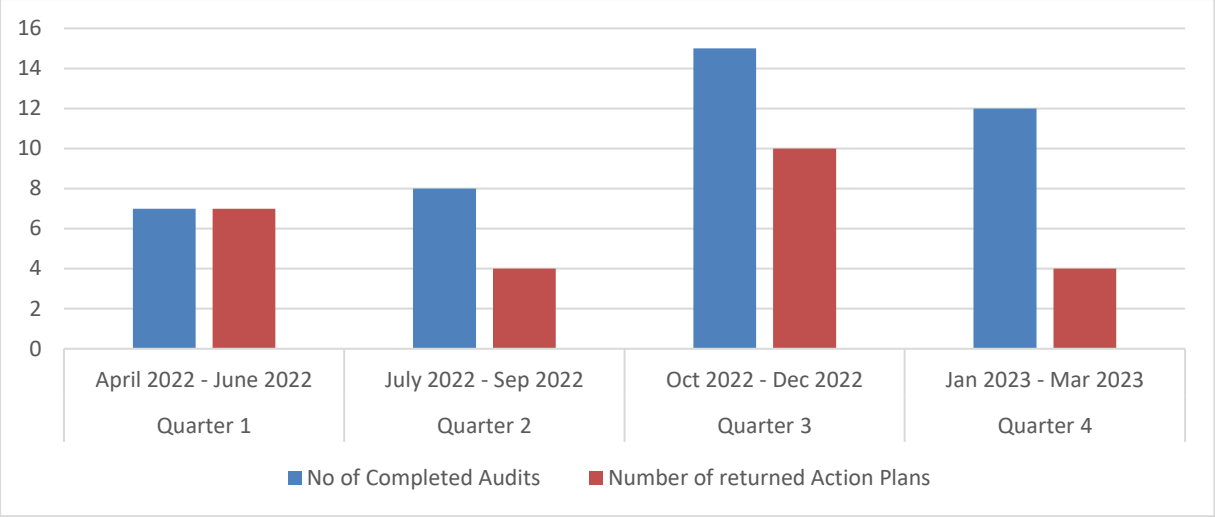
Audit Action Plans

Areas audited were asked to submit their Action Plan for improvement within a 6-week period.

The responsibility was issued to one person if electronically populated. Some areas have been manually populated and a percentage calculated. This is because of the drop-down boxes on the HUB. The drop-down boxes for the community audits were to be reviewed with the Data analyst, however she left her position in August 2022 before this was completed.

Number of returned Action Plans

In quarter 1 Lindsey Lodge's audit was completed, and two areas at Goole, these areas will be removed from the graph for Action plan returns as Goole Hospital is now covered by the Acute Team and Lindsey Lodge is separate from NLaG Community and Therapies. One Action plan returned by CES as improvements were required by the initial audit. Crowle Surgery not included.



Information

Podiatry Service at Crowle

The podiatry service at Crowle has been stopped and patients re-directed to Epworth. Unfortunately, after an IPC Environmental Audit the owners of the building withdrew use of the facility/room within the GP Surgery

Lindsey Lodge Support

IPC support to Lindsey Lodge Hospice continues as per service level agreement between the two Organisations.

Speech and Language Barton

Staff at Barton went above and beyond to ensure patient services continued for their patients due to unforeseen circumstances at their premises in Barton (these could no longer be used due to fire damage) Staff rallied to find a temporary premisses to provide the Speech and Language service for children in their care. Community staff worked multi-professionally to allow this to happen at Waters Edge Visitor's centre.

Covid Swabbing Teams

Covid Swabbing teams/tents were decommissioned in July 2022.

Activity and Engagement/Education

Mandatory Training

Face to face mandatory training continued to be postponed at the beginning of the year but has gradually come back into the training programme.

Community & Therapy Link Practitioner Forum

There was no IPC Link practitioner forum this year, or Bugs R Us due to the Covid 19 pandemic.

Link Practitioner Study Day

A 'face to face' link nurse day took place at Global House on 17th October 2022.

Glow Box HH Training

Due to the extreme pressure's community staff were under at Global House the offer to have annual hand hygiene glow box training was postponed. Pens and sweets left with the staff present.

Annual Hand Hygiene practical assessment should have been undertaken for all Community & Therapy staff and inputted onto the Oracle Learning Management system (OLM).

FIT Testing

Throughout the period April 2022- March 2023 a permanent reminder to all staff was submitted through the monthly governance highlight report for staff to be FIT tested. It was recommended that staff be FIT tested on two types of masks due to supply issues. The onus was put on staff to know which masks they passed on (make and model number) as this was essential information. If any changes to facial structure, for example losing weight, dental extractions altering facial shape or facial accidents they would need to re FIT tested.

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
NLAG	Northern Lincolnshire & Goole NHS Foundation Trust
TB	Tuberculosis
DHSE	Department of Health & Social Care

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Ellie Monkhouse, Chief Nurse
Contact Officer/Author	Victoria Thersby, Head of Safeguarding
Title of the Report	**Safeguarding & Vulnerabilities Annual Report**
Purpose of the Report and Executive Summary (to include recommendations)	This Annual Report provides an overview of the national and local context of safeguarding and vulnerabilities and associated agendas related to adult and children safeguarding, and vulnerability agendas. The report highlights the key performance activity and informs the Trust Board of how its statutory responsibilities are being met and of any significant issues or risks and how these are mitigated. We have achieved a significant number of our priorities this year and re-prioritised our objectives for 2023-2024, and in line with our Safeguarding and Vulnerabilities Strategy 2022-25. Several of our priorities for 2022-23 were not taken forward last year due to competing priorities and reviewing other ways of implementing them. Rather than a separate supervision strategy for adults we will look to include this in the clinical supervision policy. Our journal club for children was paused due to operational pressures. Following Maternity leave we will commence the transition work in January 2024. Oliver McGowan training has not been implemented due to the complexity in relation to the delivery of it we continue to work with the ICB (Integrated Care Board) to overcome these. We have met all our priorities in relation to Prevent, MCA (Mental Capacity Act) and DoLS (Deprivation of Liberty Safeguards). Integration of both Safeguarding and Vulnerabilities teams has provided opportunities to work collaboratively on a number of complex cases to support colleagues in providing a holistic quality service that both can prevent safeguarding concerns arising and monitor ongoing concerns and embed our' Think Family' approach and 'Make Safeguarding Personal.' Some of our key achievements are: • Our continued contribution across partnership arrangements in East Riding, North and North East Lincolnshire to engage and work collaboratively to safeguard children and adults • Reviewed the NHS Prevent Training Competencies Framework 2022 and remapped staff to an additional level of training • We have seen increased activity and contacts in our safeguarding adults team and developed a process to share the outcomes of safeguarding referrals made by staff on WebV • We have recruited an additional Learning Disability Nurse

	• Undertaken 295 ward rounds averaging 5 per week, ensuring we have been able to support more vulnerable patients this year • Our Transition Business Case was approved to recruit a Lead Nurse for Transition • Develop and began our Quality Improvement project for MCA DoLS • In both our Children Looked After Teams 100 % of development checks were completed • Our Level 3 safeguarding children and adult training has remained below trust target (53%-59%), and further reviews of groups of staff has been undertaken. This training has now recommenced face to face with online top up for children and worksheet for adults to improve compliance • The Launch of our Carers Strategy has been recognised at national level at the National Carers Support Service Conference by a local lead regarding the work completed in the hospital • Implemented Child Protection Information Sharing System (CP-IS) in inpatient paediatric wards for direct admissions, and further embedded this in the Emergency Department and Unscheduled Care Setting with a Standard Operating Procedure. Our established database for children identified themes, patterns and trends of attendances of Children and Young People • Since the Government has announced the delay to the implementation of the Liberty Protection Safeguards beyond the life of this Parliament, it is not clear whether the next Government will see this as a priority. We have paused our meetings and completed extensive work in preparation • This year MCA is a Trust key priority and a QI project has been developed. This will build on our oversight and quality assurance mechanisms in the team of MCA/BI (Best Interest) Tool and DoLS applications Our strategic priorities for this year include embedding the NHS Charter for Sexual Safety in the NHS, this will form some of the work supporting meeting the Serious Violence Duty and our success in obtaining a DA (Domestic Abuse) Strategic Lead though funding from Pathfinder Project will support the Trust in leading its work in relation to DA and supporting victims including staff. This paper has been considered at the Quality and Safety Committee and a discussion regarding differences in referral procedures for safeguarding adults and children to different local authorities. For adults this highlighted that North Lincolnshire has a lower threshold for accepting referrals (more accepted) than North East Lincolnshire Local Authority. This is not indicative of having more safeguarding concerns at one site but how the Care Act is interpreted. The team work closely with each local authority to manage this on a daily basis.

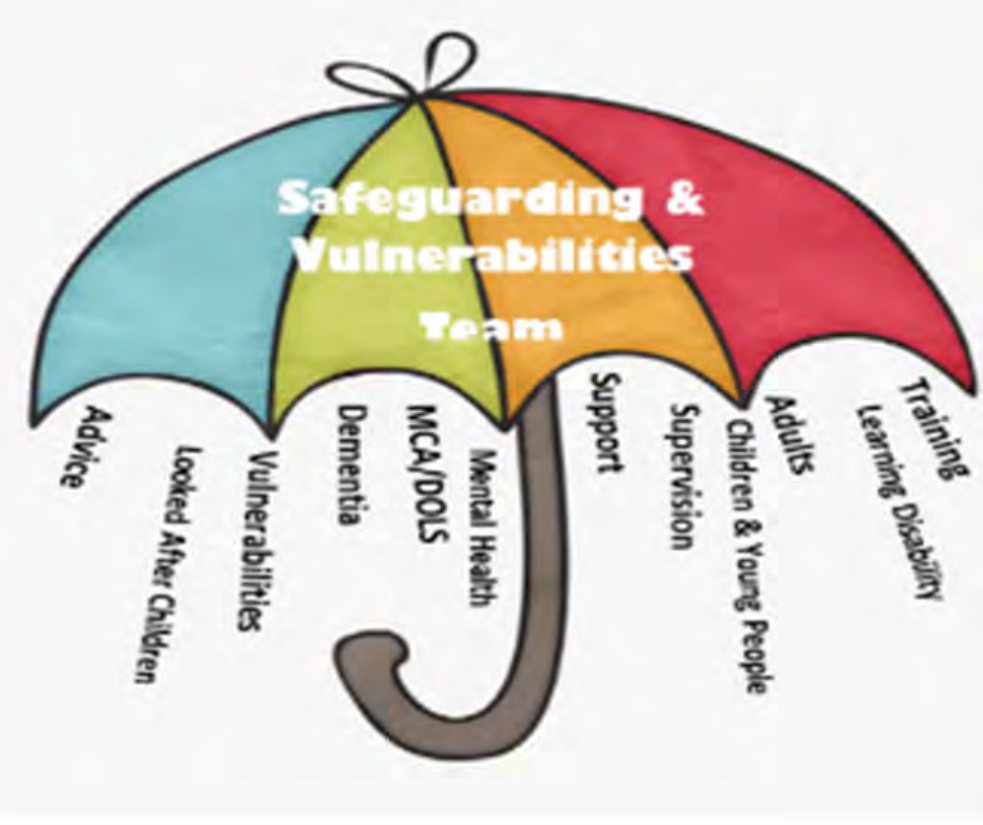
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: Quality & Safety Committee
Which Trust Priority does this link to	☐ Our People ✓ Quality and Safety ☐ Restoring Services ✓ Reducing Health Inequalities ☐ Collaborative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

Safeguarding & Vulnerabilities Annual Report 2022 - 2023



Kindness · Courage · Respect

Foreword

Safeguarding is a statutory responsibility of all NHS organisations. In order to uphold this responsibility we must work with our staff, our patients, and their families and our external partners.

Our 2022-2023 Safeguarding and Vulnerabilities annual report highlights our achievements and plans in preparation for the coming year.

Our vision: to be a safe organisation that ensures safeguarding is everyone's business, by working holistically together to safeguard the most vulnerable in society.

Our mission: to provide an exceptional service in our 'think family' approach to safeguarding by working with our colleagues, our patients, and our safeguarding partners.

Ellie Monkhouse
Chief Nurse

Introduction

Safeguarding is an integral part of Trust core business and is a shared responsibility with our staff. We work together with multi-agency partners across the districts of North Lincolnshire, North East Lincolnshire and East Riding to improve lives and protect the most vulnerable in our society from harm.

Our safeguarding work across Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) is underpinned by the the Trust's core values by demonstrating our behaviours of kindness, courage and respect.

Our Safeguarding and Vulnerabilities Strategy 2022-25 links to the Nursing, Midwifery and AHP - Future 5 and Beyond Strategy; to build on our priorities so we can focus on what matters to all of us and our patients. It will help us to keep improving the care we provide and continue our improvement journey.

As part of our annual planning we will review our Trust priorities for the year.

Our approach to safeguarding is based on the 6 principles of safeguarding

- Empowerment
- Working in partnership
- Being accountable and transparent
- A culture of prevention
- Proportionality
- Protection

Throughout this report we have highlighted our key areas of responsibility and achievements.

TABLE OF CONTENTS

Our Team

Our safeguarding and vulnerabilities team are led by the Head of Safeguarding who reports to the Deputy Chief Nurse and Chief Nurse. The Safeguarding and Vulnerabilities Team and Named and Designated Professionals provide both strategic support and direction to the governance and safeguarding arrangements within NLaG, and operational advice and support to all Trust staff. The integration of our team has meant specialist vulnerabilities nurses in Leaning Disability and Dementia work closely with safeguarding nurses in the early identification of care and support needs, support trust staff to make reasonable adjustments to care and environment which in turn can prevent any safeguarding concerns arising.

Our Children Looked After Teams based at Scunthorpe General Hospital and Diana Princess of Wales Hospital co-ordinate and collaborate with our partners in the Local Authority to ensure the health needs of vulnerable babies, children and young people are identified and met.

We meet regularly at our Safeguarding and Vulnerabilities Operational Forum and Vulnerabilities Steering Group which provides information to our Vulnerabilities Board. This overarching Board sends highlight reports to the Quality Governance Group, the Nursing Midwifery and AHP Board and the Quality and Safety Committee with direct reports to the Nursing, Midwifery and AHP Board and the Trust Board.

Safeguarding Week and Campaigns

Over the last year the safeguarding team responded to requests to participate in various campaigns and national safeguarding week using various means such as department huddle/leaflet drops and promoting partnership training highlights the importance.

The power of social media/awareness sessions in department huddles/leaflet drops and promoting partnership training to highlight the importance of safeguarding and that this is everyone's business. We promote the training offered by North Lincolnshire, North East Lincolnshire and East Riding safeguarding children and adults' partnerships and ensure any learning is delivered as part of our level 3 children and adult training and within safeguarding supervision.

Some of the things we did:

- Promoted free learning sessions and safeguarding week
- Provided training on Domestic Abuse to ward managers and teams
- Distributed staff handouts to wards 'how to complete a safeguarding referral'
- Delivered training at Care Camp
- Developed and distributed our safeguarding newsletter
- Completed twice yearly Vulnerabilities newsletter
- Promoted Dementia awareness week - all ward areas provided with Dementia information pack and completed sponsored walk to raise funds for Health Tree Foundation and update ward dementia boxes
- Delirium awareness day - promoted use of the delirium care plan
- In Carers Week we launched the Carers Strategy and carers lanyards across the Trust, took part and presented at a system wide awareness session at the Baths Hall
- Learning Disabilities awareness week - promoted reasonable adjustments for patients
- Celebrated Learning Disability week and Dementia action week
- Awareness sessions delivered by the Child Sexual Assault and Assessment Unit (Anlaby Suite) in Hull
- Awareness of water safety/FLOAT campaign
- Promoted SUDIC (Sudden Unexpected Death in Infants and Children) Month
- Safer sleeping awareness
- Contribution to the paediatric conference from SUDIC nurse
- Safeguarding newsletter bi-monthly- included topics such as covered topics such as safeguarding adults' awareness, MARAC (Multi-Agency Risk Assessment Conference), LADO/ PiPoT, Safeguarding referrals and thresholds, Neglect awareness and Legal Orders
- Raised awareness of an increase in dog bites with ICB and Public Health
- Domestic Abuse information added to NLaG parking tickets

Prevent

NLaG's Prevent Duty under the Counter terrorism and Security Act (2015)requires that we work in partnership to prevent people being drawn into terrorism. To comply with this and fulfil our responsibilities we follow our Prevent Strategy Implementation Policy. This supports and safeguards those most at risk of radicalisation which is a form of exploitation.

NLaG have met its statutory responsibilities in relation to ensuring prevent training is delivered in line with the NHS Prevent Training and Competencies Framework (2022), Prevent leads are in place in the Trust and collaboratively link with our partnership and local arrangements and subsequent meetings.

Achievements

- Completed NHS England Prevent returns on time 100%
- Attendance at local Prevent awareness events
- Remapping of NLAG staff against the NHS Prevent Training and Competencies Framework 2022
- NLAG security lead now attends Community Safety Partnership Meetings
- Active member of Channel in both North East Lincolnshire and North Lincolnshire with 100% attendance
- Supported staff with Prevent referrals and awareness raising of the importance of identifying people who may be at risk of radicalisation
- All achievements met for 2022/23
- Maintained 90% compliance in training

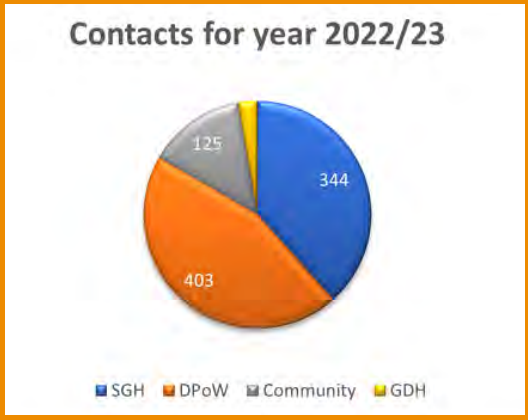
Adult Safeguarding

The Care Act (2014) provides a clear legal framework about how local authorities and other agencies should protect adults at risk of abuse or neglect. As a partner agency we fulfil our statutory, regulatory, and contractual Safeguarding Board requirements and obligations, by ensuring there are robust governance arrangements, policies and procedures, and support mechanisms in place to ensure these requirements are met.

Achievements

- MARAC referrals via WebV
- Audited our safeguarding referrals
- Worked closely with PALS (Patient Advice & Liaison Service) and Complaints Teams
- Links with Probation and the Management of Sexual or Violent Offenders (MOSOSVO), enabling flagging records and supporting wards with management plans
- Communicating the outcomes of safeguarding referrals on WebV enabling staff to receive feedback
- Development of missing/absconding meetings
- Delivered bespoke safeguarding training for specific teams/departments
- Attended key internal meetings; falls, pressures ulcers, safer medications
- Increased our number of telephone/emails requesting advice and support from the team by 137% this year
- Attended Local authority Safeguarding Adults Board and sub-group meetings

The WebV referral form enables data capture more easily. It is likely that more referrals are sent to North Lincolnshire as the Trust has a large community team and hospital locality. Staff have a good awareness of safeguarding, and the new process is well embedded.



Calls and requests for advice and support have been increasing over the year from 51 to 121 (April 22-March 23). Good indicator of Trust wide awareness of the team and recognition of safeguarding concerns.

The contacts into the team demonstrate that the biggest area of worry is neglect, closely followed by domestic abuse and self-neglect.

Section 42 allegations against NLaG

The Local Authority has a duty to make enquiries under Section 42 of the Care Act (2014) where an individual with care and support needs is experiencing, or at risk of abuse and if their care and support needs are preventing them from protecting themselves. The Trust may be asked to investigate when a patient, relative or another provider has referred a safeguarding concern to the Local Authority about abuse/neglect that an individual has allegedly suffered in our organisation. These enquiries are all logged on Ulysses and sent to the appropriate ward/department for a response.

Children and Young People

NLAG is fully committed to the principles set out in the government guidance 'Working Together to Safeguard Children (2018), The Children Act (1989/2004) and to jointly work with both North Lincolnshire Multi-Agency Resilience and Safeguarding Board (MARS) and North East Lincolnshire Safeguarding Children Partnership. NLaG works closely with our neighbouring local authorities in North and North East Lincolnshire, East Riding and Lincolnshire.

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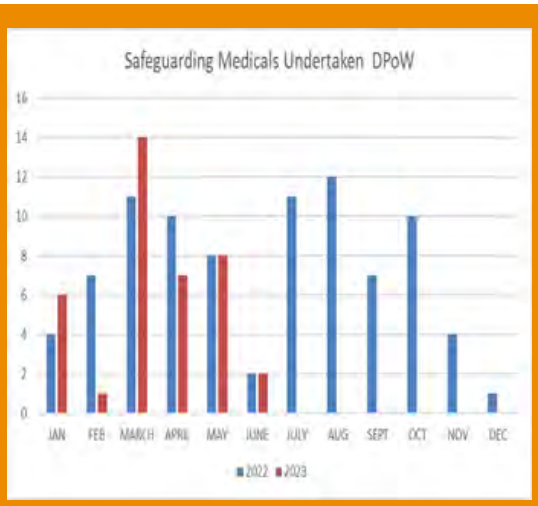
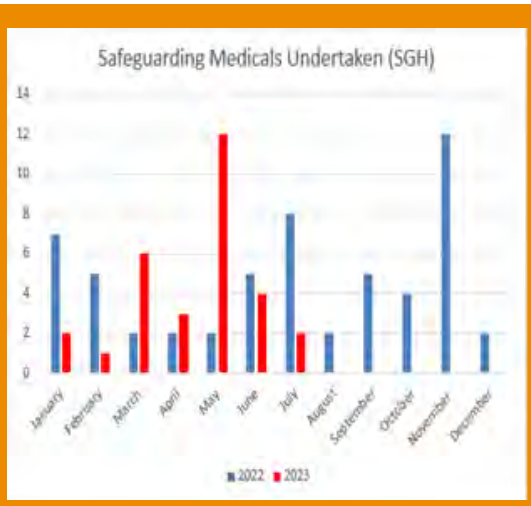
Our policies are linked and aligned with multi-agency policies and procedures and our safeguarding responsibilities are effectively discharged by the provision of day-to-day advice, supervision, support and promoting good professional practice. This includes identifying the training needs of all staff and volunteers in relation to safeguarding children and delivering a comprehensive mandatory programme of training, which includes key safeguarding messages from research, safeguarding incidents, and safeguarding children practice reviews/learning lessons reviews and lines of sight.

Achievements

- Continue to benchmark NLaG against the RCPCH standards for safeguarding paediatric medicals and support the action plan development
- Embedding the Child Protection Information Sharing (CPIS) System in ED and UCS implemented a standard operating procedure
- Improved and developed Paediatric liaison data bases which enable the team to identify themes and trends
- Collaboratively worked with NLaG legal team with complex cases
- Collaboration with North Lincolnshire Integrated Care Board updating the MARS board 'Perplexing presentations and FII guidance' in line with the RCPCH guidance
- Collaborative working with Safer NEL to update multi-agency policies for discharge planning, Safer Sleeping, Section 47 enquiries and Social Work assessments and child sexual abuse
- Monthly peer reviews for children who have had child protection medicals
- Provided updates in relation to increased number of dog bites
- Developed meeting templates in Web V for community and paediatric meetings
- Team induction booklet for staff who attend and present at MARAC
- Reviewed the Failure to be Brought Policy
- Rolled out CPIS in paediatrics for unscheduled attendance
- Attendance at regular paediatric peer review meetings at each site by the safeguarding team
- Updated Parent/Carer Child Protection medical information leaflet





This has identified both sites an increase in safeguarding medicals for children for physical harm.

There has been a steady increase in the number of referrals made to children's Social Care at both sites during the first half of 2023. This is a new date capture since the introduction of the electronic referral from on WebV.

Vulnerabilities (Learning Disability and Dementia)

The Vulnerabilities team is committed to ensuring that vulnerable patients in our hospitals receive excellent patient centred care and that they and their relatives/carers have a quality experience. The team supports the Trust strategic objectives to 'reduce health inequalities,' by ensuring patients have the adjustments required to ensure equitable access, excellent experience and optimal outcomes.

Our team undertake and complete structured judgement reviews (SJR's) of patients with a Learning Disability and/or autism who pass away in the care of NLaG, and a referral is made to the LeDeR programme. There were no specific identified actions to NLaG of the reviews undertaken.

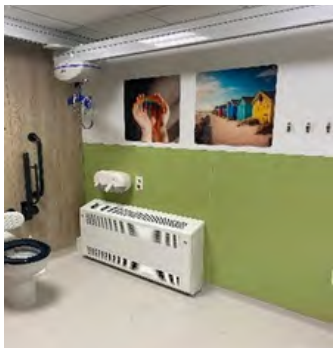
Identified good practice from SJR's

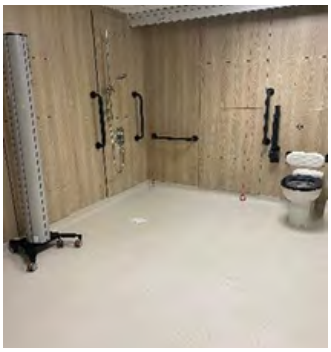
- ReSPECT document reviewed during hospital admission
- Evidence of consideration of MCA and best interests' decision making
- Evidence of patient centred care planning
- Good interaction and engagement with patient advocates
- Evidence of the patient being involved in decisions about his care whilst in hospital
- Excellent joint working between professionals
- Evidence of compassionate patient centred care with involvement of the relevant multi-disciplinary team

Achievements

- At least twice weekly vulnerability rounds
- Recruited an additional Learning Disability Nurse
- Further developed the vulnerabilities dashboard for oversight of activity and awareness
- Further developed the Vulnerabilities Steering Group
- Collaborating with the community LD team to reduce admissions and re-admissions and improve patient/carer experience
- Changing Places facility at Scunthorpe General Hospital
- Carers Strategy developed and implementation group set up with carers and carers support group representatives
- Evaluated the AFLOAT tool and Supportive care policy and re-launched
- Progression of the legacy work for inpatient improvement facilities
- Working closely with other agencies, such as carers support service to improve services for our patients
- Updated and re-launched the 'My Life' document to include paediatrics
- Virtual dementia tour visited all three hospital sites

Our new changes places facility at SGH





Vulnerabilities Patient Story

John had multiple admissions during his declining health and inability to manage at home. Despite the best efforts of medical teams John's health continued to deteriorate and was recognised as nearing the end of his life and placed on the end-of-life pathway. Our team along with the nutritional support nurse provided advocacy to ensure that the patient's care was optimised and managed effectively throughout his care journey, and supported both John and his family who lived some distance away. His daughter thanked our team for their involvement and support.

Our Vulnerability Rounds

These focus on the safeguarding and vulnerability team visiting wards to support staff and patients whilst in hospital. This has enabled us to identify patients not flagged with a vulnerability on our electronic system; for example dementia/delirium, Learning disability or autism. In addition we have a joint huddle with the safeguarding/nutritional and divisional teams on a weekly basis to discuss any patients of concern.

We can:

- Work closely with the nutritional support nurses to support and manage patients who aren't taking adequate nutrition.; advise and support around the use of the ward nutritional pathway
- Advice and support about the use of the delirium care pathway
- Supporting patients for procedures/surgery
- Supporting patients antenatally, at delivery and postnatally
- Supporting complex discharges to assist in preventing re-admission
- Support the wards to manage patients' needs
- Ensure patient are supported with reasonable adjustments and explore the reasons for any challenging behaviour

- Provide ad-hoc supervision and training to staff
- Improve the quality of the patient experience including relatives/carers
- Support patients with complex needs attending for outpatient appointments and procedures

Achievements

- Undertaken 295 ward rounds averaging 5 per week which means we have been able to support more vulnerable patients

Transition Children into Adulthood

The transition from children to adult services can be a very stressful and difficult time for young people and their families. The successful seamless transition for young people with long term conditions and/or complex health needs into adult health services is essential to reduce health inequalities, ensure young people receive the right care at the right time and receive the support they require as a young adult.

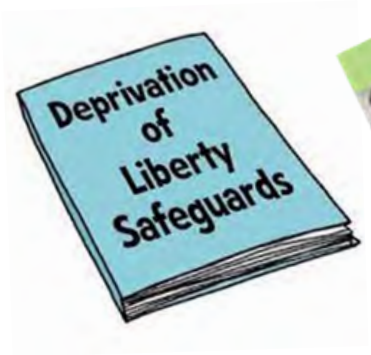
This year we were able to develop a quality improvement project and alongside ran a small pilot project over 4 months with key goals and achievements.

Key Achievements

- Developed a Transition Steering Group
- Approved Business Case to recruit Lead Nurse Transition
- Approved Transition Strategy
- Commenced a Quality Improvement Project
- Transition trolleys now at Grimsby and Scunthorpe to make our adult ward areas more young people friendly
- Transition theme boards promoting Transition
- Ready, Steady, Go tool added to WebV and designed
- Flagging on WebV approved

Mental Capacity Act (MCA) & Deprivation of Liberty Safeguards (DoLS)

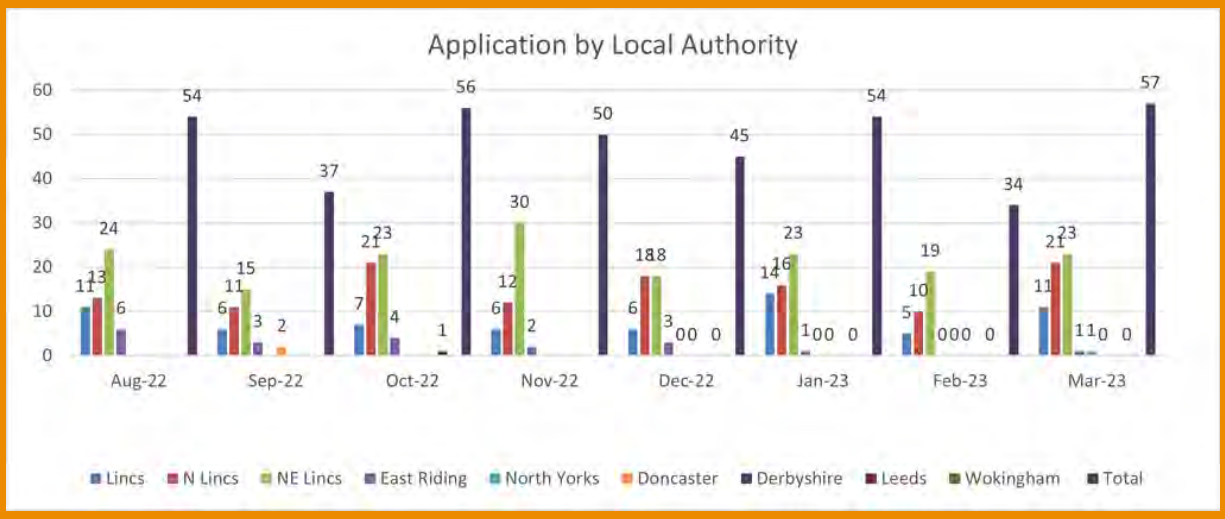
NLaG is committed to ensuring that all staff follow the principles and practice of the Mental Capacity Act (MCA 2005), and Deprivation of Liberty Safeguards (DoLS 2009). Our team works with our Local Authority partners and attend relevant meetings relating to MCA and DoLS. The MCA DOLS team continue to be available to support wards where required with the process to ensure that staff are thinking and evidencing Capacity and Best Interest.



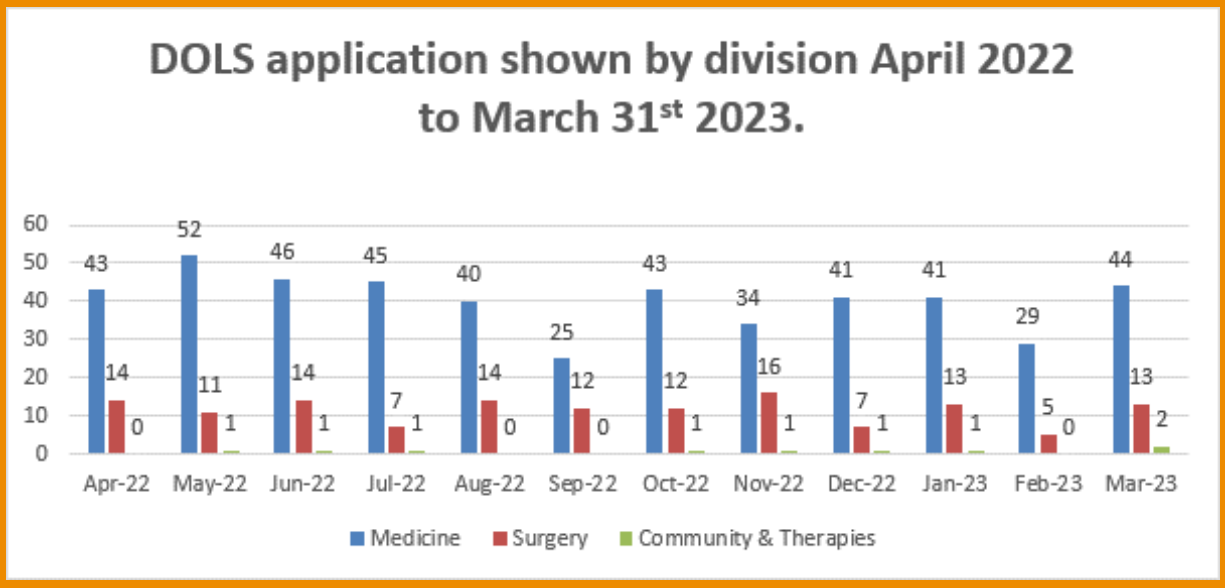
Achievements

- Quality assure all DoLS applications
- Robust oversight electronic data for mental capacity assessments and best interest tools completed
- Year on year increase in DoLS applications - average 52 per month
- DoLS data recorded and shared at the Nursing Metrics meeting and Vulnerabilities Board
- Reviewed the MCA/DOLS training package in 2023, previously a 2-hour session as part of the Level 3 Safeguarding; this is now a 3.5 hour standalone session
- Continued work embedding knowledge and skills in all areas regarding MCA/DOLS and continue to work with the wider Vulnerabilities Team
- Reviewed and amended the MCA template and Best Interest Decision Tool as an action from the qualitative audit completed in 2022
- Continued to support wards in completing their own DoLS applications
- The team monitored the progression of the Bill and collaborated with Partners to respond to the Draft Code of Practice last July and worked with Legal services to review this
- Met all our priorities for 2022-23
- Developed a quality improvement project to implement 2023-23

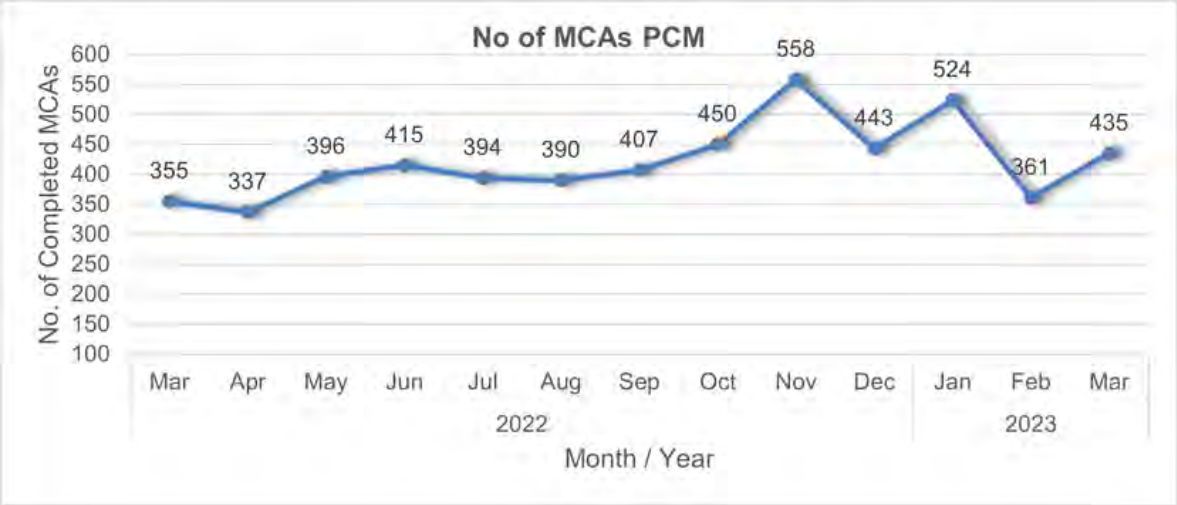
Data



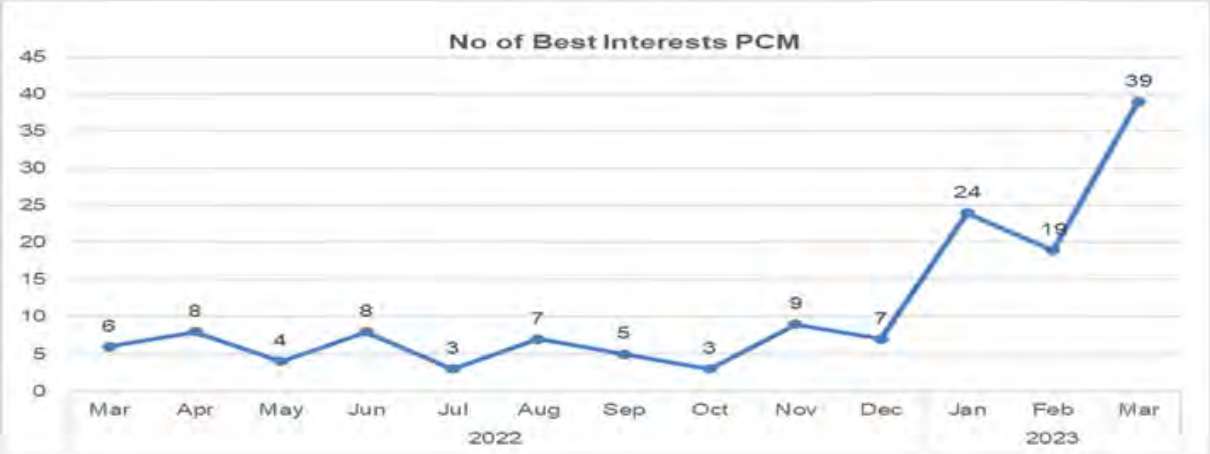
The majority of DOLS applications are sent to NEL or NL Council. We do have several patients from out of area whose applications are sent to the responding local authority councils.



The total number of DOLS applications were 630 with majority submitted by Medicine Division (483). Surgery reported 138 and community and therapies reported 9.



Note this data shows the number of Mental Capacity Assessments completed on Web V March 22- March 23. This does not reflect any capacity assessments that may have been documented in paper records.



We are seeing improvements in the use of the tool since a link was added to the mental capacity assessment form.

Quality Improvement

The Mental Capacity Act is one of the Trust's key priority areas for 2023-24. Our project goal is to improve the quality and compliance with the MCA across the Trust. This will start on our wards, working intensively with selected wards to audit current levels of knowledge and confidence and work with staff by providing intense support, bespoke training, and guidance. We are hoping to be able to role this out across all wards and build on the project's success alongside our division's leaders.

Mental Capacity Act (Amendment Bill)

Since the Government announced to delay the implementation of the Liberty Protection Safeguards beyond the life of this Parliament our workstream meetings have not progressed. We have continued to embed the principles of the Mental Capacity Act as a sound basis to re-visit this work in the future.

Key Achievements

- Provided a detailed report to Board of Directors regarding Liberty Protection Safeguards, implications of the Bill and Codes of Practice
- A Business case was completed after reviewing the Department Heath and Social Care Workforce Tool and benchmarking ourselves and our DoLS activity, an audit of all patients Trust wide on a particular day enabled us to write a comprehensive Business case based on fact and not assumption

Mental Health

Mental health is important within Acute Trusts to ensure holistic care is provided, ensuring that our patients presenting with acute general health needs also receive holistic care regarding their mental health needs. NLaG continues to work in partnership with our mental health provider partners; RDaSH, Navigo and Humber NHS Foundation Trust.

Our Mental Health Strategy (2021-25) identifies key objectives.

- Mental Health training
- Improved compliance with the Mental Health Act
- Continue the Mental Health Quality Improvement Project
- Implementing relevant NICE guidance
- Completion of NCEPOD Treat as One and Children and Young People Mental Health Care action plan

Alongside the Trust strategy the lead nurse for mental health clinically leads the restrictive physical interventions model and policy aligned with the restraint reduction network and the high intensity users workstream.

Our Mental Health Lead nurse has strategic and operational oversight of all mental health patients and pathways throughout the Trust and works collaboratively with our safeguarding and vulnerabilities team to ensure our patients continued safety.

Achievements

- Collaboratively worked with Safeguarding Adults Lead with Missing and Absconding meetings
- Continued Suicide prevention work
- Training delivered at Care Camp, student nurse forums, Gold on-call programme
- Safe Mental Health Rooms in both ECC
- Mental health pathway for Goole District Hospital
- Quarterly meetings with Mental Health Act offices RDaSH and Navigo
- Training needs analysis prepared for return to Board
- Continue to improve compliance with Mental Health Act through a quality improvement project

Safeguarding and Midwifery

Our Named Safeguarding Midwives support our maternity services for safeguarding children, vulnerable women and families for concerns arising in the ante and post-natal periods of pregnancy. We support the most complex cases for example cases relating to domestic abuse, substance misuse, neglect or poor mental health. Our team offer safeguarding advice and supervision either on a group or one-to-one basis for staff.

High risk women with a diagnosed mental illness or severe depression are referred to the perinatal mental health midwife for close partnership working where safeguarding oversight is required and appropriate referrals and signposting to appropriate external agencies. The named midwives and the specialist perinatal mental health midwives engage in regular supervision for high-risk cases to ensure a safe outcome for mother and baby. Mental ill health, both in the ante natal or post-natal period can have a negative impact upon the attachment between the mother, baby, and family unit so it's essential we collaborate.

The named midwives work closely with the specialist learning disability nurses within the safeguarding and vulnerability team. Together they can enhance the care given to a woman with a learning disability or difficult; or a partner to ensure that all appropriate services are included in the pregnancy care. This can include support at hospital appointments and liaison with children's social care at meetings to support the family.

Achievements

- Delivered mandatory safeguarding training in midwifery face to face every 2 weeks; the training has been updated to reflect current safeguarding themes
- Attendance at MAPLAC/Pre- Birth Meetings at North and North East Lincolnshire
- Recruitment to new post of specialist safeguarding midwife SGH – to support implementation of the cascade supervision model

- Attendance at regional and national safeguarding forums
- Developed and implemented training for targeted support - this will be ongoing into 2024
- Supported Midwifery services with attendance at Case conferences
- Raised awareness regarding the 'myth of Invisible man in Midwifery'
- Developed a draft subconjunctival policy for new born babies
- Completed a safeguarding communication pathway for new electronic system in Badgernet
- Promoted safe sleeping
- Ongoing work developing a Learning Disability and Pregnancy guideline for Midwives
- Implemented a Health Visitor liaison form to align the process with North Lincolnshire following the pilot within North East Lincolnshire
- Named midwives have supported local authority and midwifery colleagues to complete legal statements in a timely manner

SUDIC (Sudden Death in Childhood) arrangements)

Arrangements across North and North East Lincolnshire are the responsibility of Public Health and the Integrated Care Boards to ensure this statutory framework is implemented. Child Death Review (CDR) managers in the Local Authorities are responsible for the operational management of these arrangements. Not all babies, children and young people will have safeguarding concerns however where concerns do arise these are referred through the safeguarding children's procedures.

All deaths of children and young people under the age of 18 years of age are reviewed under this process, regardless of the cause of death, including the death of any baby that shows signs of life at birth, regardless of their gestational age and viability. The statutory partners must ensure CDR arrangements are in place to review the deaths of all children who are normally resident in the local area and as appropriate for any non-resident child who has died in their area with appropriate referrals to other area CDR managers.

Where a baby, child or young person has died we need to understand why and if there are any modifiable factors to prevent future deaths and identify any learning any immediate safety concerns and any wider support needed for the community should a tragedy occur.

As a partner agency our SUDIC (Sudden Unexpected Death in Childhood) Nurse, ensures that the Trust fulfils its requirements to the CDR process along with the Designated Doctor for Child Deaths, supported by the Associate Chief Nurse for Neonates, Children and Young People and the Head of Safeguarding.

Achievements

- Promoted SUDIC Awareness month
- Promoted Safe Safer Sleep week
- Delivered training across the Trust to Paediatrics, the Emergency Departments and site management teams
- The Designated Doctor for Child Deaths and SUDIC Nurse spoke about sudden infant death syndrome at the Paediatric Conference that was held in May 2023 at Grimsby Hospital
- Offered debriefs to staff involved in child deaths
- Supporting the keyworker role for bereaved families
- The SUDIC Nurse has suggested to the NCMD regarding the Reporting Forms for non-viable babies that come under the CDR process, and they are taking that idea forward to their development panel
- Links with other Nurses for Child Death Review Peer Network

Risks Outside the Home (Contextual Safeguarding)

Risks Outside the Home (ROTH) is a safeguarding approach to understanding young people's experiences of significant harm beyond their families and recognises the impact of the public and social context on young people's lives, and consequentially their safety.

It seeks to identify and respond to harm and abuse posed to young people outside their home, either from adults or young people. This can include exploitation (sexual and criminal), peer on peer violence, abuse, modern day slavery, harmful sexual behaviour, abuse in gangs and groups, going missing from home or care, and radicalisation. These behaviours should not be seen in isolation as they often overlap, creating a harmful set of circumstances and experiences for children, young people, families, and communities.

The safeguarding team works closely with our local partnership arrangements in developing local protocols and working in partnership to ensure how individual cases are managed locally. We attend local partnership meetings of MACE cross-site.

Achievements

- Training delivered around CSE/CCE
- Flag high risk children on the ED electronic patient record
- CSE/CCE is included and discussed in the Level 3 safeguarding children training
- Promotion of CSE/CCE in supervision and encourage staff to use the KYSS tool and the "Warning and Vulnerability Check List" which has been made available to all staff in gynaecology, midwifery, paediatrics and Emergency Departments

- Through attendance at MACE and the pre-birth pathway meetings any concerns relating to CSE /CCE are raised, shared, appropriate referrals and risk management plans are made
- Reviewed and updated the Flagging Policy
- Developed the KYSS tool in WebV

Female Genital Mutilation (FGM)

Where a pregnant woman has herself been a victim of FGM midwives will offer support to the woman emotionally and sensitively

Female Genital Mutilation (FGM) encompasses 'all procedures which involve partial or total removal of the female external genitalia, or any other injury to the female genital organs for non-therapeutic reasons. FGM can have far reaching consequences for the physical, psychological, and sexual health of the women and girls affected.

It is a violation of their human rights, a form of child abuse and is illegal in the UK. Midwives will offer sensitive support to survivors of FGM to ensure the safety of the new baby if a daughter is born and provide support and guidance to midwives providing care for these families. Our midwives complete eLearning training which is reinforced at annual mandatory training. Named midwives collate all data for FGM to record on the National Data set. Each case is individually assessed by health and social care to ensure the essential conversations have taken place with the parents. If a baby girl is born the named midwife will add the Flag to FGM- IS. This will remain on the child's record for 18 years to ensure that other professionals such as health visitors, GP's, and school nurses aware that there is a family history of FGM and ongoing safeguarding intervention.

At NLaG we have in place

- The Trust has an identified FGM Lead
- FGM-IS Standard Operating Procedure
- All cases are reported to the Trust FGM lead
- Quarterly reporting to NHS Digital

Achievements

- FGM training is delivered in all levels of safeguarding training
- Female infants identified at risk at birth are flagged via the FGM – IS system Information is shared with the health visiting service and GP via discharge information and liaison meetings with any concerns shared via a multi-disciplinary forum and strategy meetings with children's social care
- FGM policy including a flow chart to support staff in assessing the levels of risk
- Updated the FGM Policies and Procedures

Domestic Abuse

Domestic abuse is any incident or pattern of incidents of controlling behaviour, coercive behaviour, violence, or abuse between those aged 16 or over who are family members or who are, or have been, intimate partners. This includes psychological, physical, sexual, financial, and emotional abuse. It also includes 'honour'-based violence and forced marriage.

The Domestic Abuse Act (2021) expanded the definition to include non-physical forms of abuse such as coercive control, emotional and economic abuse. It strengthened protection measures; preventing cross examination of victims by their abusers in court and established Domestic Abuse Protection orders.

Children can also be seen as victims of Domestic Abuse

At NLaG we have:

- Named Nurses in Children and Adults to offer support
- Access to Independent Domestic Violence Advocates (IDVA)
- Domestic Abuse Guidance for all staff
- Policy for Trust staff affected by Domestic Abuse
- Continued to support MARAC meetings North Lincolnshire and North East Lincolnshire
- Ongoing risks/challenges
- It has been publicised and discussed nationally around the impact COVID 19 lockdown may have in relation to increased and unseen domestic abuse; this has been reflected in North East Lincolnshire and North Lincolnshire by the number of victims discussed at high-risk MARAC meetings which increased during 2020/21 and has continued to remain high

Achievements

- Active participant at Domestic Abuse groups of NEL and NL
- Raised awareness during October 2022 Domestic Abuse Awareness week
- Promoted MARAC training within the Trust
- 100% compliance with flagging high risk victims of domestic abuse on ED electronic patient record
- Continued to support staff members who have disclosed domestic abuse
- Domestic abuse is included in the face to face and top up session for safeguarding children and adults' level 3
- Contributed and represented the Trust at Domestic Homicide Reviews for NEL, NL, East Riding, Lincolnshire, and London
- MARAC referrals are now electronic on WebV allowing Safeguarding team oversight

Children Looked After North and North East Lincolnshire

Our Children Looked After Health teams work in partnership with North and North East Lincolnshire Councils to ensure that the health needs of children who are looked after (CLA) and young people are met, reduce health inequalities, improve health and wellbeing outcomes for children who are looked after, care leavers and those placed for adoption. The health team provides advice and support to health and social care practitioners to improve these health outcomes.

A Looked after Child is subject to a care order (placed into the care of local authorities by order of a court), and children accommodated under Section 20 (voluntary) of the Children Act 1989. Looked after children may live within foster homes, residential placements or with family members (connected carer's).

Our team reports to the Vulnerabilities Board, Women and Children's Governance Group/Family Services and partners in the NHS Humber and North Yorkshire Integrated Care Board (ICB). We work with the Local Authority to provide timely health assessments that contribute to the review process and improve health outcomes for Children who are Looked After. In line with the Intercollegiate Document our specialist teams have attended relevant training and development.

Numbers of Children Looked After for more than a year (SSDA903 Data Collection to Government). Note this does not include all children who became looked after and ceased to be looked after during the performance year 1 April 2022 – 31 March 2023 who have undertaken statutory health assessments.

North East Lincolnshire - 456
North Lincolnshire - 188

Achievements from NEL CLA Team

- 100% of development checks were completed
- 92.8% of immunisations up to date
- 89.5% of children had their teeth checked
- 98.9% had their statutory annual health assessment
- 40% of children scored high on their Strengths and Difficulties Questionnaire (SDQ)
- 2.2% had an identified substance use
- Permanent administrative and nursing staff in post promoting team stability

Achievements from NL CLA Team

- 100% of development checks completed
- 97% immunisations
- 82% of children had their teeth checked
- RHA completed on time 92.71%
- 100% SDQ screening completed
- 2.2% age 10 and over had an identified substance misuse
- 44% scored high on SDQ age 5 and over

Challenges

- Post Covid access to dental services and increased waiting lists for children to attend appointments
- Attendance at strategy meetings both sites

Case
We have supported a particularly difficult transition of a family from out of area into our local area and due solely to the support from the CLA team going above and beyond for the family our interventions made a big difference to this family who were experiencing health issues and social issues, our team was able to make referrals to not only health but to other services which made their move so much smoother, this was acknowledged at the time by all those working with the family.

Training and Supervision

The provision and delivery of safeguarding training for both children and adults remain a key Trust priority. It is a mandatory requirement for all staff to undergo this training to attain competencies appropriate to their role in line with the Intercollegiate Document for Safeguarding Children (2019) and Adults (2018). This ensures staff understand and know what to do and who to contact when safeguarding concerns arise.

Our safeguarding children and adults training targets are core specific (level 1) at 90% and Level 2-5 as role specific with a target of 85%. Last year one of our focus areas was to improve level 1 compliance.

Training	March 2021	March 2022	March 2023	Variation
Deprivation of Liberty	86.4%	85.6%	82%	Decrease 0.8%
MCA	81.8	80.6	74%	Decease 6.6%
FGM	78.2%	84.6%	88%	Increase 3.4%
Prevent Level 1	84%	90.6%	90%	Decrease 0.6%
Prevent Level 2	91.3%	87%	90%	Increase 3%
Adult Level 1	86%	89.5%	87%	Decrease 1.5%
Adult Level 2	82.5%	88.4%	88%	Decrease 0.4%
Adult Level 3	54.4%	70.4%	53%	Decrease 17.4%
Adults Level 4	87.5%	100%	100%	Static
Children Level 1	85.7%	89.3%	86%	Decrease 3.3%
Children Level 2	87.8	88.1	90%	Increase 1.9%
Children Level 3	86.3	76.2	59%	Decrease 17.2%
Children Level 4	76.4	100	80%	Decrease 20%
Children Level 5	50	50	100%	Increase 50%

Achievements

- Maintained compliance of FGM, Prevent, Adult and Children level 2
- Reviewed Level 3 Children and Adult training with specific groups of staff to ensure compatibility
- Continued to offer safeguarding children supervision and adult safeguarding supervision to community and ED staff
- Increased level 5 compliance
- HR Business Partners review training in divisions monthly, medical staff compliance has been highlighted in divisions
- Focused and planned delivery of training to meet needs of those coming out of compliance
- Provided safeguarding adult supervision sessions for community nurses
- Re-introduction post covid of Update of Level 3 training and initiation of face-to face training and updating training packages
- The safeguarding children team have recommenced face to face delivery of level 3 training as well as continuing to offer the on-line eLearning level 3 with a two hour top up
- The safeguarding children team have offered a face to face and two-hour top ups monthly as well as ad hoc sessions for paediatrics as well as Emergency Department staff

Safeguarding Reviews

The safeguarding team are active participants in Safeguarding Children Partnership reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews. These types of review analyse in detail how partner agencies have worked together to prevent abuse and neglect. The purposes of safeguarding reviews are to enable Local Safeguarding Boards/Safeguarding Partnerships and Community Partnerships to fulfil their obligations under the Children Act (2004), The Care Act (2014) and the Domestic Violence and Victims Act (2004).

Serious Practice Reviews

- 2 new Serious Practice Reviews commissioned by the Local Safeguarding Children Partnerships; both concluded and recommendations shared with divisions to progress
- Thematic Reviews (Children Line of Sights (LOS)/Rapid Reviews)
- 6 thematic reviews have been led by the Children's Partnerships in NEL, NL and East Riding during January – May 2023

Safeguarding Adult Reviews (SARs)

- The Trust have been asked to contribute to 6 new Safeguarding Adult Reviews and a learning lessons review commissioned by the Local Safeguarding Adults board across our area
- The Trust has been involved in 1 case from previous years where action plans have been revisited by the Safeguarding Board

Domestic Homicide Reviews (DHRs)

There have been 6 DHRs commissioned locally and nationally which have involved the victims known to NLaG which are at various stages of completion going into 2023.

- 6 cases in North East Lincolnshire
- 1 case in Sunderland
- 1 case in London
- 2 cases in Lincolnshire

Challenges

Due to the high number of SAR, DHR Requests and LOS we have prioritised our attendance at multi-agency meetings to ensure our contribution as a safeguarding partner remains paramount

Achievements

- Fulfilled partnership requests for information and contributed as authors and panel members to Line of Sight meetings, Children's Practice Reviews, Safeguarding Adult Reviews and Domestic Homicide Reviews
- Met the Rapid Review timescale process of 5 days in sharing information. All chronologies submitted to the relevant SAR panels in a timely manner
- Contributed to monitor reviews and action plans through the Safeguarding and Vulnerabilities Operational Forum and Vulnerabilities Board meeting

Learning and Audit

In line with our internal governance and multi-agency partnership arrangements we have participated in several audits this year. We are required to assure our Safeguarding Adults Boards and Children's Partnership's that safeguarding is embedded in our organisation. We do this by attending safeguarding Board meetings and their sub-groups across NEL, NL (East Riding in a limited capacity) and our commitment to working together to safeguard children and adults. There are several statutory audits we complete and report on.

Achievements

- East Riding Safeguarding Adults Board Assurance
- ICB Self-Declaration
- Audit of Missing/Absconding patients
- Completed the National Audit for Dementia and Learning Disability
- Re-audited the use of ReSPECT and end of life pathway documentation for Learning Disability patients
- Safeguarding medical report audit
- Partnership audit with CAMHS service regarding young people attending ED with mental health presentation
- Developed a programme of audits
- Audit of the KYSS Tool (an assessment tool to support the identification of Child Sexual Exploitation)
- Audit of CSE /CCE across Trust
- Contributed to National Audit FGM (published September)

Key Learning from Audits

Self-harm audit

- Staff to ensure that safety plans are documented in the ED patient record
- All self-harm attendances to have an under 18yrs mental health assessment tool completed
- All attendances to have the reason for the self-harm behaviour to be recorded

Learning from KYSS Tool audit

- Staff to ensure that KYSS Tool is completed for all under 18yrs attending Gynaecology department
- Amendments to be made to the KYSS Tool with associated awareness training
- School nurse information to be available in all ED and Gynaecology departments.

Safeguarding Boards/Partnerships

The safeguarding partnership arrangements of Safeguarding Children and Safeguarding Adult Board arrangements in North and North East Lincolnshire are on a statutory footing and ensure the arrangements for safeguarding children and adults are embedded into partner arrangements across the NLaG footprint. By co-ordinating this work and promoting the welfare of children and adults at risk it ensures the effectiveness of the arrangements, monitoring and evaluating effectiveness and advising on ways to improve safeguarding performance.

We have developed our Safeguarding and Vulnerabilities Strategy 2022-2025 and aligned this with the priorities in our local areas and our Trust Board priorities.

Key focus areas are:

- Domestic Abuse
- People who are homeless
- Family carers
- Transitioning from childhood to adulthood
- Child Exploitation
- The impact of Domestic Abuse on children
- Neglect
- Familial sexual abuse
- Making safeguarding personal and the voice of the child

The Trust is represented by the Head of Safeguarding at the following Partnerships and Boards:

- North East Lincolnshire SCP and LSAB
- North Lincolnshire MARS and LSAB
- East Riding SCP and LSAB

There is representation by other key professionals on the sub committees of the above Partnerships/Boards.

Achievements

- Submitted assurance statements to the Integrated Care Board relating to our safeguarding arrangements
- Responded to Section 11 Audit requests from Children Partnerships
- Provided assurance reports to Safeguarding Adult Boards

Conclusion

The Safeguarding and Vulnerabilities Annual report 2022-23 reflects that safeguarding continues to be a far reaching and an often-challenging area, but also demonstrates that safeguarding children, young people, families and adults at risk remains a key Trust priority, demonstrating that NLaG is meeting its statutory responsibilities in relation to safeguarding children and adults in a highly complex and changing legislative framework and from a national perspective.

The Trust has responded to these challenges to ensure that everyone is aware of their own individual responsibilities as part of a wider multi-agency partnership arrangement.

Whilst significant achievements have been made in all the key safeguarding agendas detailed in this report, the team have prioritised and identified the key strategic developments required for 2023-24. We are ambitious in the delivery of these key priorities in the report whilst working in a challenging and ever-changing Health Service.

Our key underpinning message in this report is that Safeguarding is everybody's responsibility regardless of their role within the Trust.

Appendix 1 - Our Priorities for 2023-24

Prevent

- To increase the training compliance of the level 3 Prevent training within NLaG

Adults

- Homelessness referrals
- Audit of feedback from Level 3 training
- Re-audit of quality of WebV safeguarding adults' referrals
- Commencement of missing/absconding meetings
- Finalisation of 'Was Not Brought' Policy
- Patient leaflet to support with safeguarding referrals.
- To consider formal guidance for Safeguarding Adult Supervision

Children and Young people

- Develop an electronic safeguarding medical proforma
- Audit level 3 safeguarding children training
- Referrals to Children's services in North Lincolnshire and the child's journey through the Child protection medical process in North Lincolnshire
- Work in partnership with NEL CSC to develop and embed the revised Early Help offer in North East Lincolnshire
- Revisit the KYSS tool with NLaG staff to encourage use in identifying young people at risk of CSE / CCE
- Develop a joint multi-agency policy for Non-Mobile Babies across NLaG footprint.
- Improve level 3 children training compliance
- Roll out phase two of CP-IS in line with national guidance
- Reintroduce the safeguarding team journal club to share learning and good practice
- Embed the WebV electronic safeguarding communication and meeting templates in NICU
- Explore the liaison practitioner role in supporting the paediatricians gaining background information for child protection medicals
- Continue to work with Designated and Named Paediatricians to embed the RCPCH 2019 standards
- Continue to develop the safeguarding champion role with ED
- Develop a robust process to accurately record child protection medicals.
- Work with Paediatric teams to integrate SBAR into nursing documentation.
- Revisit the Early Help Offer in North Lincolnshire
- Further raise awareness of CSE/CCE within Gynaecological assessment unit, SDEC and IAAU (Ward 24)
- Continue to promote the journal club
- Visible presence in operational areas
- Develop electronic nursing documentation SBAR

Vulnerabilities

- Develop reports from Lorenzo in conjunction with patient admin to enable pro-active management of patients attending for outpatient appointments.
- Complete the National Audit for Dementia
- Evaluate results from National Audit of Dementia 2022
- Continue to improve Community and Therapies engagement.
- Develop accessible appointment letters on the patient administration system for vulnerable patients
- Continue to recruit Vulnerability Champions and arrange meetings quarterly
- Develop a robust system to ensure the patient/carer voice is being heard when redesigning our services, work has started with partners but needs further work within NLaG
- Implement mandatory Oliver McGowan training
- Involvement in the dementia friendly ward environment in conjunction with Health Tree Foundation
- Completion of the Learning Disabilities Benchmarking audit
- Celebrate Dementia Action, Learning Disabilities, and carers awareness weeks.
- Over the next 5 years implementing the national learning disability improvement standards (NHS Long Term Plan 2019)
- Continue to work across the partnership with community colleagues to provide the right care at the right time and working towards preventing hospital admission.
- The team is currently involved in a project across the ICB looking at identification of patients on both outpatient and inpatient waiting lists with a learning disability and/or autism in line with the Core20PLUS5 approach
- Working with the Health tree foundation to refurbish a ward at Scunthorpe General Hospital though legacy monies to enhance the environment for patients with dementia
- Work with the Chief Nurse information officer to have an automatic referral to the team for patients identified as having dementia/delirium/learning disability or autism once the new admission documentation goes live
- Launch of the Carers Strategy and carers lanyard during carers week in June 2023

Transition

- Develop transitional Health services in line with NG43 and QS140 (Nice Guidance)
- Raise staff understanding of Transition
- Develop pathways
- Launch Transition Strategy
- Flagging to be added onto Lorenzo when launched
- Once Web V Ready, Steady, Go tool approved QI pilot to launch within Children's Paediatric and Adult Diabetes Specialist Nurses – training will need to be arranged
- Transition Guideline

MCA DOLS

- To undertake the QI project
- To embed digitalisation of applications to authorise deprivations of liberty and develop a referral process
- To continue to support staff to embed MCA in practice
- Continue to monitor capacity assessments, Best Interest decision records and DOLS applications to improve quality should they come under legal scrutiny
- To fully review our training offer in line with the MCA Competency Framework
- Further electronic development in WEB V of the Form 1 to support staff
- To review the MCA Code of Practice once further revisions have been received and review the responses to the MCA consultation

Mental Health

- Quality Improvement project to improve compliance to the Mental Health Act
- Webinars of mental health topics for the Trust
- Review physical interventions policy and rapid tranquilisation policy to assess physical intervention provision
- High Intensity Users into our emergency departments – established as clinical lead/ chair for the Trust – provided at SGH site, to commence at DPOW
- Safeguarding and Midwifery
- Develop and support the new specialist named midwife post
- Audit the effectiveness of the electronic family files
- Develop a LearningDisability and Pregnancyguideline for Midwives
- Implement the 'hope box 'project within midwifery services working collaboratively with Hull university supporting women and families who are separated at birth due to court proceedings
- Promote the 'Myth of Invisible Men' project that includes fathers in the pregnancy booking pathway which will look at consent from fathers in relation to their mental health and probation history. SIRS project
- Implement the Subconjunctival haemorrhage in Infants Policy
- Develop the safeguarding communication pathways when Badgernet is implemented. Named nurses to undergo super user training
- The development of a Web V template for a neonate on NICU for the recording of neonatal safeguarding information
- Audit the effectiveness of the ICON rollout
- Develop a pathway that includes fathers' information and signposting in the maternity booking process
- Electronic family files from Web V to Badgernet
- Develop the safeguarding supervision in midwifery cascade model

Safeguarding & Midwifery

Priorities 2023 - 24

- Develop and support the new specialist safeguarding midwife role
- Audit the effectiveness of the electronic family files on Web V
- Implement the 'hope box ' project within midwifery services and work collaboratively with Hull university supporting women and families who are separated at birth due to court proceedings
- Continue to promote the 'Myth of Invisible Men' project that includes fathers in the pregnancy booking pathway (SIRS project)
- Implement the Subconjunctival haemorrhage in Infants Policy.
- Develop the safeguarding communication pathways when Badgernet is implemented.
- Named midwives to undergo super user training for Badgernet
- The development of a Web V template for a neonate on NICU for the recording of neonatal safeguarding information

SUDIC

- Develop a leaflet for NLaG staff who are undertaking the Keyworker role
- Memory work improvements in paediatrics
- Study day for bereavement planned in September (CuddleCot UK)
- Contacted Health tree foundation to develop a bereavement booklet
- Develop a SOP for Snuza Hero Monitor - early alert for reduced movements
- Awaiting Cuddle Blankets sought through Charity 4 Louis

Contextual Safeguarding

- Roll out the electronic KYSS tool on WebV
- Re audit use of KYSS tool in gynaecology department
- To continue to raise awareness of the complex issues relating to Risks Outside the Home and the use of multi-agency meetings to share intelligence around this
- Invite NEL GRAFT team to raise awareness of CSE /CCE in ED and paediatrics
- NL Mace team in partnership with the NLAG safeguarding team to raise awareness of CSE/CCE in ED, ED assessment units, Gynae assessment unit and Paediatrics

FGM

- Ensure that clinical staff working Paediatrics can identify FGM
- Participate in multi – agency task and finish groups to promote best practice in safeguarding women and children re the responsibility all agencies to report to NHS digital and share information
- Embrace local and national networking opportunities to share knowledge and learning around FGM
- Explore routine enquiry in all areas of Gynaecology
- Explore how FGM if flagged for female siblings on FGM-IS if a female
- child is born and there is a family history of FGM

Domestic Abuse

- Re-establish co-located IDVA's at Scunthorpe and Grimsby due to previous IDVA's moving roles and being off site due to Covid
- QI project for routine enquiry
- To develop a DA tile on the safeguarding Hub to share domestic abuse information
- To continue to embed the electronic WebV MARAC referrals forms and audit their quality
- Review and update Domestic Abuse Policy and Guidance to come into line with new DA Bill
- Routine enquiry into nursing admission documentation
- Review the Serious Violence Duty

Children Looked After

- Appointment of Designated Dr NL
- Formalisation of Service Level Agreements NL and NEL
- Develop a Strategy to deliver training in line with the Intercollegiate Document for Children Looked After Training
- Child in Care reviews NL

Training and Supervision

- Increasing compliance in Level 3 children and adults safeguarding training
- Improve safeguarding children supervision compliance in maternity and paediatrics
- Increase safeguarding children level 4 compliance

Safeguarding Reviews

- Continue to strengthen lessons learned arrangements for external reviews into revised internal processes
- Progress the QI project of rolling out routine questions in ED following recommendations from DHR
- Continue to fulfil partnership requests for information and contributed as authors and panel members to Line-of-Sight meetings, Children's Practice Reviews, Safeguarding Adults Reviews and Domestic Homicide Reviews
- Continue to share learning from reviews in the form of 7-minute briefings, supervision, and training

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- Continue to share learning from reviews in the form of 7-minute briefings, supervision, and training
- Continue to review our audit calendar and embed actions from audits

Kindness · Courage · Respect

NLG(23)220

Name of the Meeting	**Trust Board of Directors – Public Board**	
Date of the Meeting	05 December 2023	
Director Lead	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Contact Officer/Author	Susan Liburd, Non-Executive Director and Chair of Workforce Committee	
Title of the Report	**Workforce Committee Minutes - September 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Workforce Committee Minutes from the meeting held on Tuesday 19 September 2023, and approved at its meeting on Tuesday 21 November 2023, 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.
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

WORKFORCE COMMITTEE

Meeting held on Tuesday, 19 September 2023 at 14:00 hours via Microsoft Teams

Present:

Susan Liburd	Non-Executive Director (Chair)

In Attendance:

Paul Bunyan	Interim Deputy Director of People
Jenny Hinchliffe	Deputy Chief Nurse
Simon Nearney	Interim Director of People
Simon Parkes	Non-Executive Director
Shaun Stacey	Chief Operating Officer
Christine Ramsden	Head of Education, Training and Development (item 5)
Karl Portz	Equality, Diversity, and Inclusion Lead (items 6 and 7)
Annabelle Baron-Medlam	Inspection Compliance and Assurance Manager (item 8)
Jane Heaton	Associate Director of Strategic Medical Workforce (item 9)
David Sprawka	Head of Recruitment and Employment Services (item 12)
Wendy Stokes	Executive Personal Assistant to Director of People *(taking minutes)*

Governor Observer:

Robert Pickersgill	Membership Office

1. Welcome and apologies for absence

Apologies received from Kate Truscott, Linda Jackson, and Kate Wood

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, 18 July 2023

Page 10, first paragraph, from end of line three should read:

Jenny added that there is a risk with the number of vacancies in the emergency departments and therefore the number of newly qualified and international nurses they will be supporting.

She had hoped to get some additional funding for supervisory time for the clinical sisters to support emergency departments and wards with high numbers, but the funding expected with exiting special measures has not been received and work is ongoing with the finance division.

With the above amendment the minutes from the previous meeting held on Tuesday, 18 July 2023 were accepted as a true and accurate record.

4. Matters arising from the previous minutes

No matters arising from the previous minutes.

4.1 Review of Action Log

Action 07 - Equality, Diversity, and Inclusion from a patient perspective – discuss with NEDs
In May 2023 Linda Jackson suggested an EDI conversation with NEDs to see if a more strategic discussion was needed. The Chair reported this item had not been taken to the NEDs meeting due to other pressing agenda items. Following the presentation of the WRES and WDES reports today, given Karl Portz is starting to work more closely with the ICB and the conversation with NEDs has not taken place to date, this is action is no longer deemed a priority, and it was agreed to remove the item from the action log.

Action 10 – Present the Apprenticeship Report
To be discussed at agenda item 05. Therefore, it was agreed to remove this item from the action log.

Action 11 – CQC Progress Report Trajectories
Annabelle Baron-Medlam confirmed this had been addressed and will be included as part of the update at agenda item 8. It was agreed to remove this item from the action log.

Action 12 – Occupational Health – provide a milestone update
To be discussed at agenda item 10.1. It was agreed to remove this item from the action log.

5. People Strategy Focus / Deep Dive - Apprenticeship Report

Christine Ramsden presented the Apprenticeship Report available on SharePoint and taken as read.

Simon Parkes stated that good progress had been made particularly around clinical apprenticeships and the scope for increasing numbers of nurses going through the scheme. Nationally, there are quite disappointing figures for nursing undergraduate degrees which will result in smaller numbers qualifying in three years' time. Simon Parkes asked what capacity was in the model, and should the trust be doing more to help train people where they work and also to try and attract more people from low-income backgrounds. Christine Ramsden reported nursing apprenticeships are moving forward with the full degree course commencing in September 2023. Top-ups are also being offered for those at level 5 to work up to level 6. The trust has just gone out to recruit for the next batch of apprenticeships commencing January 2024 and those numbers are looking higher. There are also healthcare assistants (HCAs) doing top-ups. The new cohort only includes three external apprentices. Jenny Hinchcliffe confirmed there are fifteen places on the three-year program. Fifteen staff have also registered for the Nursing Associate scheme with the original cohort only providing ten places. A lot of applicants did not have Maths and English and for the quality of the programme they were not where the trust would have liked them to be. This year the trust is making sure people are fully prepared and coaching has been provided around interview skills. As a result, the quality of applications is much better, and the trust will fill

all available places. Jenny added that they had probably underestimated the time needed to coach people through the programme and support them properly, so the trust did not lose them.

Simon Parkes stated if he can do anything to help within his role at the University of Lincoln or work with colleges in North Lincolnshire and North East Lincolnshire, do please let him know. There are good development routes best delivered through colleges who are closer to students on the ground. Simon Parkes concern would be around capacity and trying to get as many routes as possible open whilst ensuring the operation of the trust is not damaged by having too many people going through training. Regarding nursing capacity Jenny Hinchcliffe felt that is being managed quite well at the moment. They have increased clinical placement capacity and she is quite confident they will get quality placements although there is more work to be done in the next twelve months.

The Chair asked further about capacity and whether there is a formal mechanism to monitor staff in a position of supervision and for those who offer support to international staff, apprentices, and people from university. Jenny Hinchcliffe confirmed that is done through the professional development team who get feedback from staff around capacity when placing students. There is a coaching model on some wards, and they have other initiatives underway to constantly review that. The Chair confirmed that she felt more assured about capacity.

Paul Bunyan added that the trust used to be one of the top performing organisations for apprenticeships but was too focused on volume. It lost the quality and did not focus on areas of need for the longer term. When bringing in new apprenticeships evaluation and not getting too big too quickly is important. There are niche areas such as Operating Department Practitioners (ODPs) that need to be integrated and affordable to the existing establishment. Approaching year four, the trust is linking the programme into a workforce tool for niche areas and looking at how it can fill those gaps in the future. The trust is also bringing in T-levels and pre-programmes to enable people to develop further.

Shaun Stacey felt the report is excellent and refreshing to read. He asked about withdrawal and whether 38% is normal for the amount of training being undertaken and what the main drivers for that were. From an employer perspective the service is all consuming, and he went on to ask if the trust is doing all it can to make sure people who sign up are getting the right level of support from their colleagues to complete their training. Christine Ramsden who comes from an educational background stated, although 38% on paper looks high, the recently brought in apprenticeship standards consider that as normal. The figure was from 2017 and Christine is not concerned about that, the trust needs to look at where it is now. When the standards were first changed no one was really clear about what the training entailed. Christine and her team can now make sure that both managers and apprentices are fully aware of what training involves. Regarding capacity which has been formalised in nursing, it still needs to be formalised in other areas, and that is the reason for starting small and then building on that. Shaun Stacey's recollection of running an ODP school to support City and Guilds, whilst part of the service, stated to get ODPs trained was challenging if people did not buy into that from the very beginning. Shaun offered his help if needed to encourage uptake as the reality is the trust must grow its own and put effort into training the future workforce and this route needs to be encouraged.

The Chair asked about the financial impact of withdrawals and Christine Ramsden confirmed the trust does not get the 20% completion payment. The levy gets paid each month and the final 20% is paid one month after the end of the course. The trust is predicting a 2% reduction in the underspend against the Levy in 2023-2024. The levy transfer allowance is 25% of the previous year's annual funds so the trust has £365,104 in the transfer pot. There is quite an easy mechanism in place to support local health and care enterprises and the trust can get requests

from anyone non-Levy paying. The trust already works closely with HUTH and North and South of the Humber.

6. Workforce Race Equality Standard (WRES) Annual Report

Karl Portz presented the WRES Annual Report available on SharePoint and it was taken as read. Karl reported there had been a change in the way the trust reports WRES, it had already submitted data taken from ESR and the National Staff Survey. The data had been agreed, signed off and put into the standard format that NHS England require and that cannot be changed. Karl explained that Appendix 2 shows any gaps and a comparator with both HUTH and NHS England's Standard average data for acute trusts. Karl is working closely with the equality team in HUTH to see how they can support each other.

Simon Nearney felt the comparator data was useful and he was impressed with the 7% increase in BME staff believing that the trust provides equal opportunities for career progression or promotion. That is a big positive swing and he thanked Karl and his team for their engagement with BME staff.

The Chair highlighted the positive point evidenced in WRES 3. There were fewer staff entering the formal disciplinary process and the culture framework is starting to have an impact.

Simon Parkes stated there is progress, but he found WRES 2, the relative likelihood of BME staff being appointed from shortlisting compared to that of White staff quite worrying. The data shows white staff have a greater likelihood compared to a minority group and that has increased from 1.46 last year to 1.73 this year. The staff survey scores around bullying and harassment are quite significantly higher in proportionate terms and give the impression the trust is not as welcoming as it might be to BME staff. When the trust is trying to attract and retain people, that does not look great. Regarding Freedom to Speak Up (FTSU) there are some similar kinds of stories and some challenge from patients about local demographics. Simon Parkes went on to ask what the issues were and whether they were broadly in trust control. Karl Portz reported that is why the trust is introducing unconscious bias training and growing the BAME network to help understand trust staff. The trust needs to start listening to staff more and then they will start to tell the trust more. Unconscious bias training is really important, geographically NLaG is seen as remote, and the culture can also be quite remote. The organisation needs to be up to speed in terms of what is acceptable in terms of behaviour and the Just and Learning Culture. The new Group Chief Executive wants more involvement in the BAME network and that will help both expand and move that forward. Simon Parkes stated that unconscious bias is not universal. Karl Portz stated that if the trust gives staff training, they cannot come back and say they could not do that, that is the start to making the shift around appropriate behaviour. Paul Bunyan added that unconscious bias is one of many types of training and regarding data the trust is continually active on the international front. The trust receives a lot of natural applications through NHS Jobs for administrative and healthcare posts that do not meet the visa criteria, and at present, it is not easy to try and separate that data out. There is still some work to be done.

Simon Nearney felt the top factors would be recruitment, which is an area to focus on with managers and bullying and harassment from staff in the last twelve months stands at 10% which is above the national average. There are increased BAME numbers, and the trust knows from intelligence when people have not worked with different cultures, they do not understand them. Instead of celebrating that, they do not talk to them and then they think they are being treated differently. People want to do the right thing and are scared of doing it wrong. The trust needs to talk with managers to work that through. The Chair asked if the WRES includes temporary and bank staff. Karl Portz replied no, there is a shadow report and from next year a WRES will come into force for medical and bank staff.

The Chair asked, regarding the action plan and creating a Staff App to engage with staff, how will that improve EDI engagement. Karl Portz replied that would give staff more ways to access information, give them a voice, and is a different mechanism to share their issues with the trust.

The Chair confirmed the Committee approved the WRES Annual Report.

7. Workforce Disability Equality Standard (WDES) Annual Report

Karl Portz presented the WDES Annual Report available on SharePoint and it was taken as read. Karl reported the trust is challenged around staff engagement and staff survey results and has a small number of staff that identify with a disability. The action plan at Appendix 1 is similar to the WRES and looks at how the trust breaks down and monitors that data. Unconscious bias training is around all protected characteristics including disability. Karl is looking at how the trust develops and grows its staff network. Karl has been involved in the Calibre talent development and leadership programme for people who identify as disabled or neurodiverse or who have long-term physical or mental health conditions. Karl is also involved in Project Search which involves a small group of people with a learning disability being brought into the organisation and this links into the Oliver McGowan Mandatory Training on Learning Disability and Autism programme, giving people a catalyst to move that forward. A further four engagement events are taking place in October one in DPOWH, Goole, SGH and in Community. Disability History Month runs from 16 November to 16 December 2023.

Regarding the Disability Equality Network, the Chair referred to Metric 5 on page ten of the report around disabled staff being 12.3% less likely to believe that the trust provides equal opportunities for career progression or promotion compared to non-disabled staff. The gap has worsened since the 2021 Staff Survey and the Chair asked how that is presenting and what is the trust consciously doing to address that. Karl Portz confirmed that is being addressed through the Disability Equality Network to understand that group of staff better and to listen to them. The network is growing, and Karl and his team are working with Human Resource (HR) colleagues looking at policies and supporting staff in different ways.

The Chair went on to ask if the Disability Equality Network has an equality impact assessment running through that. Karl Portz replied that the Disability Equality Network is in its infancy and is keen to work with HUTH in terms of peer support.

The Chair confirmed the Committee approved the WDES Annual Report.

8. CQC Progress Report

Annabelle Baron-Medlam presented highlights from the CQC Progress Report available on SharePoint and taken as read. Annabelle reported the number of actions had reduced from thirty-nine to twenty-nine with thirteen actions fully closed and submitted to CQC. Some staff are going above and beyond and are happy to do as much as they can to improve compliance. The End-of-Life Nurse is starting work at 5 am to support people that are out of compliance. The numbers for Syringe Driver Training have increased every month, although dipped slightly this month to 84.8%. The Chair asked if there is a way to formally acknowledge those staff going above and beyond. Shaun Stacey felt he could do something and asked Annabelle to link in with him to acknowledge that.

Action: Annabelle Baron-Medlam and Shaun Stacey

Simon Parkes was concerned about three of the recommendations and asked if there was sufficient assurance. On page 9 of the report there was limited assurance around mandatory training compliance with medical at 60% and nursing at 85% and medical staff being compliant with the trust target for Mental Capacity Act training. Simon Parkes stated the risk is that patient care will suffer, and he asked how that can be turned around against the current operational challenges. The Chair stated there was a conversation at the previous Workforce Committee meeting around safeguarding, and again there is a marginal increase. Regarding Mental Capacity Act training, a range of mitigations were put in place. This was reported and escalated to trust Board and the Chair asked what is being done differently to move this at a faster pace.
Shaun Stacey stated he was disappointed with the figures because this was raised at the Operational Management Group meeting and Anabelle Baron-Medlam is reporting the facts. Shaun is also aware that with the current industrial action, catch up on mandatory training is possibly taking second place to clinical delivery. Shaun agreed to take this back to operational teams. Shaun is also worried as he himself has two outstanding training needs, because of his inability to get onto training over the previous six months. Shaun felt that the trust must release people to undertake mandatory training but questioned whether anyone has checked whether the trust has the capacity to deliver the volume of mandatory training needed. The trust must make sure the balance is right. The Chair went on to ask if training can be accessed across the whole Group to try and offer better access if that is a problem. Shaun Stacey reported that the trust already pays medical staff to undertake their training and they have designated time in their job plans to do that. It is also holiday season so numbers may be better going forward after the summer period. The Chair felt that with winter pressures and industrial action, it may be more difficult to undertake mandatory training in the next quarter and she asked Shaun Stacey where he will raise this issue. Shaun Stacey confirmed it will be at the Operational Management Group meeting and his expectation would be that the figures on page 9 around the medical workforce should increase.
Action: Shaun Stacey

Paul Bunyan reported that Christine Ramsden and her team have looked at mandatory training and will look specifically at the two issues mentioned. The Portfolio Governance Board looks at delivery methods, including whether ward staff need to leave the ward to undertake training or if they can do a mixture of both e-learning and in-person training on a rota basis. Shaun Stacey felt that main issue is to encourage managers to encourage their staff to undertake training.

Regarding there being a capacity or access issue, Simon Nearney stated that no one had raised that with him, or Christine Ramsden and he felt 60% for medics is a commonality that should probably be a performance management issue. Medics need to be told that is not acceptable, they need to reach the target of 85% and management do expect to see improvement.
Annabelle Baron-Medlam collates the report and if there are any significant increases in numbers or something is not expected she will present that to the Workforce Committee, Quality and Safety Committee, Finance and Performance Committee and Trust Management Board.
Annabelle Baton-Medlam reported that at the last Care Quality Commission (CQC) monthly meeting they discussed syringe driver training and got feedback from a medical member of staff, who was not even aware he/she had even been booked onto training. The emergency department have also undertaken a review of nursing staff that have two roles, they may be out of compliance for one role and already completed training and compliant in their substantive role.
Annabelle Baron-Medlam added that this is also discussed and monitored as part of the PRIMs meetings.

The Chair felt that this had been raised in various forums and if there are no consequences, or this is not being prioritised, the same conversations will be taking place going forward. Shaun Stacey stated that at meetings from today, he would expect to see a difference. This is presented weekly

at the Operational Management Group with the operational leadership team and monthly at the Performance Review meetings although for the last two or three months those meetings have been cancelled due to industrial action. The divisions are undertaking service improvement and meeting with individual services, there is a lot of discussion, but they are not getting outcomes therefore, they need to apply consequences. Shaun Stacey assured the committee this will happen, and improvement should be seen in three months' time.

Regarding item 3 on page 13 (2022-MAT04), the trust must ensure bank and agency staff receive a full, formal induction so they are assured bank and agency staff are familiar with equipment, policies, and emergency escalation procedures. The Chair was concerned about the expected timescale being extended twice and moved to 31 December 2023 and she asked does that mean nothing is changing. Annabelle Baron-Medlam reported after initial feedback from the division she felt assured it was one rogue person and once investigated they evidenced inductions had taken place. The division does not have a recorded mechanism and suggested putting something in place, but they will need to find an assurance system that can be used across sites. Regarding the action log and trajectories, the Chair went on to ask if the committee wanted anything adding. Annabelle added that Maria Wingham has confirmed this is work in progress and once a system is in place the division will review which areas need trajectories. The Chair stated with that assurance she was happy to close this item down.

9. Annual Doctors in Difficulty (DID) Report

Jane Heaton presented highlights from the Annual Doctors in Difficulty Report available on SharePoint and taken as read. Jane Heaton reported that Kate Wood and colleagues in Human Resources (HR) have oversight of the report to ensure that support is in place for doctors experiencing difficulties. Going forward, following discussion with the General Medical Council (GMC) Employment Liaison Advisor around areas of good practice, Terms of Reference (TOR) and a formal process will be put in place. Kate Wood, Jane Heaton, Simon Nearney and Paul Bunyan will finalise the draft procedure prior to discussions with Divisional Directors to take that forward. This will give the trust assurance that a more formal process is in place going forward that will involve operational colleagues. The Chair commented that the current process felt very informal and gave limited assurance to the committee. Jane Heaton added that will of course need to be balanced with the extremely sensitive and confidential information and be dealt with through tried and tested HR processes. Kate Wood will retain oversight particularly if there are any GMC concerns.

Regarding the current case load referred to in section 4 of the report, Simon Nearney stated that the numbers were big for sickness, and he asked if the cases were for one or three days and whether they proceeded to stage one and two sickness monitoring. Simon also highlighted that the figures did not add up to the total number of seventy-seven as stated in the report and he asked if others were included. Jane Heaton confirmed that was an overview of records that they know about, they do not actively manage those, that should be done at divisional level. She confirmed there are issues in managing sickness for doctors at local level. The Chief Medical Office and HR colleagues are looking at putting a clear process in place for those that manage doctors. Going forward figures for sickness will not be included in the DID report they will be managed through the Managing Attendance Policy and Procedure. The Postgraduate Medical Education (PGME) department note information about doctors that are struggling with their training and the Director of PGME provides support. Simon Nearney agreed the need to move to a more formal process and working with doctors to resolve any issues. Jane Heaton added that at present it is a combination of formal, informal, and anecdotal information that needs to be put into a more formal process.

Simon Parkes stated that a number of doctors may have been accused of poor practice or potentially harming patients and he asked who is responsible for the support the trust gives to patients as a result of what doctors may have done. Jane Heaton felt that will have been fed into the Ulysses Risk Management System for reporting serious incidents and will get picked up by trust governance routes. Simon Nearney agreed with Jane Heaton, and he added that information is also presented at the Quality and Safety Committee.

The Chair asked how the committee can be assured that this is being picked up elsewhere when looking at the new TOR. Jane Heaton replied when the process is changed to a more robust system with specific reporting mechanisms and assurance given around where that is being picked up in different strands.

Shaun Stacey added that divisional Human Resources Business Partners (HRBPs) work closely with divisions around sickness and if you look at historical performance review letters from previous performance review meetings, there is a high volume of medical sickness absence. That is now being monitored to drive that improvement and current numbers are lower than they were three months ago. Shaun felt that the trust needs to think about the impact of sickness when treating and caring for patients. This contributes to the agency overspend, delivery of clinical care and supporting nurses in the delivery of care.

10. Quality and Safety Actions

10.1 Occupational Health (OH) Progress Report

Paul Bunyan reported OH performance is in line with recruitment performance and there are only a few cases that are more complex and need OH physician input. The trust is looking at outsourcing that and is working on an ICB solution to potentially work with HUTH and York to employ an OH Physician with a wider approach focus to the ICB and more of a public health role.

OH have a new service manager and deputy service manager which will give more capacity to expand preventative work and look at mental health and musculoskeletal (MSK) to see what can be done to reduce sickness levels. There is a new service mode which is far more responsive to the needs of the organisation. Triage is in place, and the OH team are looking at specific clinics to see if they need to be led by the most senior person in OH. The department wants to reduce timescales and they are learning from the OH Team at HUTH as most of their clearances are processed by the administrative team and not the nursing team. They are also looking at service innovations and trying to get to the twenty-day mark, probably January next year as part of the next phase of the project.

11. Workforce Integrated Performance Report (IPR) – Trust and Directorate

Paul Bunyan presented highlights from the Workforce IPR available on SharePoint and taken as read. Paul reported three positives; the medical vacancy rate has decreased to 12.9% against a target of 15%, core mandatory training remains above target at 91.24% and the turnover position is at 10.8%, which is the lowest since recording began via the IPR. The three main challenges are role specific mandatory training that remains below target but slightly decreased in month by 0.71%, trust wide PADR is at 83.8% against a target of 85% and the sickness position increased in August for the first time in six months to 5.2% against a target of 4.1%. Paul added that seasonal sickness with Flu and Covid should peak out in January 2024 and then start to reduce again. The trust continues to focus on retention and improving the culture of the organisation.

Regarding the point Simon Parkes raised earlier about mandatory training for medics at 60% and nurses at 85%, Simon Nearney felt there was more assurance with the figures in the IPR and suggested a conversation with the performance team. Paul Bunyan advised that conversations are already taking place with the performance team to try and close all other forms of reporting.

The Chair asked if the increase in sickness rates is part of an annualised pattern and Paul Bunyan confirmed there is an annualised pattern, which has started lower than previously, so hopefully the highest figure will also be lower.

12. Recruitment KPI Dashboard – August 2023

Dave Sprawka presented highlights from the Recruitment KPI Dashboard available on SharePoint and taken as read. The recruitment team has maintained more applications than ever before, and all recruitment plans are generally good. Registered nurse vacancies have reduced, and they are building on the nurse pipeline with staff from Kerala, India. Unregistered nurse vacancies should be down by forty whole time equivalents (WTEs) by the end of the financial year. The AHP pipeline is currently static although that will change from an establishment and recruitment pipeline point of view. Medical staff overall is not looking as good, although the position was recovered in August after medics left the trust in July to take up training elsewhere. Performance against KPIs has been outside target for a number of months but there are new OH processes in place. Disclosure and Barring Service (DBS) applications are taking a long time to process because of candidates moving around the country.

Jenny Hinchcliffe added the increase in nursing vacancies was twenty-five WTEs in August, with fifteen of those being surgery and critical care operating department practitioners (ODPs) converting to registered nurses (RNs). The new bed-based establishment review numbers have been completed and will go into budgets from September. Dave Sprawka added the recruitment dashboard is a snapshot in time, the IPR is different, there are some exclusions with the data although the establishment review numbers will be across the board. Simon Nearney asked if candidates have been lost from the registered nursing pipeline. Dave Sprawka confirmed there were no concerns with the pipeline, there has been an increase in establishment numbers.

Simon Nearney felt that from the start of the year medics seem to be going in the wrong direction. The key challenge is how the trust makes inroads into that and Allied Health Professionals (AHPs), particularly Advanced Clinical Practitioners (ACPs) coming online. Simon asked what else the trust can do and is it doing everything possible. Dave Sprawka stated that the forecast is conservative, the number of leavers has actually come down and shows thirteen leavers per month. There is additional capacity in the talent acquisition team looking at recruitment5 plans for Accident and Emergency (A&E), Acute Medicine, and Radiology. Paul Bunyan added consultant recruitment is a bigger problem and a lot of work has been done to develop non-training pathways for medics including Fellowship programmes and Cesar programmes. The trust is establishing relationships with Indian hospitals around positive conjoint training programmes. Conversations are taking place and a meeting is being held next week to see how the trust starts to develop a group programme with HUTH.

Regarding the KPI around time taken form conditional offer to starting in post the Chair stated that was at twenty-five days. There was a real problem with both OH and DBS at the beginning of the year and with the investment in OH the committee were told that the process was much quicker. The Chair asked is it OH or DBS and is it only small numbers. Dave Sprawka reported there are still issues in OH, although less than previously, and they are still being worked through. The main issue for the recruitment team is DBS for doctors and the time that takes. Paul Bunyan added that it is the sheer volume, it is immense, the trust has never dealt with that number of applications

previously. Paul thinks with the plans in place, and perhaps some slight tweaking, improvements will be seen. The Chair went on to ask if the KPI is correct given the volume or should that be revised. Dave confirmed that he would like to think that they could meet the KPI.

13. Industrial Action

Paul Bunyan reported that the BMA have confirmed for the first time ever, junior doctors will take industrial action at the same time as consultants. A four-day period of action will start today and on Wednesday 20 September action will overlap with both consultants and junior doctors only providing a Christmas Day level of service for twenty-four hours. When junior doctors take industrial action in isolation that will result in a full withdrawal of services and all elective activity will be stood down. A further four-day period of action will run from 02 to 05 October for both consultants and junior doctors. The RCN do not currently have any industrial action planned for the immediate future. Shaun Stacey added that Emergency Preparedness, Resilience and Response (EPRR) planning processes are in place and elective care will be stood down. Shaun reported out of one hundred and forty-three doctors, forty-two are striking, with the biggest area being surgery and critical care where twenty-three are striking out of sixty-five available and family services where ten are striking out of twenty-three available today. The Board will be provided with a summary on each of the days. The trust will have lost one hundred and fifteen sessions of activity this week and tomorrow with both consultants and junior doctors being on strike more activity will be stood down. Patients are being rescheduled within twenty-eight days and the trust is trying to recover some of the lost activity and balance that against the financial risk. Cancer patients remain within statutory requirements.

The Chair asked if staff are experiencing any backlash from patients or other staff. Shaun Stacey stated there has been little media interest so far today, although there was some interest nationally over the weekend. Shaun added, at the beginning of the strike action the trust did see a reduction in attendance numbers but as the strike has gone on, that has by far been maintained and the trust is managing that as safety as it can. Simon Nearney highlighted staff are experiencing fatigue as a result of covering additional strike action and it is becoming increasingly difficult to cover gaps and shortfalls and that will only get worse going into winter. Simon believes that some organisations will declare major incidents as there is no planned dialogue between the Government and the BMA. The Chair commented that she was also concerned about fatigue going into the autumn and winter pressures.

14. Annual Workplan

The Chair reported the committee is working to the existing plan, changes will be made moving to the Group structure and Committees in Common.

15. Trust Board Highlight Report

The Chair stated that going forward highlight reports are to advise of any points of escalation.

It was agreed the following items be highlighted to Trust Board:

- Apprenticeship Levy Annual Report
- Workforce Race Equality Standard (WRES) Report
- Workforce Disability Equality Standard (WDES) Report
- Doctors in Difficulty (DiD) Annual Report
- Mandatory and Role Specific Training

- Industrial Action

16. Items for Information

Items listed in Appendix A were shared with the committee for information.

17. Any other urgent business

The Chair stated that the financial deficit, temporary and bank staff had been discussed at Board. She asked if there had been any further conversations around reducing agency spend.
Shaun Stacey reported that a lot of work is ongoing around filling recruitment vacancies and developing an internal medical bank, to neutralise some of the competitive spend due to the number of medical vacancies. The trust is also looking at HOLT and a further meeting takes place on 26 September and the hope is that as the trust goes into winter it should be able to mitigate the spend better. Shaun highlighted this is a slow burn, will not happen quickly and is built onto trying to get more people into substantive roles. It takes a minimum of five years training to become a doctor and nationally it is hard to recruit respiratory physicians, oncologists, and breast surgeons.

18. Date, time, and venue of next meeting:

Date: Tuesday, 21 November 2023
Time: 14:00 hours
Venue: Via Microsoft Teams

The Chair asked for Tony Curry, Non-Executive Director from HUTH to be invited to the next Workforce Committee meeting, as Tony and Sue will be working together next year. The Chair thanked Simon Parkes for his invaluable contribution to today's meeting.

The meeting closed at 16:26 hours.

Cumulative Record of Workforce Committee Attendance (2023/2024)

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Sue Liburd	3	3	Paul Bunyan	3	2
Kate Truscott	3	2	Jenny Hinchcliffe *	3	3
Linda Jackson	3	1	Gillian Ponder *	1	1
Simon Nearney	3	2	Simon Parkes *	1	1
Shaun Stacey	3	2	Abolfazl Abdi *	2	1
Ellie Monkhouse	3	0	John Awuah *	1	1

* Deputy or representative

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Dr Kate Wood – Chief Medical Officer
Contact Officer/Author	Dr Liz Evans – Guardian of Safe Working
Title of the Report	**Guardian of Safe Working Hours Quarterly Report**
Purpose of the Report and Executive Summary (to include recommendations)	To provide quarterly information on the exception reporting of Doctors in Training which is a contractual requirement.
Background Information and/or Supporting Document(s) (if applicable)	This is a requirement of the Doctors in Training Terms and Conditions of Service and the report is shared both with internal stakeholders and external stakeholders at NHS England.
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)	
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

Guardian of Safe Working Quarterly Report

Dr Liz Evans
Guardian of Safe Working
1st October 2023

Contents

1. Executive Summary

Exception reports for the quarter 1st July 2023 to 30th September 2023 saw an increase from 37 to 61 exception reports. The majority of the exception reports submitted were in connection with working hours, with some also submitted around service support, educational opportunities and work patterns which the Director of Post Graduate Medical Education continues to oversee and discuss within the relevant divisions/directorates.

There is still work to be done in relation to engagement of the Educational Supervisors in ensuring a timely response to exception reports in addition to ensuring any concerns highlighted through this reporting mechanism are actioned and lessons learned are shared.

Once refresher training has been carried out for the Educational Supervisors, the time spent by the Guardian of Safe Working in relation outstanding exception reports should reduce. Around 38 of the 175 educational supervisors in the trust have been through the training, with more dates planned in September and December this year.

Current numbers of Doctors in Training within NLaG is as follows:

Number of Training Posts (WTE)	319
Number of Doctors/Dentists in Training (WTE)	284
Number of Less than full time (LTFT) Trainees (Headcount)	27
Number of Training post vacancies (WTE)	35

Source Finance data

During the period of this quarterly report (1st July 2023 to 30th September 2023) there have been a total of 61 exception reports submitted through the allocate exception report system.

This showed an increase of 24 reports from the last quarter (1st April 2022 to 30th June 2023).

Of the 61 exception reports submitted, 51 were linked to hours. This showed an increase of 27 reports from the previous quarter.

The exception reports for this quarter relating to hours have been compensated by the Guardian of Safe Working (GoSW) for either payment or time off in lieu (TOIL). They have mostly been closed successfully.

The below table is a breakdown of the exception reports over the last quarter (April 2023 – June 2023)

Exception Reports Open (ER) between 1st July 2023 – 30th September 2023	
Total number of exception reports received	61
Number relating to hours of work	51
Number relating to pattern of work	5
Number relating to educational opportunities	0
Number relating to service support available to the Doctor	5
Number initially relating to immediate patient safety concerns	1

*Within the system, an exception relating to hours of work, pattern of work, educational opportunities and service support have the option of specifying whether the report constitutes an immediate safety concerns (ISC). ISC is not an exception by itself.

Exception Report Outcomes (ER) between 1st July 2023 and 30th September 2023	
Total number of exception reports resolved as at 30/09/2023*	62
Total number of exception reports unresolved as at 30/09/2023**	4
Total number of exception reports where TOIL was granted	23
Total number of exception reports where overtime was paid	29
Total number of exception reports resulting in a work schedule review	0
Total number of exception reports resulting in no further action	9
Total number of exception reports resulting in fines	0

"Note:

* Compensation covers obsolete outcomes such as 'Compensation or time off in lieu' and 'Compensation & work schedule review'.

* Some exceptions may have more than 1 resolution i.e. TOIL and Work schedule review.

* Unresolved is the total number of exception where either no outcome has been recorded or where the outcome has been recorded but the doctor has not responded."

2. Immediate Safety Concerns

During this quarter there was 1 exception report submitted where a Doctor raised an immediate safety concern in addition to a concern around working hours and clinical supervision. Within the system, an exception report relating to hours of work, work pattern, educational opportunities or service support has the option for the doctor to specify if they feel there is an immediate safety concern. An immediate safety concern is not an exception field on its own.

Any exception report which flags an immediate safety concern is investigated by the Guardian of Safe Working administration and progressed appropriately.

This quarter there was only one Immediate Safety Concern, contrasting with six in the previous quarter. This concern was received from medicine in Grimsby and concerned a FY1 doctor being unable to escalate a lack of supervision. This issue was a legitimate safety concern, and was raised with the rota coordinators and the DMDs for medicine. A meeting is planned between the Guardian of Safe Working and the DMDs later this month to make sure that the issue does not recur.

3. Work Schedule Reviews

During this quarter there were no work schedule reviews required.

4. Trend in Exception Reporting

There has been an increase in exception reports received this quarter. This is to be expected- there is always an increase in the number of reports received in the first quarter of the academic year. As the new doctors settle in and become more familiar with their roles the number of reports tends to decrease. Improved engagement with the doctors during induction has embedded a culture of exception reporting well among the doctors in training, particularly at a foundation level, which has meant that this system is being used appropriately to highlight staffing issues.

5. Fines Levied against Departments this quarter

There have been no fines this quarter.

6. Communication and Engagement

Work continues regarding communication and engagement with our Doctors in Training.

The Guardian of Safe Working/Junior Doctors Forum has been up and running now for a year, has formal terms of reference, agenda and notes. Work to improve engagement and attendance at the forum is ongoing. The time of the JDF has been re-discussed at the first JDF of the new academic year to confirm that this time is convenient for the Doctors in Training, and a survey sent out to the doctors to ensure that the time is appropriate.

The Guardian of Safe Working runs a drop-in session to allow for face to face contact with the Doctors in Training. This is usually run by the guardian of safe working, but several times a year is a joint session with PGME or the Freedom to Speak Up Guardian. There is also a joint drop in session in the canteen run by both the Guardian of Safe

Working and the Freedom to Speak up Guardian to raise awareness of the role and to promote the culture of open reporting. A range of information including the fatigue charter and information on the junior doctors contract is available at this session, which is run in both Scunthorpe and Grimsby.

In addition there is a regular quarterly newsletter which is circulated via e-mail. Information pertaining to the guardian office is available on the HUB, and there is a leaflet which is provided to all doctors in training on joining the trust containing details of the support available. There is also now a regular meeting between the Guardian of Safe Working, the Freedom to Speak up Guardian, and a representative of PGME. This enables the support mechanism for Doctors in Training to establish any common themes and co-ordinate an approach to finding solutions. An exit survey for doctors leaving the trust has been circulated, with good response. Finally a new screen saver has been implemented across the trust this quarter which reminds the Doctors in Training of the exception reporting system.

7. Support for the Guardian Role

There is a dedicated administrative resource for the Guardian of Safe Working which sits within the Medical Director's Office.

The Trust's Guardian of Safe Working, Dr Liz Evans, Specialty Doctor in Anaesthetics at DPOW, commenced in this role in June 2021.

8. Key Issues and Summary

Exception reporting during this quarter demonstrated an increase compared with the previous quarter. This rate is not in excess of what we would expect for this time of year. There has been an decrease in immediate safety concerns, which is reassuring. Concerns raised have been escalated appropriately and actions taken to prevent recurrence.

Continued engagement with the Junior Doctors has been very helpful and by working in partnership with them, we have been able to resolve most issues as and when they arise. We will ensure that we continue with this work, as it provides real-time information about the situation on the wards, in addition to being a contractual obligation.

Engagement of the Educational Supervisors still remains an issue which needs improvement- this will ensure a timely response to exception reports, in addition to providing improved support to the doctors in training, and contributing to our efforts to make the training experience at NLaG a positive one. Further refresher training for the educational supervisors who have not completed this course is planned for December.

Dr Liz Evans - Guardian of Safe Working

Date: 1st October 2023

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Gill Ponder, NED/Chair of Finance & Performance Committee	
Contact Officer/Author	Georgina Birley, Executive Personal Assistant to COO	
Title of the Report	**Finance and Performance Committee Minutes – September and October 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The Finance and Performance Committee minutes from the meetings held in September and October 2023 and subsequently approved at the following months meetings.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
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)		
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

Finance & Performance Committee

Meeting held on Wednesday, 20 September 2023 from 13:30 to 16:30 by MS Teams

Present:	Gill Ponder	Non-Executive Director (Chair)
	Shaun Stacey	Chief Operating Officer (COO)
	Lee Bond	Chief Finance Finance
	Brian Shipley	Deputy Director of Finance
	Jug Johal	Interim Joint Director of Estates and Facilities
	Simon Parkes	Non-Executive Director
	Fiona Osborne	Non-Executive Director
In attendance:	Ian Reekie	Lead Governor
	Annabelle Baron-Medlam	Acting Head of Compliance & Assurance (section 6.1)
	Ab Abdi	Deputy COO (section 8.3)
	Ashy Shanker	Deputy Director of Planning and Performance (section 8.5)
	Carla Ramsey	Chief of Staff (Observer)
	Richard Peasgood	Executive Assistant to COO
	Georgina Birley	Executive Personal Assistant to COO (for the minutes)

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1. Welcome and Apologies for Absence

Gill Ponder welcomed everyone to the September Committee meeting. There were no apologies.

2. Quoracy

It was noted that the Committee was quorate.

3. Declaration of Interests

There were no Declarations of Interest declared.

4. To Approve the Minutes of the Previous Meetings held on 19 July and 23 August 2023

The minutes of the meeting held on 19 July 2023 were approved.

The minutes of the meeting held on the 23 August 2023 were reviewed.

The following points were reviewed by the Committee and, once amended, the minutes were approved:

1. Page 12, point 10.1 in relation to the review of the high level risk register as part of the Board Assurance Framework (BAF) deep dive: Fiona Osborne requested for the addition of 'strategic threats to be added to the first sentence to read 'Fiona Osborne stated the 'Strategic Threats' section which stated there was a widespread loss of organisational focus on patient safety and quality of care, leading to increased incidence of avoidable harm should be under SO1-1.1, not SO1-1.2.'
2. Page 7, last paragraph of point 7.2 Lee Bond stated Shaun Stacey's comments inferred that all of Northern Lincolnshire and Goole NHS Foundation Trust's (NLaG) long waiters were due to accepting long waiters from other Trusts. Shaun Stacey stated that there were other factors contributing and he would provide amended wording to more accurately reflect his statement at the meeting to Georgina Birley for inclusion in the minutes.

Action: Shaun Stacey to meet with Georgina Birley to amend the wording of his statement in the minutes.

5. Matters Arising

5.1 Action Log

24 05 2023

5.3 – Lee Bond stated that he had discussed with Shaun Stacey outside of the meeting and that for some projects it was too early to see benefits realisation for them, such as the expantion of the operating theatres. They had asked internal audit to do a formal review of the benefits of the two new Emergency Departments (ED's). Gill Ponder stated the action was for the Committee to have assurance that there was a process for benefits realisation, not to discuss each project's individual benefits realisation. Shaun Stacey stated that himself and Lee Bond would create a plan as part of the investment that six to 12 months after the investment was made, an internal audit would review the outcome of the benefits realisation. Fiona Osborne asked if it was done as part of the Capital Investment Board when a financial investment was approved as part of the project timetable. Lee Bond stated that he would check. It was agreed that the action would be carried forward to October 2023.

Annabelle Baron-Medlam joined the meeting.

7.4 - Deferred to October 2023, as it would be included with the annual report due to come to the Committee in October.

12 – Shaun Stacey stated that the recovery plan had not yet been published. He added that it might come as part of the Winter plan. It was agreed to carry forward the action to the next meeting.

19 07 2023

9.1 – Confirmed action complete and to be closed.

9.4 – Confirmed action complete and to be closed.

23 08 2023

5.4 – Confirmed action complete and to be closed.

7.2 – Shaun Stacey stated it was in the Planned Care report which would be distributed after the meeting, so the action was closed

Action: Shaun Stacey to distribute the Planned Care report which included the MRI backlog improvement trajectory after the meeting.

7.2 – Confirmed action complete and to be closed.

7.2 – Lee Bond stated that he had not received the information but would pick it up with Ashy Shanker outside of the meeting so the action could be closed.

5.2 Terms of Reference (ToR)

The Committee noted the Terms of Reference. Fiona Osborne added the paper had not been circulated with the rest of the papers. Gill Ponder agreed that it had been added to Sharepoint late.

5.3 2023-24 F&P Committee Workplan V3

The Committee noted the Workplan. Fiona Osborne added the paper was not circulated with the rest of the papers. Gill Ponder agreed that it had been added to Sharepoint late.

5.4 Action Plan

The Committee noted the Action Plan. Fiona Osborne added the paper was not circulated with the rest of the papers. Gill Ponder agreed and added that it had been added to Sharepoint late. Gill Ponder requested to meet with Richard to update the Action Plan prior to the next meeting.

Action: Gill Ponder and Richard Peasgood to meet to update the Action Plan prior to the October meeting.

6. Presentations for Assurance

6.1 CQC Progress Report

Annabelle Baron-Medlam took the report as read and stated there had been positive progress made. Actions rated full assurance had increased from 14 to 18 and 13 had been fully closed and submitted to the Care Quality Commission (CQC). The number of actions with limited assurance had decreased from 32 to 29. Two more assurance papers had been submitted to the CQC and more were currently going through governance. A piece of work was being finalised identifying the financial costs in relation to the CQC actions which was initially done in February 2023 and it was being reviewed by the divisions. The second version of the report that was circulated to the Committee included an appendix which was for Committee feedback and approval. It included what the rating was, the divisions' highlights and lowlights and outstanding actions.

Fiona Osborne asked in relation to EOL02 the number of deaths and asked what the new deceased patient tool was. Annabelle Baron-Medlam stated the new deceased patient tool had been transferred to WebV instead of a paper document, but the process that automatically processed the data had been delayed due to the Patient Access System (PAS) system upgrades. Due to that, the team manually pull the patient death data from the system and compare it to the total number of deaths to audit how often the tool on WebV was being used. When done via paper around 50% of deaths were recorded, but since the tool had moved to WebV nearly all deaths were being recorded. The risk related to using two systems for recording patient deaths, the tool and WebV. Gill Ponder asked when the work should be completed as it said both December 2023 and February 2024 in the report. Annabelle Baron-Medlam stated that the End of Life team had a clear scope of which aspects would be completed by December and February.

Fiona Osborne asked relating to 4DAii what 'monitoring continues' meant. Annabelle Baron-Medlam stated that the action was nearly closed nine months ago but then a month later a backlog occurred so by 'monitoring continues' it meant the division were monitoring the blacklog figures closely and the actions around that. Fiona Osborne stated it would be useful for the action to be changed to 'monitoring to tackle fluctuations'.

Fiona Osborne asked if late papers were going to be a regular problem and if any support was needed. Annabelle Baron-Medlam stated no and it was a one off due to the addition of the appendix.

Gill Ponder stated in relation to page 31, appendix 1, that it was very helpful having the green or red flags against the performance figures stating if the increase or decrease was positive or negative.

Annabelle Baron-Medlam asked the Committee if they approved of the new appendix and if it should be continued for each meeting. The Committee agreed that it would be useful.

Annabelle Baron-Medlam left the meeting.

7. Estates & Facilities (SO1.4)

7.1 Sustainability Report

Jug Johal took the report as read and stated the content of the report was based on the Annual Governance Report. The report focused on the utilities usage which was included in the Trust's annual report. He stated that the size of the estate had increased due to the new ED's and so utility usage had also increased, as well as the price. There had been a £2 million increase in energy costs since 2022/23 due to the increased footprint, price rises and an increase in the number of scanners which use a lot of electricity.

The Combined Heat and Power (CHP) Unit had not been performing well at Diana, Princess of Wales (DPoW) Hospital but, due to the contractual agreement in place, the Trust would receive some money from British Gas to compensate for that. There had been an increase in water costs, not due to using more water than normal but due to more metering being installed around the estates. As a result, it was predicted that future bills would be higher than in the past.

The Trust was trying to reduce the amount of medical gases released through anaesthetics with a reduction in Desflurane and increase in Sevoflurane which was more carbon efficient. Nitrous Oxide had not been installed in the new ED's. The Trust could not replace any more diesel or petrol cars with electric cars due to not having enough capital funding to install more charging points. Jug Johal stated that the Trust needed to reinvest money that was saved when selling steel and recycling waste and ringfence that to reinvest in infrastructure to support the green agenda. He suggested that he met with finance colleagues to look at how that could be done.

Action: Jug Johal to meet with finance colleagues to discuss how the Trust could reinvest money from selling steel and recycling waste into expandinginfrastructure.

Jug Johal stated that £1m had been paid in travel claims. Although that seemed high, it was the same as the amount paid in 200, due to staff now using more sustainable modes of transport such as the shuttle buses. Containing those costs whilst progressing the green agenda was a significant achievement.

Fiona Osborne asked if the Committee were receiving the report on behalf of the Trust Board or if it was there for assurance. Jug Johal stated it was only submitted for assurance and that it would not be in the same format in the annual report. Fiona Osborne stated that it would have been useful to see targets like in the green plan and the future plan for the coming year to give context. Jug Johal agreed and stated that he would have put tables into appendices and that next time it would be a Group report of a better quality. Fiona Osborne asked if the same narrative would be used in the annual report. Jug Johal stated it would not be the same narrative due to the audience being different to the Committee. Fiona Osborne stated as an example on page five that it was good to hear the context around Nitrous Oxide being actively monitored.

Lee Bond asked in relation to the increasing take up of the cycle to work scheme if the Trust had expanded the number of shower facilities for staff. Jug Johal stated that had only been done in new developments such as ED, not across the Trust. Lee Bond asked if the Trust putting more water meters in was the cause of the increase in the amount of water the Trust was paying for. Jug Johal stated there was no difference as the same level of water was being consumber, but metering gave better intelligence on the usage and location of leaks which wasted water

and money. As an example, there had been a major leak at Castle Hill Hospital and due to the lack of metering it had taken a long time to locate the source.

Lee Bond asked if the Trust's strategy was to get rid of all Desaflurane and Sevoflurane gases, but Sevoflurane usage was increasing. Jug Johal confirmed the strategy was to get rid of all medical gases but the push was also to reduce the Trust's carbon footprint.

Gill Ponder asked why the CHP Unit had not been performing well and Jug Johal stated it was due to mechanical breakdowns and the lead time on replacement parts and an engineer to fix the unit.

Fiona Osborne asked how big the risk was of the Trust slipping behind on the green agenda. Jug Johal stated that the Trust would not achieve the sustainability plans due to not keeping up the pace of required investments to get to net zero, but that the Trust was heading in the right direction.

Simon Parkes stated that net zero was a challenge, but not the biggest challenge the Trust was facing. He stated that the backlog of maintenance and risk of critical infrastructure failure was more important. The cost of getting to net zero would fall over time due to advances in technology so it would get easier but there were bigger problems the Trust faced at the moment. Gill Ponder agreed but stated assurance still needed to be provided on other objectives.

Gill Ponder asked why there was a large drop in the Photovoltaic solar at DPoW Family Services for 2021/22. Jug Johal replied that he had highlighted it too and would ask the team to look into it for the next meeting. Simon Parkes did a quick calculation and stated it was a typing error and confirmed the reading should be 33,354.

7.2 Assurance Confirmation & Board Highlights

Gill Ponder summarised the highlights to Board to be the energy costs and usage and travel costs containment. Jug Johal asked to highlight the slow progress being made towards net zero, which was not in line with what had been planned.Iif the Trust had been able to complete the Salix funded work at Scunthorpe and had not lost out on Salix funding in the current year due to the bid timing out within a few minutes of the submission process opening, further progress would have been made. There were higher risks that needed to be addressed with the small amount of capital available from the Trust's own funds

8. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2 / SO1.6)

8.1 Unplanned Care

Shaun Stacey took the report as read. In August, there was a decrease in 60 minute ambulance handovers but an increase in 30-60 minutes handovers. ED performance continued to be a challenge and was below the target the Trust set for the month for the four hour wait. There had been a small decrease in ED and Urgent Treatment Centre (UTC) attendances. The increase in ED performance, the decrease in patients waiting over 12 hours without a decision to admit and the

decrease in patients waiting over 12 hours from a decision to admit demonstrated some improvement around the acute model. This reflected the pathway management with partners in the community to avoid patients being admitted. The number of patients being seen in Same Day Emergency Care (SDEC) had also fallen. The frailty service was an area of concern and impacting urgent and emergency care. Overall, length of stay had decreased in extended stays of seven and 14 days, but there was an increase in bed occupancy linked with the slowing of the Discharge to Assess (D2A) and community partner movement, but actions were being taken to mitigate that.

Lee Bond left the meeting.

8.2 Planned Care

Shaun Stacey stated the Elective Recovery Fund (ERF) activity level was ahead of plan but the Trust was about to head into a period of difficulty where activity numbers would be quite challenging.

The use of Advice & Guidance (A&G) had significantly increased. The Cancer two week wait performance had positively increased for the fourth month in a row. Unfortunately, the 28 day faster diagnosis, request to test in 14 days and 62 day GP referrals had missed their targets. The Cancer 62 day backlog had increased which was unfortunate with the work being done to keep it down and some of that was related to the Industrial Action (IA). The total number of referral to treatment pathways had increased and the corresponding 65 week and 52 week waits had already gone up a very small amount. The 18 week performance had also decreased with treating longer waiting patients. Overall, the DM01 performance had improved and congratulations were due to the radiology team for getting the mobile scanners up and running so quickly after their arrival onsite. There were still challenges around cystoscopy, colonoscopy and neurophysiology assessments. The Did Not Attend (DNA) rate fell again in August which meant calling and messaging patients to remind them about their appointments was having a positive effect on outpatient attendance. Overdue follow ups had increased and there was still work to do on clincians discharging patients who were on a routine follow up pathway on a regular basis, as there had been little traction on reducing follow-ups by the planned 25% to increase capacity for new appointments.

Ab Adbi joined the meeting.

Fiona Osborne stated that last month it was reported that the Trust was in negotiations with the independent sector and this month they were now in use, so what impact would that have on waiting lists going forward. Shaun Stacey stated it would be October before it made any impact. Fiona Osborne asked about the Hull University Teaching Hospitals (HUTH) Urology Oncologist who had been redirected to Breast and whether the agency person backfilling the urology post was the same person. Shaun Stacey confirmed that it was an experienced and competent agency locum that was undertaking the work; however there was financial competition from Leeds and Sheffield Hospitals who had a similar shortfall. Further work needed to be done on the Oncology workforce and that would likely come in November.

Simon Parkes stated that he was worried about Industrial Action (IA) showing no signs of abating and the Trust would see some significant deterioration in performance. He asked if any assessments had been carried out where risks were likely to occur and where more resource would need to go to protect critical activity within the Trust. Ab Abdi stated the Trust was already seeing the impact with the Cancer backlog, as 118 theatre sessions would be cancelled due to IA and the Trust were working proactively to try to recover those. Shaun Stacey added that patients would be given priority based on their waiting time and their risk stratification. The impact of IA was going to get worse and we were not seeing the full extent of it as the Trusts' workforce was still committed. Some clinicians had chosen not to strike but the challenge was planned care as the Trust could not take the risk of booking patients into clinics or theatres and no clinicians turning up to attend to them. The Trust was in a strong place from a waiting time perspective being in the upper quartile, but waiting lists would continue to grow if the treatment pathways were not managed.

Gill Ponder stated IA was a concern to everyone. Shaun Stacey stated out of a potential 154 consultants, 47 chose to strike that day, with 95 out of 143 F1/F2's and 3 out of 157 Associate Specialists; the previous day had seen similar numbers. Compared to last year, there were 13% more patients seen in ED even though attendance had dropped recently.

Gill Ponder referred to page 12 of the IPR and the statement that DictateIT was not delivering the planned benefits on outpatient improvements which had been in the IPR narrative two to three months running and asked what actions were being taken to replace it. Shaun Stacey stated that the Trust was rolling out an assisted speech tool which would assist in the improvement of summary letters. The technology needed to be used consistently by clincians as it learnt how the user speaks and the language used. The Patient Administration team were working on improving the take up of it.

Gill Ponder stated that the narrative in the IPR, for example on pages 16 and 22, was poor and it had been copied and pasted from previous months. Shaun Stacey agreed and stated he had some concerns about the narrative on a number of pages which he would be picking up with his team.

Gill Ponder referred to page 24 on theatre productivity and the statement that unavailability of porters was impacting on theatre productivity and asked if a piece of work had been carried out to see if it would cost less to increase the portering service than fail to fully utilise theatres. Shaun Stacey stated that it had not been done, but he felt that was an excuse and was disappointed to see that narrative. If theatres were running efficiently there should not be an impact.

Action: Shaun Stacey to discuss the quality of the narrative within the IPR with the operational teams.

8.3 PCIP including deep dive into Productivity Efficiency Programme including Outpatient Transformation

Ab Abdi took the report as read and stated theatre utilisation was at 74% in August due to peak annual leave and IA, however the average was at 93% with capped at 80.9% and uncapped 81.66%. The challenge of inconsistent data reporting

remained but they had been looking into an external source of reporting. Lots of positive actions had come from the national team on anesthetic assessments and pre-operative assessments. The Cancer 62 day backlog had deterioirated standing at 9.9% when reported, but currently stood at an improved 9.2%. In July the Trust exceeded its target of 28 day Faster Diagnosis of 75% at 78.1%. The three Cancer targets were now 28 day faster diagnosis, 31 day decision to treat and 62 day decision to treat. Lung Health Checks were a priority for 2023/24 which were happening five days per week, increasing to six days per week in November on the South Bank. A big challenge had been MRI capacity but with two mobile scanners in place the MRI trajectory had stayed the same. Outpatient Referral to Treatment (RTT) was on track to meet zero 65 week plus patients by the end of March 2024. There were eight patients reported to have been waiting over 78 weeks but that had reduced to five patients.

Lee Bond joined the meeting.

Elective Recovery Funding (ERF) in month five was 111% and year-to-date was 114%. Outpatient Transpormation Programme patient initiated follow up (PIFU) had increased to 3.29%, against the target of 5% but had since decreased to around 3%. Advice and guidance rates were at 36.5% against the national target of 16%.

Fiona Osborne asked for clarification on the first highlight that stated that the Trust had received 914 patients in mutual aid and if it was in the current financial year as the previous report in April stated 910, so had the Trust only received four more patients in five months? Ab Abdi stated it would be four during this financial year. Fiona Osborne stated that was a very low number considering the discussions the Committee had heard around performance due to mutual aid.

Action: Ab Abdi to confirm the number of mutual aid patients received this financial year.

Fiona Osborne stated under ‘lowlights’ it stated that the 18 weeks RTT was progressing well, but on the IPR it was special cause for concern and asked what was meant by progressing well. Ab Abdi confirmed the Trust was on target to meet zero 65 week waiters by the end of March 2024 but the internal target was December 2023 and, due to this, it was low risk and would be three months ahead of the national target.

Ashy Shanker joined the meeting.

Simon Parkes stated it was difficult to have assurance when there were issues with the reporting figures. Gill Ponder agreed and stated the report and IPR had inconsistencies in reporting data such as the percentage of Face to Face (F2F) consultations was 20-25% in the report but the IPR stated it was 18%. Ab Abdi agreed with the inconsistencies and stated from a theatre productivity perspective it needed to be improved so there was a single truth, as there were differences between the theatre utilisation data on the IPR and GIRFT paper. Work was ongoing with the Digital team to achieve that, but they had capacity issues due to working on major projects to replace the patient administration system and implementing an electronic patient record system. In the meantime, the measure definitions being used were in line with those used by the national team.

Lee Bond asked which areas were most vulnerable on the productivity agenda. Ab Abdi stated that NLaG were one of the best Trusts on productivity regionally exceeding the faster diagnosis target at 77.7% The Cancer position was worrying due to capacity and interdependency on the north bank. Gill Ponder agreed with the worrying Cancer position and stated there were 29 cancer patients waiting over 104 days and asked Ab Abdi to focus in his next report on the long waiting Cancer patients and the actions being taken to get to zero 104 day waits.

Action: Ab Abdi to focus on long waiting Cancer patients in his next report and the actions being taken to get to zero 104 day waits.

Ab Abdi left the meeting.

8.4 Buisiness Continuity Updates

Deferred to October 2023.

8.5 Elective Recovery Board Checklist

Ashy Shanker stated the checklist came from the Winter letter the Trust received from Sir James Mackey and Professor Tim Briggs on 4 August 2023 asking for the Trust to provide assurance that they would protect and expand elective capacity through Winter. Ashy Shanker stated that hardly any elective activity had been cancelled last Winter. Fiona Osborne stated that she had not read the paper due to the lateness of the paper and requested to take approval offline until core members of the Committee had had a chance to review the document. Ashy Shanker apologised for the lateness of the paper due to it going to the executive meeting the previous week and Trust Management Board (TMB) the previous day.

Gill Ponder stated that 97% of outpatient follow ups with no due date had not been risk stratified and asked if that was a risk to patients and what was being done about it. Ashy Shanker responded that the risk stratification process was being led by the Associate Director of Patient Services. The cohort was large and they were looking at ways of working with the clinicians to reduce the risk. They were hoping to discharge around 30% of patients in that category and move another 10% to Patient Initiated Follow Ups (PIFU).

Shaun Stacey stated that the paper required the signature of the Chief Executive and Chair of the Trust and came to this Committee for information only. The approval was made at TMB..

Gill Ponder stated that, as an assurance Committee, they needed to see progress on the actions included in the Trust's response to the checklist. Shaun Stacey confirmed that the items on the checklist would be covered in the PCIP report to prevent another workstream being created.

Action: Shaun Stacey to ensure that assurance was provided on progress with the actions included in the response to the Elective Recovery checklist in future PCIP reports.

8.6 Assurance Confirmation & Board Highlights

The Committee agreed to raise to the Board the Cancer patients waiting over 104 days, the small improvement in ambulance handovers and the ED four hour wait and continued length of stay figures. Also, that the elective recovery paper was discussed, the differences in the theatre utilisation data on the IPR and GIRFT paper and the national recognition the Trust had received on the high percentage of non-elective work being carried out.

Ashy Shanker left the meeting.

9. Review of NLaG monthly Financial position (Finance Report) (SO3.1 / SO3.2b)

9.1 Finance Report M5

Brian Shipley stated the Trust reported an in-month deficit for month five of £2.4m, £0.3m favourable against the plan. The year-to-date (YTD) position was a deficit of £11.6m, £2.2m favourable against the plan. The Trust was forecast to still hit plan and remain in £13.5m deficit with no new risks, but risks already raised in previous months included continued IA and releasing all of the planned balance sheet items. The risk of Elective Recovery Funding (ERF) was now being included but it was not known if the further IA would adjust the baselines of the ERF target. The original target of 107% had been reduced for the IA in April, but no further reductions had been announced for IA that had taken place since then. Lost activity from IA this year was £300k. The risk of the increase of the junior doctor British Medical Association (BMA) rates was also included this month.

The Trust CIP was behind plan year to date due to not releasing all of the planned balance sheet items, but was ahead on the core programme. The forward projection had slightly improved from £10m to £9.8m. However, savings tended to be skewed towards non-recurrent items, which would add to future financial pressures. System performance was £13.3m adverse to plan at the end of month four with the Trust being the only provider not in deficit.

The Medical Staffing pay award cost to the Trust was calculated at £800k which deteriorated the underlying position. The Trust was behind on the Capital plan due to delays on the new ED's and Acute Assessment Units (AAU's) but was still forecasting a plan compliant position.

NLaG's straight line projection of current expenditure was £25m, with the possibility of reducing that to £22m, which left £10m that needed to be absorbed to hit the plan with tangible actions not in place to reduce that. Next month the report table would include the increased trajectory for planned activity. Lee Bond had raised the Capital position to the Executive Team and a workable proposition for a revised Capital plan for the current financial year, involving changes to 2024/25 plan, was close to being finalised.

Gill Ponder stated that the underlying deficit was a big risk and should be flagged to the Board. Fiona Osborne stated that high absence rates correlated directly to the high bank and agency spend and asked if it was the same at divisional level . Gill Ponder added that nursing and midwifery absence rates had fallen from the previous year but the bank and agency spend remained high and asked why. Lee

Bond stated that he was not sure but as an example, the ICB South West were only allowing Trusts to fill ward staffing levels to 90%. Fiona Osborne requested that it be flagged to the Board. Brian Shipley stated that sickness rates were lower than the previous year and down to pre-pandemic levels and that the biggest driver for agency spend was vacancies. 80% of bank and agency spend was to cover vacancies and filling over 100% of ward staffing levels and stated that that was due to skill mix of staff booked and escalation beds being open.

Gill Ponder stated a solution needed to be found to reduce the run rate due to the impact on the exit position into 2024/25 and felt that the Committee should highlighted that to the B.

Fiona Osborne asked about the cash balance forecast that had a £5m shortfall and how much opporitnity would be left to ask for support if needed. Lee Bond stated that there was time to manage that and request support if needed.

Gill Ponder asked if any provisions had been included in the forecasts for the risks of continued IA and further potentially unfunded pay awards. Brian Shipley confirmed unquantified risks were not included in the forecast.

Gill Ponder referred to the cost pressures for the AAU schemes, the slipped timeframes and the cost increases and asked what was being done to control project scope creep. Lee Bond stated there was no scope creep and the problem was that delivering the existing scope was highlighting more problems than expected as the build work progressed. Jug Johal agreed and stated that old underground drainage drawings of the Trust didn't match the actual drainage, so Kier the contruction company were having to redo all the drainage and add in new lines which was over and above what was in the agreed contract. The flooring screed in both ED's had crumbled due to the poor quality and it had not been possible to do a more thorough survey on it beforehand due to the need to close beds in the ED's which could not happen given the level of demand on those services. Lee Bond stated that lessons had been learnt and he would not for example agree to reduce the contingency budgets for the new CDC's in Scunthorpe and Grimsby.

9.2 Financial Recovery Planning

Lee Bond stated that the report was requested due to the increased stricture as a result of having the deficit plan. The analysis was of vacancies being held over six months that were not being covered through bank and agency and had been presented at Trust Management Board (TMB). It was requested within the next three weeks that the divisions take out their recurrent vacancies to reduce the recurrent deficit. It was asked that the clinical leads work with their financial business partners if they needed to recruit to those posts and the reasons why. If they removed the vacancies and needed to re-establish them in the future, it would need to go through the normal business planning process. It should be noted that those unfilled vacancies were supporting the in year cost saving position non-recurrently.

The workforce growth analysis showed the growth of the workforce since 2019/20 split into categories including elective care and urgent and emergency care. It showed the increase in workforce had not created an increase in productivity. It

was requested at TMB that the paper be presented at the next Board meeting. Lee Bond asked for input from the Non-Executive Directors as to whether or not they reached the same judgement as the Finance Team had from the paper.

Gill Ponder stated that there appeared to be limited opportunity to disinvest due to safety, quality and the need to staff expanded capacity but there were some viable opportunities around the unfilled vacancies that she thought should be explored. Lee Bond stated that he would work with the management teams on the vacancies and take the papers to the Board together.

9.3 Cost Comparisons

Deferred to October 2023.

9.4 Business Case Assurance

Lee Bond stated that the funding was short for the CDC Scunthorpe site but it had been verbally agreed with North Lincolnshire Council that they would invest £1.2m.

9.5 Assurance Confirmation & Board Highlights

Gill Ponder summarised that the Committee should highlight to the Board the current financial position including the forecast plan with risk and the potential for further risk due to IA or unfunded pay awards. Also the Capital solution and the ongoing Executive Team work to look at removal of vacancies. Fiona Osborne requested that the continued concern about the level of bank and agency spend was raised.

10. BAF – 10.1 SO1-1.4 Deep Dive

Gill Ponder stated that she had reviewed the strategic risk register and would send her questions to Jug Johal as there were too many to go through them all at the meeting. Fiona Osborne stated the risks around the infrastructure of the core buildings were not mentioned in the BAF. Jug Johal stated that the report had been changed several times but he would pick that up with his team. The backlog of maintenance was also considered to be a gap in control, rather than a risk.

Gill Ponder also stated that the risk from Reinforced Autoclaved Aerated Concrete (RAAC) was not included. Overall, the Committee agreed with the current risk score of 20.

Action: Gill Ponder to send her list of queries on the strategic risk register to Jug Johal for him to answer offline.

Action: Jug Johal to review the BAF entry to include the risks from the condition of the core infrastructure due to historic underinvestment in maintenance.

11. Items for Information (Not For Printing)

11.1 Performance Letters to Divisions following PRIMS Meetings

No meetings had taken place.

11.2 Capital Investment Board Minutes

No meetings had taken place.

12. Any Other Urgent Business

No items were raised by the Committee.

Matters to Highlight to Other Trust Board Assurance Committees

No items were raised that required referral to othercommittees.

13. Matters for Escalation to The Trust Board (Public/Private)

Items to be included in the Board Highlight Report were captured at the end of each section of the agenda.

Review of Meeting

Fiona Osborne stated that it had been a good meeting despite the time pressures, late papers and issues with embedded documents.Simon Parkes stated that the Committee discussed the right things but did not have enough time to discuss the final agenda item and it was a risk that was likely to eventuate and could be catastrophic. Gill Ponder commented that the Committee regularly discussed the various aspects of building infrastructure risk in the Estates and Facilities part of the agenda, but that the final item on the agenda that day was to review the BAF entries rather than the risks themselves.

14. Date and Time of the Next Meeting

The next meeting will take place as follows:

Date: 18 October 2023
Time: 13:30-16:30
Venue: Exec Board Room, Diana Princess of Wales Hospital

Annual Attendance Details:

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√	√	√	√	√	x	√	√	√			
Fiona Osborne	√	√	√	√	√	√	X	√	√			
Lee Bond	√	√	√	x	√	x	√	√	√			
Jug Johal	√	√	√	√	√	x	X	√	√			
Shaun Stacey	√	√	√	√	√	√	√	√	√			
Ian Reekie	x	√	√	√	x	√	√	√	√			
Richard Peasgood	√	√	√	√	√	√	√	√	√			
Simon Parkes	x	x	√	√	√	√	√	√	√			
Brian Shipley	√	√	x	√	x	√	√	√	√			
Annabelle Baron	√	√	√	√	√	√	√	√	√			
Abdi Abolfazl	√	x	x	√	x	x	√	X	√			
Ashy Shanker	x	√	√	x	x	√	√	√	√			
Shiv Nand	√	x	x	x	x	x	X	X	X			
Dr Peter Reading	x	√	√	x	x	x	X	X	X			
Linda Jackson	x	x	x	x	x	√	x	X	X			
Craig Hodgson	x	x	x	x	x	√	√	X	X			
Kate Truscott	x	x	x	x	x	x	√	X	X			

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

Finance & Performance Committee

Meeting held on Wednesday, 18 October 2023 from 13:30 to 16:30 in the Exec Boardroom, Diana Princess of Wales (DPoW) Hospital

Present:	Gill Ponder	Non-Executive Director (Chair)
	Ab Abdi	Deputy COO
	Brian Shipley	Deputy Director of Finance
	Jug Johal	Interim Joint Director of Estates and Facilities
	Simon Parkes	Non-Executive Director
	Sue Liburd	Non-Executive Director
In attendance:	Annabelle Baron-Medlam	Acting Head of Compliance & Assurance (section 6.1)
	Matt Overton	Associate Director of Central Operations (section 8.4)
	Richard Peasgood	Executive Assistant to COO
	Georgina Birley	Executive Personal Assistant to COO (for the minutes)

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1. Welcome and Apologies for Absence

Gill Ponder welcomed everyone to the October Committee meeting.

Apologies were received from Shaun Stacey (Chief Operating Officer), Fiona Osborne (Non-Executive Director), Helen Harris (Director of Corporate Governance), Ivan McConnell (Director of Strategic Development), Lee Bond (Chief Financial Officer) and Ian Reekie (Governor Observer).

It was noted that the Committee was quorate.

2. Declaration of Interests

There were no Declarations of Interest declared.

3. To Approve the Minutes of the Previous Meeting held on 20 September 2023

The minutes of the meeting held on the 20 September 2023 were approved.

4. Matters Arising

4.1 Action Log

24 05 2023

5.3 – Due to Lee Bond and Shaun Stacey not being able to attend the meeting, no update on progress with the action was available. It was requested that the action be completed before the next meeting in November due to it being deferred several times.

7.4 – The EPRR report, which included the progress with the electrical failures action plan, would be discussed during agenda item 8.4. Action closed.

12 – Ab Abdi stated that the Trust was still awaiting the plan from the ICB so it was agreed to defer the action to the November meeting.

20 09 2023

4 – The wording had been amended. Action complete and closed.

5.1 – Ab Abdi would circulate the MRI backlog trajectory to the Committee immediately after the meeting. Action closed.

5.4 – The action plan had been updated, so action complete and closed.

7.1 - Jug Johal met with finance colleagues and confirmed that the Trust does reinvest money saved when selling steel and recycling waste by allocation money to green travel planning. Action closed.

8.2 - Confirmed action complete and to be closed.

8.3 - Confirmed action complete and to be closed.

8.4 – Gill Ponder stated the number of 104 day wait cancer patients had risen from the previous meeting and the action to bring a plan to get to zero back to the Committee was deferred to the November meeting.

8.5 – Gill Ponder stated that the recovery plan checklist had been completed and had been to Trust Board but the date of the action to confirm progress with delivery of the plan was unrealistic. Ab Abdi stated he would cross reference the checklist against the next PCIP update that would come to the Committee in December. It was agreed to defer the action to December and an update would be provided within the PCIP report due then.

10 - Confirmed action complete and to be closed.

10 – Jug Johal agreed that the BAF did not reflect the poor core infrastructure and it was agreed that the action to update the BAF would be deferred to the November meeting.

4.2 Terms of Reference (ToR)

The Committee noted the Terms of Reference.

4.3 2023-24 F&P Committee Workplan V3

The Committee noted the Workplan.

4.4 Action Plan

Gill Ponder stated that she had met with Richard Peasgood to update the Action Plan. Some actions had been closed and it had been circulated within the Committee papers.

Ab Abdi stated, in relation to action three, reporting theatre session utilisation was an ongoing challenge but the capped and uncapped data was included in the weekly board assurance report. The five indicators that were not reported on were not a priority for the Digital team due to them focusing on other projects. The sub measures needed to be available in BI to understand what was driving the lack of productivity.

Action: Gill Ponder and Richard Peasgood to meet to further update the action plan.

Brian Shipley stated, in relation to action six, that papers would no longer go to the Group Executive Meeting before Committies; they would only go to the Group Executive Meeting before going to Trust Board.

5. Presentations for Assurance

5.1 CQC Progress Report

Annabelle Baron-Medlam took the report as read and stated there had been a small amount of progress made. The number of actions with a limited assurance rating had decreased from 29 to 28 and the number of actions with a moderate rated assurance had decreased from 58 to 56. A number of actions had passed their timescales but she was working with the divisions to support them. She was being trained on clinical systems to help the divisions with spotchecks so actions could continue to progress. Family Services and Medicine divisions had not provided their update to her in time for her to submit the paper to the Committee so their data was not included. but she had received The Medicines update had been received on the day of the meeting, so it would be circulated to the Committee following the meeting.

Action: Annabelle Baron-Medlam to circulate the Medicine update to the Committee after the meeting.

emphasise the importance of papers being submitted prior to their deadline and it needed to be taken more seriously by staff to ensure Committees got assurance. Gill Ponder referred to MED-18 and MED-19 on the CQC report and stated that it was unlikely that Medicine would achieve their targets of follow up appointments and 62 day cancer waiting times by the completion dates shown on the report. The

update for those points was that the report data continued to be monitored which was generic and did not state how the actions would be achieved by the dates stated. Annabelle Baron-Medlam stated that she would feed the comments back to the division.

Action: Annabelle Baron-Medlam would request a more specific update from the Medicine division on MED-18 and MED-19.

Simon Parkes and Gill Ponder stated that they were not assured on the 62 day Cancer waiting times for Medicine in the CQC action plan because the PCIP report continued to show that the target had not been achieved and was unlikely to be achieved in the near future. Ab Abdi stated that the division could have reached their internal target, but he would check with the division.

Action: Ab Abdi to review Medicine divisions 62 day Cancer waiting times target and CQC action plan updates with the division.

6. Review of NLaG monthly Financial position (Finance Report) (SO3.1 / SO3.2b)

6.1 Finance Report M6

Brian Shipley stated that the Trust was adverse to plan by £0.4m in month six with a £2.8m deficit, the main reason being it included the Elective Recovery Fund (ERF) penalty of £0.7m. The ERF target had still only been adjusted for the Industrial Action (IA) in April 2023 and there had been no further clarity on changes for subsequent strikes. The year-to-date (YTD) position had deteriorated with a deficit of £14.4m, £1.8m favourable against plan. The year-end forecast had not changed and the Trust was forecasting a £26.1m deficit before management action at the year end, although the risk of ERF penalties had not been included in that forecast. Technical savings and improvements on CIP delivery would bring the position in line with the planned £13.4m deficit.

The Trust lost activity due to IA during August and September with £1.15m YTD cost and a forecast of £3.4m if IA continued for the rest of the year. The cost of back filling during the junior doctors strikes was around £150k, the cost for back filling during the consultants strikes was lower but resulted in more activity being lost. The other main risk in the forecast was the annual leave provision of £6m. The annual leave balance was at the same level from August 2022 to August 2023, but a communications email would be sent to staff shortly to encourage staff to take their annual leave, but that would reduce activity and increase bank and agency spend.

The ICB reported a deficit of £42.4m, £19.1m adverse to plan for the first five months of the year.

Gill Ponder asked if the financial controls checklist recently submitted was being followed up by the Audit, Risk and Governance(ARG) Committee to get assurance that the controls reported were operating effectively. Simon Parkes confirmed that the actions would be reviewed by the ARG Committee. Brian Shipley stated in the

NHSi oversite meeting they were less concerned with NLaG compared to others in the system, but the Trust was still a risk.

Action: Gill Ponder to refer the Committee's request for assurance that the financial controls in the checklist were in place and operating effectively to the ARG Committee.

The Trust was due to hit the Capital forecast with a revised plan and things being brought forward from 2024/25 if necessary. There was a risk with the delay of the Community Diagnostic Centres (CDC's) but the Capital Investment Board (CIB) would manage that and escalate any risks to this Committee.

The cash flow forecast showed that the Trust would need cash support from February 2024 for £5.5m. That could possibly be deferred to 2024/25 but the Trust was looking into the process to request support now to be ready if it was needed.

Gill Ponder questioned the need for a provision for ERF penalties if the Trust had an activity target of 107%, that was adjusted to 105% because of IA, and was delivering at 110%. Brian Shipley replied that the NHSi 2019/20 baseline was originally 104% and the target was 107% which was then adjusted to 105% for the year. The internal operational plan to achieve that was backended delivery due to the impact of 3 theatres being refurbished at the start of the year.However, NHSi delivery profile was flat across the year. As a result, the Trust reported performance against both profiles, but they should even out by the end of the year as the total activity target for the year was the same.

Simon Parkes stated that if NHSi had accepted the Trusts new profile, it would have avoided the confusion. Simon Parkes stated that he thought it was unlikely that penalties would be imposed without the Trust being given an additional amount to cover the strike costs.

Ab Abdi added since the first strike in that financial year, 3,901 activities had been cancelled, with 1,091 of those being in September. Gill Ponder added that there was a risk of lower theatre productivity during the Winter period, as the Trust may have to prioritise urgent and emergency care if demand exceeded capacity and the measures in the Winter plan proved to be insufficient. Brian Shipley stated that the Trust was doing everything it could to hit the plan, but further Industrial Action was the biggest risk.

Simon Parkes stated that he hoped that the Chief Executive and Chief Financial Officer were on top of this but the Committee did not have assurance the Trust was as productive as it could be. Gill Ponder added that the Committee needed the missing theatre utilisation data to see if the lack of productivity was due to late starts, attendance patterns or other things. Ab Abdi stated NLaG was picked up nationally as a productive hospital but that did not mean that it could not do better and he understood why the Committee was not assured with the finance figures as they were and discrepancies in the theatre productivity data coming from himself and the national team.

Simon Parkes asked Brian Shipley what the Trust should be doing that it was not already doing. Brian Shipley replied that they were trying to address the ED costs, but there were 15% additional attendances and there was still had a £10m

unidentified gap going into the next financial year within the Cost Improvement Programmes (CIP). The Trust needed to turn non-recurrent vacancies into recurrent savings and reduce agency spend. He added the recruitment drive within nursing was going well, but it was less successful with doctors and consultants.

6.2 Financial Recovery Planning

Brian Shipley apologised for the late paper and stated it was with the Committee for information only. The paper was brought last month and identified vacancies that had been vacant for more than 8 months. The paper would be taken to the Group Executive meeting to review and for them to challenge the divisions on back office posts that had been vacant for some time. A different approach was needed for clinical vacancies due to needing to understand the impact of removing the post and clinical leads and medical directors were involved.

Simon Parkes stated that the Group Executives needed to look through this with hard scrutiny due to the Trust being short on recurrent CIP. Gill Ponder suggested that the Committee should review the paper again after the Executives had completed their review.

6.3 Cost Comparisons

Deferred to November 2023, due to the data not yet being available from the national team.

6.4 Business Case Assurance

CDCs

Jug Johal stated two business cases had been submitted, the first spreadsheet was for £19.4m for Scunthorpe and the second business case for £10m for Grimsby with a total revenue implication of £29.4m. NHS England would support the revenue costs up until 2024/25 but had not committed support beyond that year. The forecast cost for Scunthorpe was £21.7m and for Grimsby was £9m, with a plan to transfer the £1m remaining from Grimsby to Scunthorpe. There remained a gap of £1.3m which the local authority had verbally agreed to provide; written confirmation was expected soon. The full business case had not been presented to Trust Board yet due to the team wanting the full funding to be confirmedfirst. There remained a risk to the programme from delays with the planning permission process.

There was an issue with the land for the Scunthorpe site due to needing access from a local sports hall next door, but the local authority had stated it would not be an issue. The Scunthorpe site would be a Hub but the Grimsby site would be a Spoke utilising five shop units within the Freshney Place Shopping Centre. It had been agreed that the Ophthalmology service at DPOW would transfer to one of the shop units as part of the Spoke. Although there would be a Capital cost involved, it would relieve car parking pressures at the hospital and be a positive addition to the scheme.

Brian Shipley added that the Income and Expenditure model needed to be explored if Ophthalology was moved due to car parking incomeat Grimsby being

reduced and if central revenue funding support was withdrawn, itwould pose a future financial challenge to the Trust.

Sue Liburd stated in relation to page 17, there were significant risks and was concerned with only a 10-14% contingency. Jug Johal stated the surveys had already taken place at the Scunthorpe site and the risks were low and that the contingency could be set too high, but it would not be reduced due to the issues encountered with the Emergency Departments (ED's) and Integrated Acute Assessment Units (IAAU's). The Trust were the main contractor for the build with a separate work package for each aspect which had resulted in savings. Brian Shipley stated that it was not clear what would happen after 2024/25 regarding the funding as it had not been announced.

Simon Parkes asked how the site would be staffed when completed and Brian Shipley stated that international recruitment was taking place. Sue Liburd stated that the new staff would need to be supervised and asked where the staff would come from to supervise. Brian stated the recruitment had already started to ensure they were trained and able to work solo when the CDC's were ready. It was agreed that a referral would be made to the Workforce Committee to ask them to review the staffing strategy for the CDCs.

Action: Gill Ponder to raise a referral to the Workforce Committee about the staffing strategy for the CDCs.

Gill Ponder asked, in relation to page 8 on revenue projections, why it stated the revenue would fall in years 2026/27 and 2027/28 and what level of inflation had been included in the projections. Brian Shipley stated the fall in revenue was due to the reduction in agency spend due to more substantive staff and that the inflation rate was the standard market rate. Gill Ponder asked if the rate was realistic and if the contracts agreed were fixed price. Brian Shipley confirmed they were fixed price contracts unlike the Same Day Emergency Care (SDEC) and IAAU builds.

Pathology LIMS Replacement Tender

It was agreed by the Committee to defer this item to the November meeting and to invite Elaine Graham (Blood Science Directorate Operational Manager and Path Links Assistant General Manager) and Chris Evans (Deputy Chief Information Officer) to attend the Committee to present the business case and take any questions. The Committee were interested to understand the strategy for Pathlinks and any potential opportunities within the Group Structure.
Action: Georgina Birley to invite Elaine Graham and Chris Evans to attend the meeting and advise them of the areas that the Committee were interested in gaining assurance on.

6.5 Assurance Confirmation & Board Highlights

Gill Ponder summarised that the Committee would highlight to the Board the position on Finances, delivery of activity and the risk of ERF penalties. Also that there were concerns about the level of contingency and workforce for the CDCs and the potential future revenue risk if central revenue support was withdrawn after 2024/25. The request for assurance on the strategy for Pathlinks and any

future opportunities presented by the Group structure would also be included in the report.

7. Estates & Facilities (SO1.4)

7.1 Asbestos

Jug Johal took the report as read and apologised for the late amendment to the report, due to the reduced risk rating. The asbestos management group met to discuss identified asbestos and incidents. It reported to the Estates and Facilities management, group which then provided assurance to the Committee. The red dot plan had been completed showing the location of all asbestos on each site and the risk register had been updated with a reduced risk score as asbestos was no longer considered to be a major risk. A number of staff had been trained on P405 on the management of asbestos. There had been five asbestos related incidents between 1 October 2022 and 20 August 2023 and no concerns had been raised with how they had been managed.

Simon Parkes stated that the Trust had followed process and managed the incidents well and that asbestos was not a great risk if managed safely. The media had caused attention to be on Reinforced Autoclaved Aerated Concrete (RAAC) and he asked if the Trust would see any focus on asbestos on the back of it. Jug Johal stated that there could be equal attention paid to the pipework or electrical cables but the Trust had been proactive with asbestos by getting rid of it during refurbishments. Gill Ponder stated that it was good to see that the actions taken had led to reduction in the risk.

Gill Ponder stated that there were team members awaiting training and asked what the risk was from them being untrained and what their training plan was. Jug Johal responded that the training was on a rolling plan, so there would always be people awaiting training. There were enough staff currently trained in asbestos management so there would always be someone available if needed and it was not a concern. She asked if there was an authorised engineer for asbestos and Jug Johal stated that it was not a requirement.

Jug Johal also advised the Committee that the water improvement notice at Scunthorpe Hospital had been discharged.

Jug Johal reported regarding RAAC that there was low availability of structural engineers due to schools hiring them for their RAAC issues. He had spoken with NHS England (NHSE) and the Trust had made contact with a different company who had inspected the gym roof at Scunthorpe General Hospital (SGH) and they had confirmed the plaster was intact, but it needed a structural engineer to confirm that there was no risk in writing. There was no timeframe for this but they were being chased weekly. In the meantime, both areas affected had been taken out of service. The Trust was on the national RAAC programme along with other Trusts.

7.2 Assurance Confirmation & Board Highlights

Gill Ponder summarised the highlights to Board to be the RAAC inspection update, the reduced risk score for asbestos and the discharge of the water improvement notice.

8. Review of NLaG Monthly Performance and Activity Delivery (IPR) (SO1.2 / SO1.6)

8.1 Unplanned Care

Ab Abdi took the report as read and stated that Ambulance Handovers and ED four hour performance had not met the planned trajectory at 64.3%, Urgent Care Service (UCS) achieved the four hour performance target with 99%, 368 patients waited over 12 hours without a decision to admit/discharge, 625 patients had waited over 12 hours for beds, 43.7% of SDEC patients were discharged the same day. The inpatient elective length of stay had decreased to 1.9 nights and non elective had increased to 3.5 nights. The percentage of extended stay patients of seven days had increased to 54.2%, over 14 days had increased to 28.9% and over 21 days had increased to 15%.

IA had impacted the level of patient discharges, as there were fewer experienced consultants available to discharge patients. COVID infections had resulted in two closed bays. During previous IA, ED attendances fell, but in October they had remained high with attendances on 9 October 2023 at 567. Patient acuity had also been high. Pre-COVID, over 400 ED attendances would have resulted in the site being classified as OPEL 4.

Simon Parkes stated that there were much higher levels of ED and SDEC attendances and that the four hour target was holding up even with the increase in attendance. Gill Ponder stated that attendances had been static for five months and that the IA had had an impact but there appeared to be an additional issue. Brian Shipley stated that the last five months this year, compared to 2022, saw an increase of 15% in ED attendance. SDEC was working well as it had seen a nearly 30% increase in patients. Ab Abdi stated that patient attendance had remained static but the strikes meant that it took more time seeing, caring and discharging patients and there was an impact on performance for three to four days post IA. During the IA, the workforce was not as robust and the clinicians did not have the level of confidence to discharge patients which resulted in longer length of stays.

Simon Parkes thanked Brian Shipley and Ab Abdi for their comments and understood now the impact IA was having on performance, but it did not explain the poor four hour performance against the 95% target. Gill Ponder stated that John Awuah would cover that next month in the unplanned care deep dive. Ab Abdi stated that quality improvement programmes helped in urgent and emergency care and that NLaG was fairly efficient but was underproviding on beds and struggling to become more efficient. Brian Shipley stated that there had been a 29% increase in SDEC attendances with 43% of non-elective admissions going home the same day. Non-elective long stays had been at 5.3 days but had reduced to four days which should have reduced elective pressure, but due to the 15% rise in ED attendances there had been no relief. Ab Abdi stated that not all SDEC division pathways were in place but as the Group structure was brought together and the new builds were opened, that would be completed.

8.2 Planned Care

Ab Abdi stated that in September theatre utilisation was at 80% with capped at 81.6% and uncapped at 82.2%, but he was still trying to understand the external data inconsistency. The Cancer position had deteriorated with a backlog of 9.4% in September and the current position was 8.9%. There were 44 patients waiting over 104 days and faster diagnosis was at 69.5%, which although it did not meet the target of 75% was good within the Integrated Care System (ICS). The Inter Provider Transfer (IPT) 38 day target was a challenge but the lung health check was on track to go to six days per week. The Trust had received 200 mutual aid requests so far that year and follow up appointments were meeting trajectory, but the waiting list was increasing. The diagnostic MRI trajectory was improving and Patient Initiated Follow Ups (PIFU) was at 2.8%. There had been 3,901 activities cancelled from April 2023 due to IA, with 1,091 cancelled during September's IA alone.

Gill Ponder stated that the IPR was worrying with areas not improving and asked what the Trust could do to improve the areas consistently failing to meet the standards. Ab Abdi stated planned Cancer was the top priority. There had been proactive planning during the Summer but the ongoing IA had impacted on delivery of the plans. Pathology was a challenge but seven day working would reduce reporting times. A deep dive within the Group was being carried out with Dr Gavin Anderson, Clinical Lead for Cancer at HUTH and, as part of the Group structure, Cancer would have single PTL's which would be helpful.

Gill Ponder raised that the report stated theatre utilisation was at 56.2% but Ab Abdi had stated it was 80% when presenting his report. Ab Abdi stated he would check that the report was correct.

Action: Ab Abdi to check and confirm the theatre utilisation percentages.

Simon Parkes stated that the Committee needed to focus on what was not changing, the underlying story and how it could be changed, not focus on the latest hour to hour data. Gill Ponder stated that she would rather the data and report was not rushed to meet the deadline for submission of Committee papers and that it would be preferable to discuss the previous month's correct data.

Action: Ab Abdi to discuss with Shaun Stacey about bringing the previous month's data to the Committee to reduce errors and improve the quality of the narrative in the IPR.

Gill Ponder asked how the CT and MRI capacity was reduced due the CDC constraints, as that was not clear from the report. Ab Abdi replied it was due to an issue with the mobile pads but they were now in place and the backlog was reducing.

Gill Ponder asked about reducing follow ups by 25%, increasing adoption of PIFU and, what the significant challenges were and what change management skills and resources were being used to drive this forward. Ab Abdi stated that the change was from follow up to new appointment capacity and it required a change in traditional models used by clinical leads. It had already been discussed with medical directors but clinical leads would be taking a risk if the patients were to

initiate their own follow up appointments as it had not been done at any other Trust in the country. A letter had been sent from Dr Kate Wood, Chief Medical Officer, to the clinical leads to ask the divisions for help with the change. Innovations across the Group would be shared to improve performance. The pathology seven day working would hopefully start in January or February 2024 as the team were recruiting to fill the funded posts.

8.3 PCIP including deep dive into Elective Care and Waiting List Recovery

Discussed within agenda item 8.2.

8.4 Emergency Preparedness, Resilience and Response (EPRR) Annual Report

Matt Overton took the report as read and stated that the annual report covered the period from 1 April 2022 to 31 March 2023. The NHSE core standards for EPRR showed the Trust as substantially compliant as part of the three yearly internal audit from Audit Yorkshire. The Trust was completing the assessment for the current year, but the process had changed with a lot more detailed requirements. As a result, it was thought that there would be reductions in the level of compliance ratings for many Trusts. There had been a challenge with workforce availability for training and new national guidance had been published following the Manchester Arena bombing. The annual workplan covered what had been done so far and what was scheduled for the rest of the year including the training programme. The action plan produced following the electrical infrastructure failure in December 2022 had been completed, apart fromone action on the Uninterupted Power Supply (UPS) at SGH. On 5 October 2023, an electrical spike in Scunthorpe caused an IT service unit at SGH to lose power causing the UPS to fail. A full investigation was being carried out and a post incident report would be produced. He asked the Committee to approve the report for submission to the Public Trust Board meeting in December.

Gill Ponder asked about the training issues mentioned in point 2.3 and if they were Trust wide or just at SGH. Matt Overton stated the Chemical, Biological, Radiological and Nuclear (CBRN) training of staff at DPoW was now up to date but SGH was further behind due to a lack of Train the Trainers. but there was A plan was in place to improve completion of that training.

Action: Matt Overton to amend the report to specify the training issue was at SGH.

Gill Ponder enquired about the lack of timescales or dates for completion on the actions in the action plan on page 18. Matt Overton stated it was a national template but he would add in a column for completion dates for internal use.

Action: Matt Overton to include completion dates on the action plan report.

Gill Ponder stated that there were lots of items due to be completed by 1 November 2023 and asked if they were on track. Matt Overton replied that the Trust was awaiting receipt of the national Wnter guidance to incorporate it in Winter planning, but a lot had been completed.

Gill Ponder asked when the first action on the electrical infrastructure failure post incident action plan would be completed. Jug Johal stated it was not a cable failure but due to a spike in electricity when the power returned to the area. The UPS was old and replacement was recommended which had been agreed by the Capital Investment Board as a priority.

Based on the discussed changes, the Committee approved the report for submission to theTrust Board.

8.5 Business Planning Timetable

The Committee noted the paper and asked for the timetable to include the dates when plans would come to the Committee.

Action: Ashy Shanker to add when plans would come to the Finance and Performance Committee to the timetable.

8.6 Assurance Confirmation & Board Highlights

The Committee agreed to raise to the Board their continued concerns with emergency care and ambulance handover times, the increasing number of 104 day wait Cancer patients, the impact of further IA on planned activity and the 15% increase in ED attendances. The reduction in follow up appointments leading to increased waiting lists would also be included, along with the positive news on the reduction in MRI waiting lists from 10,000 to 8,200 as a result of the mobile units and the good performance of SDEC in discharging 43% of patients on the same day. The report would also highlight that the EPRR report had been approved for submission to the Board by the Committee.

9. BAF – Review of the current BAF risk ratings against the target risk ratings

The Committee agreed with the risk scores given to the updated BAF risk ratings of SO1-1.2 and SO1-1.6.

10. Items for Information (Not For Printing)

11.1 Performance Letters to Divisions following PRIMS Meetings

No meetings had taken place.

11.2 Capital Investment Board (CIB) Minutes

The Committee noted the CIB minutes from 23 August 2023.

11. Any Other Urgent Business

No items were raised by the Committee.

Matters to Highlight to Other Trust Board Assurance Committees

Items to highlight to other Committees were captured throughout the meeting.

12. Matters for Escalation to The Trust Board (Public/Private)

Items to be included in the Board Highlight Report were captured at the end of each section of the agenda.

Review of Meeting

Simon Parkes stated that it had been a very useful meeting and although he was not very assured, he had learnt more about performance areas within the Trust and was grateful to members of the Committee for the open levels of discussion. He stated meeting face to face was better for having open discussions.

Sue Liburd stated it had been her first Finance and Performance Committee meeting and she had been impressed with the quality of the papers and the outstanding depth of the discussions. She had learnt new things and thanked the Chair for allowing the members of the Committee to have detailed discussions as the level of intelligence was refreshing.

Ab Abdi stated that he was grateful to attend the Committee as Acting COO for his development.

Gill Ponder stated that there had been a good level of discussion and agreed that meeting face to face was positive. There were a lot of issues to tackle and she was disappointed that things were not moving forward quicker but it was due to lack of effort. She thanked members of the Committee for attending and for their contributions to the meeting.

13. Date and Time of the Next Meeting

The next meeting will take place as follows:

Date: 22 November 2023
Time: 13:30-16:30
Venue: Via Microsoft Teams

Annual Attendance Details:

	Jan 23	Feb 23	Mar 23	Apr 23	May 23	June 23	July 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23
Gill Ponder	√	√	√	√	√	x	√	√	√	√		
Fiona Osborne	√	√	√	√	√	√	X	√	√	X		
Lee Bond	√	√	√	x	√	x	√	√	√	X		
Jug Johal	√	√	√	√	√	x	X	√	√	√		
Shaun Stacey	√	√	√	√	√	√	√	√	√	X		
Ian Reekie	x	√	√	√	x	√	√	√	√	X		
Richard Peasgood	√	√	√	√	√	√	√	√	√	√		
Simon Parkes	x	x	√	√	√	√	√	√	√	√		
Brian Shipley	√	√	x	√	x	√	√	√	√	√		
Annabelle Baron-Medlam	√	√	√	√	√	√	√	√	√	√		
Abdi Abolfazl	√	x	x	√	x	x	√	X	√	√		
Ashy Shanker	x	√	√	x	x	√	√	√	√	X		
Shiv Nand	√	x	x	x	x	x	X	X	X	X		
Dr Peter Reading	x	√	√	x	x	x	X	X	X	X		
Linda Jackson	x	x	x	x	x	√	x	X	X	X		
Craig Hodgson	x	x	x	x	x	√	√	X	X	X		
Kate Truscott	x	x	x	x	x	x	√	X	X	X		
Sue Liburd	X	X	X	X	X	X	X	X	X	√		
Georgina Birley	X	X	X	X	X	√	√	√	√	√		
Matt Overton	X	X	X	X	X	X	X	X	X	√		

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Simon Parkes - NED / Chair of Audit, Risk and Governance Committee	
Contact Officer/Author	Lee Bond – Group Chief Financial Officer	
Title of the Report	**Audit, Risk and Governance Committee Minutes - July 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Audit, Risk and Governance (ARG) Committee held on 20 July 2023 and approved at its meeting on 23 November 2023.	
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 ✓ 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 and Goole NHS Foundation Trust **Audit, Risk and Governance Committee**	
DATE:	**20 July 2023** via MS Teams	
PRESENT:	Simon Parkes	Chair of ARG Committee / Non-Executive Director
	Gill Ponder	Non-Executive Director
	Kate Truscott	Non-Executive Director
IN ATTENDANCE:	Lee Bond	Chief Financial Officer
	Helen Harris	Director of Corporate Governance
	Sally Stevenson	Assistant DoF – Compliance & Counter Fraud
	Jason McCallion	External Auditor (ASM)
	Helen Higgs	Head of Internal Audit (Audit Yorkshire)
	Danielle Hodson	Assistant Internal Audit Manager (Audit Yorkshire)
	Nicki Foley	Local Counter Fraud Specialist
	Ian Reekie	Lead Governor (Observer) (Left after item 7)
	Robert Pickersgill	Deputy Lead Governor (Observer)
	Shaun Stacey	Interim Chief Executive Officer (For item 6.1)
	Ron Gregory	Head of Safety and Statutory Compliance (For items 11.1 & 11.2)
	Richard Dickinson	Associate Director of Quality Governance (For items 12.1 & 12.2)
	Sue Meakin	Data Protection Officer (For item 12.3)
	Ivan Pannell	Head of Procurement (For item 12.4)
	Tony Deal	Chief Technology Officer (For item 14.1)
	Steve Mattern	Associate Director of IM&T (For item 14.1)
	Lauren Short	Directorate Admin / PA to CFO (Minutes)

Item 1 07/23 Welcome and Introductions

Simon Parkes opened the meeting by introducing the Trust's new External Auditors, ASM and welcomed Jason McCallion, Senior Audit Manager at ASM whereby introductions took place.

The next item was taken out of sequence on the agenda.

6.1 Annual Governance Statement 2022/23

Shaun Stacey presented the item, stating that draft iterations had been shared with various people for review and comment. Simon Parkes confirmed the Committee was being asked to note the amendments and the submission of the draft version of the AGS 2022/23 and submission to NHSE by 30 June 2023, which had been done. There were no comments or questions from the Committee.

Shaun Stacey left the meeting and the Committee returned to the sequence of the agenda.

Item 2 07/23 **Apologies for Absence:**

Apologies noted from Brian Clerkin (ASM).

Item 3 07/23 **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 07/23 **Minutes of Previous Meetings and Highlight Report**

4.1 The minutes from the meeting held on 20 April 2023 were agreed subject to the following amendment requested by Gill Ponder:

- Page 5 – Item 7.1 - within the last paragraph amended to read 'Both Simon Parkes and Gill Ponder had recommended that the Board consider the impact on the Trust performance of the ongoing workforce challenges.'

4.2 The Highlight Report from 20 April 2023 had been provided and noted.

Item 5 07/23 **Matters Arising/Review of Action Log**

Action log item updates were as follows:

- Assurance Map – Helen Harris had advised that this was on hold due to the move to a Group structure. Revised date of 1 April 2024.

- Junior Doctors Rota's Internal Audit Report – Unfortunately, discussions did not take place at the previous Joint Board Development Day, therefore the action is still outstanding. Lee Bond agreed to pick this up as necessary.

- HFMA NHS Audit Committee Handbook – The new edition had not yet been published at the time of the meeting.

- Apprenticeship Levy – It was confirmed that this had been referred to the Workforce Committee by Gill Ponder. Action closed.

- Internal Audit Follow-Up Medical Staff Job Planning – Lee Bond confirmed that 100% of NLAG's team job plans had been agreed and at an individual level Consultants job plans were at 83% complete and 80% for SAS Doctors. The figures were presented at the Workforce Committee meeting on 17 July 2023. Danielle Hodson advised that a follow up audit had taken place with the Trust improving within this area.

- Document Control – Overdue Documents – Helen Harris had confirmed that Leads for overdue documents were regularly contacted and monthly reports issued to Divisions for action as necessary. Action closed.

Item 6 Annual Governance Issues 2022/23
07/23

6.2 Internal Audit Annual Report 2022/23 inc. Head of Internal Audit Opinion

Helen Higgs explained the Annual Report was a summary of the work carried out by Internal Audit over the last financial year, noting some salient points including that they had conformed with the Public Sector Audit Standards, that they had delivered the full plan with approved changes, with all KPI's met.

The overall Head of Internal Audit Opinion was 'Significant Assurance' and this had been discussed in detail at the last meeting when it was in draft. Helen Higgs encouraged the Trust to focus on all due and overdue recommendations.

Gill Ponder observed that the Trust had been doing really well with internal audits but there had been a number of 'Limited Assurance' reports recently. Gill Ponder was concerned about the data quality report, specifically an issue around anonymised external data meaning that the audit could not be completed in respect of that particular data and asked what would be done to ensure the Trust had assurance in respect of being able to rely on such external data. Danielle Hodson responded and stated that a recommendation was in the report about making sure that the Trust could validate this data themselves and obtain that assurance. Danielle Hodson also stated that as this was a limited assurance report the recommendations would be revisited in full by them in due course. A discussion took place around the issue of anonymised data and what the audit test was trying to achieve, following which Danielle Hodson offered to take an action to seek further information and bring it back to the next Committee meeting.

Action: Danielle Hodson

Simon Parkes acknowledged the points made and expressed the importance of the Data Quality audit being on the internal audit plan and noted that the outcome was 'limited assurance' not 'no assurance'.

Kate Truscott reminded the Committee of the importance of the Junior Doctors and E-Rostering audits and said that she didn't want to lose sight of these. Lee Bond assured the Committee that he would follow this up with the Executives.

With regards to the limited assurance audit for Long Term Locums, Kate Truscott raised the temporary staffing costs and wondered whether this could be picked up at Workforce Committee or Finance and Performance Committee. Limited assurance on the Surgical Checklist was also raised by Kate Truscott given the importance of the WHO checklist and its implementation and whether it would be necessary to feed this back to the Quality and Safety Committee.

Danielle Hodson reminded the Committee that all limited assurance audits would be re-visited with another audit follow-up taking place in quarter 4 and the findings reported back to the Committee for assurance.

Helen Higgs commented that it was good to receive limited assurance reports and that she would be much more concerned if she wasn't seeing some, adding that it is how the Trust responded to these that was the really important matter. Lee Bond agreed and stated that he had expected some as they had identified

areas for review where there were problems and is a recognition of how mature the organisation is. Helen Higgs concurred. Simon Parkes agreed and confirmed the Trust was looking at areas where it was suspected there were significant challenges, and that it was good to have scrutiny, adding little is learnt from pointing auditors to things which are fixed. Simon Parkes stated that it was important to ensure recommendations were actioned and implemented on time.

Simon Parkes acknowledged the issue with regards to timely management responses to audit reports and the issue of overdue recommendations and suggested highlighting this generally to the Trust Board. Simon Parkes also asked Sally Stevenson to provide him with a list of overdue recommendations for each Director so that he could contact them individually about the issue.

Action: Sally Stevenson / Simon Parkes

Robert Pickersgill made an observation about management responses to internal audit recommendations and this was responded to in general terms by Simon Parkes, stating that Internal Audit would challenge management responses at the time and additionally there was scrutiny by the ARG Committee. Simon Parkes asked that any specific comments regarding recommendations be taken later in the agenda under the relevant item. Gill Ponder also added that individual audit reports go to the relevant Committee's for review and oversight.

Helen Higgs commented that Executive leads could be asked to attend to speak to audit reports as necessary, and Simon Parkes acknowledged this course of action had been discussed before as it had been something the Trust's former CEO had strong views on. Simon Parkes acknowledged that it did work very well elsewhere and he would therefore discuss it with the new Group CEO once in post.

Action: Simon Parkes

Following discussions, the Head of Internal Audit Opinion was noted.

6.3 NHS Provider Licence 2022/23

Helen Harris informed the Committee that the Trust previously had to undertake a self-certification event each year, however this year the recommendation had been to report the provider licence within the Trust's Annual Report 2022-23. Helen Harris had undertaken a review, with the Trust still reporting against the old licence conditions. Some areas were confirmed whilst others were not, these being ones linked to healthcare standards (Cancer, RTT, Follow-ups and A&E). Helen Harris drew the Committee's attention specifically to section 3.3 of the report with a proposal to include the table within the Annual Report 2022-23, and to include detailed narrative where the Trust had complied with its licence and where it had not.

Going forward for 2023-24, it has been advised by NHS Providers that Trusts undertake more frequent reviews of the compliance against the provider licence, therefore Helen Harris proposed to review this information against the

new conditions on a six-monthly basis rather than just annually. Helen Harris advised that this proposal had been presented to the Executive team also.

Simon Parkes acknowledged the level of detail in the paper showing where things were confirmed or not confirmed. Simon Parkes did however ask if it was absolutely certain that they are the mandated standards, and if so there was no option but to report them. Gill Ponder confirmed they were correct, the Trust hadn't met them and therefore must acknowledge that fact. The following comments were raised for action:

- Gill Ponder referred to page 9 of the paper regarding the capital funding and asked for the wording to be amended as the figure stated is not what the Trust received and it was not very clear. Gill Ponder also referred to a minor change which needed to be made on page 14 with the Trust now having six limited assurance reports not one.

- Lee Bond also recommended adding a sentence to the services provided section of the report to explain the difficulties with sustaining an Audiology service at this time. Helen Harris agreed to add something to this effect.

- Sally Stevenson referred to page 3, paragraph 3 regarding the financial governance breaches and after discussion, it was agreed for Helen Harris to undertake a re-draft of this section as the breaches were historic.

- Simon Parkes noted some duplication within the report, especially around the transitional changes to the Group structure and wondered whether this could be brought together to ensure its only stated once.

Action: Helen Harris

After discussion about frequency of review, it was agreed for the Committee to continue to review this on an annual basis.

Item 7 07/23 **External Audit (ASM)**

7.1 Introduction to ASM / Next Steps

Jason McCallion informed the Committee of a couple of introduction meetings which had already taken place between ASM and Finance staff. A site visit was currently being arranged for mid-August with the intention to conclude planning procedures by the end of August 2023 with the view of issuing the planning report by the end of August / beginning of September 2023. Due to the timings of the ARG Committee's meetings the planning report would need to be shared virtually unless an extra ordinary meeting was deemed necessary.

Due to the late appointment of an external auditor, the field work is due to take place between mid-October 2023 – mid November 2023 with the view of signing off the audit in the second week of December 2023.Jason McCallion confirmed that he and his colleagues would be on site for a significant part of the audit particularly in the first year and offered for any of the Committee members to meet with them when on site if they wished.

7.2 Audit Letter – Delay in VFM work 2022/23

In terms of the audit letter and the delayed appointment, Jason McCallion explained that the timetable set out had been agreed not only with the Trust but also with NHSE and the National Audit Office. Agreement had also been reached for the 2023-34 financial year accounts submission with indicative timings and a deadline to report to NHSE by 23 August 2024.

Helen Harris asked about the timing of the Annual Members Meeting, as it needed planning in advance. Sally Stevenson advised that she would speak to Helen Harris outside of the meeting to discuss this following agreement of timings with ASM, etc.

Action: Sally Stevenson

Kate Truscott thanked everyone involved for their hard work with regards to securing an External Auditor under challenging circumstances.

Robert Pickersgill asked whether it was possible for the Governors to be sighted on the scope of the Auditors VFM work. Jason McCallion stated that there was extensive guidance for Auditors on what they have to cover as part of their VFM work and agreed to share the NAO guidance. Simon Parkes asked for it to be shared through Sally Stevenson.

Action: Jason McCallion / Sally Stevenson

Item 8 07/23 Internal Audit (Audit Yorkshire)

8.1 Internal Audit Progress Report

Danielle Hodson highlighted the new Audit Yorkshire report style and confirmed that all Q1 audits were underway with the Quality Account review complete and receiving ‘Significant Assurance’. Three other Q1 audits would be completed and reported at the next meeting. Planning for Q2 was also underway, so all Internal Audit work is on track so far this year.

Danielle Hodson also highlighted the HFMA Improving NHS Financial Sustainability checklist outcomes briefing, showing good practice areas observed and the scores, etc. as well as some key issues within section 4 for Committee members to take away and consider.

Danielle Hodson referred to the 2022-23 audits with five being finalised and the other five at draft report stage, but confirmed all were almost there.

Simon Parkes stated that clearly it was a concern that there were some challenges around data quality but not a surprise, however they were not significant enough to not be able to take assurance from some of the data points or fundamentally call into question as to whether there can be any reliance placed on the data at all, but it did suggest that they can’t be sure that it is 100% accurate, adding that Committees need to be able to rely on the data to take assurance. However, the data still gave him a strong sense of how the Trust is performing, as a result of taking multiple data points not just one. Simon Parkes commented that was his reading of the report.

Lee Bond referred to the WHO checklist and enquired about the audit sample size performed by the service (not Audit Yorkshire), adding that the WHO checklist is important from a safety perspective and asked whether the frequency and sample volume of the audit is the same across other NHS Trusts that Audit Yorkshire worked at, in order to determine whether the Trust was an outlier in its sample size. Danielle Hodson responded that this piece of benchmarking could be done if necessary. Helen Higgs stated that Lee Bond asked valid questions and added that it would be helpful for these sorts of questions to be raised at the audit feedback stage with the executive leads so that Internal Audit can deal with such queries before sign off stage.

Helen Harris noted the Clinical Audit item further down the agenda which contained a couple of references to the WHO checklist and suggested that as Richard Dickinson would be in attendance the Committee could raise the WHO checklist with him to get a better understanding of how it works internally.

Simon Parkes agreed to raise the quality of the data being audited internally within the Trust to Fiona Osbourne as the Chair of Quality and Safety Committee, and ask if she wants to look at the adequacy of management responses and also the level of checking that is being performed in different parts of the organisation.

Action: Simon Parkes

Consideration took place as to whether the 'limited assurance' outcome for the Data Quality audit should be highlighted to the Board, however after discussion it was agreed to record it in the minutes of the meeting that this is a problem and one that needs working on but not one that undermined assurance across the Trust in terms of data quality.

8.2 IA Recommendations Follow-Up – Status Report

Danielle Hodson advised that there were 11 overdue Internal Audit recommendations, however there were updates for all of them with the managers continuing to undertake work on them to ensure implemented.

The Committee were content with the progress.

Item 9 07/23 Counter Fraud

9.1 LCFS Progress Report

Nicki Foley presented the progress report and highlighted the following key points :

- Counter Fraud Functional Standard Return – submitted by the deadline with a self-assessed rating of Green.
- Mandatory Fraud Awareness Training – 87% compliant at the end of June 2023 (following becoming mandatory in January 2023) which was very positive.
- Fraud Through the Looking Glass Newsletter – Issued in July 2023.

- Cabinet Office – National Fraud Initiative (NFI) 2022-23 – An update was provided on the NFI process and recovery of £17,620.02 regarding duplicated payments.
- Investigation Referrals – One new referral received since the last report which was an allegation of working while on suspension, however after investigation no fraud was found.

There were no questions from the Committee.

9.2 LCFS Annual Report 2022/23

Nicki Foley explained that the report was a consolidated summary of the quarterly reports the Committee had received throughout the year.

The Committee had no questions.

9.3 Annual Review of Counter Fraud and Corruption Policy

Nicki Foley highlighted a slight addition to the policy under section 4.4 regarding the Fraud Risk Assessment and designated risk owners.

The Committee approved the policy.

Ron Gregory and Richard Dickinson joined the meeting. Helen Higgs left the meeting.

Item 10 07/23 Board Assurance Framework and Strategic Risk Register – Q1

The Strategy Development Committee had been disbanded by the Trust Board and the strategy risks had been reviewed by the Executive Directors, however the Trust Board will undertake the overall review at the August Trust Board meeting.

The Finance and Performance Committee, Quality and Safety Committee and Workforce Committee will review the BAF at their July 2023 meetings. Simon Parkes commented that he knew from attending other committees that they are going through the review process.

Helen Harris highlighted that this report is subject to change once it has been reviewed at the Trust Board meeting on 1 August 2023.

There were no questions from the Committee.

Item 11 07/23 Management Reports for Assurance – Items for Approval

11.1 Annual Fire Report 2022/23

Ron Gregory highlighted the following key points:

- Upgrades to the fire alarm system Trust wide was continuing which is having a positive effect with reduction in unwanted fire signals and system faults.

- Mandatory Fire Safety Training was still below target following the disruptions to the face-to-face training as a result of Covid-19.
- Fire risks had been created by cooking in areas which shouldn't take place and non-commercially rated white goods finding their way into the Trust, although there are more control measures in place now to prevent this.

Lee Bond raised the issue of the white goods and cooking, as a result of it being covered at the Finance and Performance Committee the previous day, with an action to issue a communication to all staff around reiterating the importance of not bringing electrical goods in from home and only using the Trust's approved electrical devices / white goods purchased through the Trust's Procurement team. Lee Bond asked if Ron Gregory could assist with this communication and Ron Gregory confirmed that they could do this.

Action: Ronald Gregory

Gill Ponder referred to a contradiction on page 6 of the report relating to the SGH alarm replacement being finalised by March 2024 and on page 16 it stated 2024-25, so contradicts each other. Ron Gregory confirmed that the Trust is on track to hit the March 2024 deadline for completion of SGH alarm system, but the snagging work may fall into 2025 hence the dates shown. Gill asked for this clarification to be made within the report.

Action: Ronald Gregory

Gill Ponder also queried why this report featured on the ARG Committee's agenda when it could have gone to the Finance and Performance Committee the previous day to avoid duplication of information and discussions as a separate report had gone to the Finance and Performance Committee. Sally Stevenson confirmed that this report was assigned to the Audit, Risk and Governance Committee when the former Trust Governance and Assurance Committee disbanded approximately five years ago. It was mapped across to this Committee and agreed by the Trust Board, however if it no longer needed to feature on the Committee's workplan if it was more appropriate for it to sit elsewhere then the workplan could be amended. Gill Ponder commented that she believed from the Finance and Performance terms of reference that Estates and Facilities matters should go to that committee to avoid repetition at two different committees and members reading the same information twice.

The Committee members were content with this report being removed from the Audit, Risk and Governance workplan (Sally Stevenson to action) and transferred over to the Finance and Performance Committee's workplan (Gill Ponder to action). Helen Harris reminded Ron Gregory of the Health, Safety and Fire Group Terms of Reference needing to also reflect this change.

Action: Sally Stevenson / Gill Ponder / Ron Gregory

Kate Truscott referred to the Fire Safety training, which is statutory training not mandatory, and asked whether the problem was capacity of provision and / or the release of staff to undertake the training. Ron Gregory felt it was the release of staff, as the sessions are being put on however they are rarely filled to capacity. Ron Gregory added that the team always try to facilitate the training

around certain staff groups and occasionally provide the training out of hours when requested. The Lecture Theatre at SGH was also currently out of use, which created capacity issues at present, but the team were putting on extra sessions within the smaller training rooms to accommodate this.

Gill Ponder raised an issue which had been commented on on the Staff Facebook group from staff members not being able to park to attend the training and therefore leaving site and not attending the training. The comment said that it was due to contractors vehicles and the lease car event at SGH the day before taking up a substantial amount of staff car parking spaces and Gill Ponder wondered whether spaces could be reserved for staff attending training. Ron Gregory commented that the shuttle bus was available for staff to use from their base site to attend training at another site and avoid car parking issues. Lee Bond acknowledged the frustration of not being able to park easily however felt that this was a one-off isolated occasion and although it was not ideal it would not be possible to start reserving spaces for this training as it would then likely extend to other reasons. Ron Gregory added that the training is available at all three Trust sites.

Simon Parkes noted the compliance slowly improving, however agreed to highlight this to the Trust Board due to the concerns about 23% non-compliance and recent reported incidences of fires.

11.2 LSMS Annual Report 2022/23

Ronald Gregory highlighted the following:

- CCTV upgrade largely complete.
- Joint working agreement with NHS Protect being updated due to personnel changes, and involved NLAG, Yorkshire and Humber Crown Prosecution Service (CPS) and Humberside Police. They had also commenced talks with HUTH to include them, as on the same patch with the Police and CPS.
- Continued work on achieving better compliance with the Violence Prevention and Reduction Standards introduced during Covid by NHSE.
- The upcoming Terrorism of Protection of Buildings Bill which is currently going through Parliament, which is the fall out from Manchester Arena known as Martyn's Law. This will have training implications for the Trust.

Simon Parkes commented about the ever increasing training requirements on staff as it had become a real challenge. Ron Gregory commented on the possible enforcement actions / large fines suggested. It was agreed to alert the Workforce Committee of the possible additional mandatory training which is likely to be introduced in April 2024, although was not law yet.

Action: Simon Parkes

Ivan Pannell joined the meeting and Ron Gregory left the meeting.

Item 12 07/23 **Management Reports for Assurance**

12.1 Clinical Audit Annual Workplan 2023/24

Richard Dickinson introduced the report, informing the Committee that the plan was built around national and local priorities and explained that monitoring of the plan is undertaken by the Quality and Safety Committee during the year.

Simon Parkes raised the issue of the audit of the WHO checklists discussed earlier in the meeting, in respect of the level of checking and whether this was sufficient to provide assurance, and whether Internal Audits findings and recommendations were informing the clinical audit workplan to ensure consistent.

Sue Meakin joined the meeting.

Lee Bond queried the level of resource being spent on the clinical audit programme (circa 400 projects) given the Trust's workforce challenges and whether it was possible to quantify it and also queried the value this investment brings to the Trust by undertaking 400 audits or whether clinicians could see more patients. Richard Dickinson confirmed that there is an administrative team who support the clinical services where audits need to be undertaken, but some areas do it within their own services. Every audit is mapped differently with some being yearly, three yearly, etc. and some do not always require a medical professional to undertake the audits.

Richard Dickinson also talked about the increasing linkage/alignment between local quality improvement priorities and overlapping clinical audit activities which see improvement in patient care, and benefits are achieved to that end. He added that they were trying to reduce the administrative burden where possible and increasing use of electronic records was helping with access to information. Richard Dickinson commented that it was therefore very hard to say what the exact amount of resource was needed to get the right balance.

Richard Dickinson advised that he understood that a Trust wide WHO audit was being undertaken at one time, and that it was split into divisional responsibilities with local approaches. As a result of the recent Internal Audit of WHO Richard Dickinson advised that following a discussion with Dr Kate Wood, she would ensure the Clinical Audit team were sighted on the Internal Audit plan each year so that there was sharing of information and complementary approaches.

Kate Truscott referred back to the WHO checklist and the volume of samples and asked who set the standard for sampling, querying whether there was national good practice. Richard Dickinson advised that a sampling approach was often necessary given large populations of information and explained this further to the Committee, confirming that there were some best practice standard models which he could supply if necessary. Richard Dickinson acknowledged that variances identified by the Internal Audit need addressing and monitoring needed performing by Clinical Audit rather than wait for another Internal Audit review.

Robert Pickersgill queried the linkage between the priorities identified in the report and the ten identified Trust Quality Priorities and any overarching reporting requirements / implications. Richard Dickinson responded to this and explained that the report does not cover everything within the Trust as it is clinically focused. Robert Pickersgill also queried whether the response to CQC observations was covered by the Clinical Audit programme, and Richard Dickinson confirmed there were a number of different avenues that would be taken depending on the CQC recommendations, but a number would go through the Clinical Audit route.

Simon Parkes drew comparisons with the Internal Audit plan where it is known what the annual plan resource is (number of days each year and associated cost) and commented that he wasn't sure this level of detail existed for Clinical Audit and felt it would benefit from a similar discipline. Simon Parkes commented on the significant commitment involved, not just undertaking the audits but also implementing recommendations resulting from audits and wondered whether there was maybe assurance overkill. Richard Dickinson responded and suggested that he would discuss with the team whether it was possible to capture clinician time as part of the audit evaluation process. Helen Harris suggested the possibility of benchmarking clinical audit activity against other Trusts.

It was agreed to escalate to the Trust Board to ask the question of whether it's an appropriate level of assurance first, given it is clinically driven, and then determine any actions after that.

12.2 Annual Review of Risk Management Strategy / Development Plan Progress Report

Richard Dickinson commented that the current Strategy runs from 2019 to 2024 and since he started with the Trust in January 2023 he had had some conversations with Helen Harris around the set up of the corporate risk register style, which is slightly different in NLAG using high level risk terminology rather than corporate risk terminology. Additionally with changes coming in terms of the Group structure and how the Trust manages/escalates risk he is trying to understand the set up and how everything links together. Richard Dickinson advised considering best practice models (which refer to corporate risk registers as the style) as part of the forthcoming review of the Strategy, and added there appeared to be a gap in relation to the escalation of risks identified as high level, the BAF, and whether they are divisional or organisational level risks. Richard Dickinson added that there needed to be some understanding from the Executive team who ultimately have oversight of the high-level risks for their areas, that they have oversight of what is being fed through and the risk scoring/mitigation. Richard Dickinson added that the Strategy does exist and functioned reasonably well, it was the issue of risk scoring that needed refreshing.

Steve Mattern and Tony Deal joined the meeting.

Gill Ponder commented that it would be useful to have a clear and consistent policy around the risk score once it had been mitigated, explaining what she meant by this (target risk score, risk appetite, current level of risk, mitigations if

above risk appetite to reduce the risk occurring) and stating that the score should reduce but the Trust seems to keep at the same level even when mitigated. Richard Dickinson agreed. Lee Bond added that mitigations might not only reduce the likelihood of the risk, it might reduce the consequence of it as well, adding that the current risk score should be the mitigated risk. Gill Ponder agreed, adding that in her view that was not what the Trust was doing. The Committee considered whether this was an educational failing of what inherent risk meant rather than mitigated risk, and felt it was an area where development might be helpful. Richard Dickinson commented that some reasons for colleagues not wanting to decrease their risks was due to competing for resources. Lee Bond agreed this was natural human behaviour which needed to be recognised that it happens.

Helen Harris commented on aligning with HUTH if moving to an Audit Committees-in-Common.

Richard Dickinson left the meeting.

12.3 IG Steering Group Highlight Report inc. Annual IG Toolkit Return

Sue Meakin highlighted the fantastic improvements made in respect of the Trusts DSPT return for 2022-23 which demonstrated the joint working between different elements of IT, meaning it had gone really well this year and also noting the really good working with Internal Audit.

Sue Meakin stated that the one red is IG training and the need to achieve 95% compliance by the end of August 2023, which had been reflected in the one action on the Improvement Plan to NHSE. They had been working hard to try and improve this and did an item on the Leadership Forum recently. Sue Meakin advised that the Training and Development inbox was bursting with training compliance emails which should reflect positively on the 95% target, adding that she would share this percentage once the system updated the following week.

Sue Meakin advised that other actions would sit on an internal action plan, following discussions with the Regional IT Security Lead who links directly in with NHSE, and would be monitored by the Committee.

Next year will see a change with IG Training and a little more scope to manage local training requirements through training needs analysis, and this needs to be coordinated within the ICB so that all organisations are comparable for a contracting perspective. The following year (2025) will see a big change for the Toolkit in terms of cyber requirements.

Gill Ponder stated that the Committee should formally record their thanks to the IG Team for the progress made, having come a long way, adding that it would be a phenomenal achievement if the Trust could achieve 95% by the end of August 2023 and have zero failures on the Toolkit.

It was agreed to highlight the push on IG training to the Board.

Sue Meakin also highlighted that they would be looking further into incidents and also mentioned the launch of the Fair Warning software that runs in the

background and monitors access to systems, which will identify cases of inappropriate access immediately.

Sue Meakin left the meeting.

12.4 Waiving of Standing Orders Report

Ivan Pannell took the report as read and opened up to questions. Gill Ponder queried a statement made at the bottom of page 4 regarding long standing weaknesses in internal processes for monitoring the hiring of equipment which regularly slows down the payment of invoices and asked what the Trust was doing about it. Ivan Pannell explained that this was a particular problem with the contract for the hire of bariatric beds and equipment often needed out of hours and on a weekend at short notice for patients. A slight workaround was in place to match the invoices to purchases orders after the event and they have worked on tightening this up over the years with the supplier. Lee Bond discussed having a call off order arrangement.

Gill Ponder queried whether things were sent back once no longer needed to avoid unnecessary costs being incurred. Ivan Pannell stated that they tried to ensure that items were sent back as quickly as possible but are reliant on the service areas using them to return promptly. Lee Bond suggested seeing how many such pieces of equipment are being used at any one time and determine whether it would be more cost effective to buy so many beds instead rather than hire. Ivan Pannell advised that they had looked at this previously, but agreed it was something that could be reviewed again to take a different approach.

Gill Ponder confirmed that she was assured around the reason why the Trust raised the waiver however, she was not assured that the Trust had spending control in this area due to the statement written in the report about long standing weaknesses and it was not clear what these were. Lee Bond took an action to discuss this with Ivan Pannell and feedback to the Committee at the next meeting.

Action: Lee Bond / Ivan Pannell

Ivan Pannell left the meeting.

Item 13 07/23 Action Logs and Highlight Reports from other Sub-committees

The following action logs and Highlight reports were provided and noted without question:

13.1 Finance & Performance Committee
13.2 Quality & Safety Committee
13.3 Workforce Committee
13.4 Health Tree Foundation Committee

Item 14 07/23 Private Agenda Items

14.1 Cyber Security Arrangements

This item was discussed and minuted under a private agenda item.

Item 15 07/23 Any Other Business

15.1 ARG Committee Annual Report to Trust Board

The Committee approved the report for submission to the Trust Board and Council of Governors for information.

15.2 Schedule of ARG Committee Meetings 2024 – TBC & Circulated

To be circulated once finalised.

Item 16 07/23 Matters for Escalation to the Trust Board

- Internal Audit Draft Reports and Recommendations
- Fire Safety Training
- Clinical Audit Forward Programme 2023-24
- Data Protection and Security Toolkit Return 2022-23

Item 17 07/23 Matters to Highlight to other Trust Board Assurance Committees

- Workforce Committee to be alerted to the issue of potential additional statutory training resulting from Martyn's Law.

Item 18 07/23 ARG Committee Workplan – For Information

The Committee noted the workplan and the agreed adjustment in relation to the Annual Fire Report going to the Finance and Performance Committee in future.

Item 19 07/23 Review of the Meeting

It was agreed that useful and detailed discussions had taken place, although some sections had gone on a little.

Item 20 07/23 Date and Time of the next meeting

23 November 2023
9.30am – 12.30pm
Microsoft Teams

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Neil Gammon, Chair of Health Tree Foundation Trustees' Committee	
Contact Officer/Author	Lee Bond, Group Chief Financial Officer	
Title of the Report	**Health Tree Foundation Trustees' Committee Minutes – September 2023**	
Purpose of the Report and Executive Summary (to include recommendations)	Minutes of the Health Tree Foundation Trustees' Committee (HTF) held on 7 September 2023 and approved at the following meeting on 9 November 2023	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
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)		
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

MINUTES

MEETING:	Northern Lincolnshire & Goole NHS Foundation Trust **Health Tree Foundation Trustees' Committee**	
Date:	**7 September 2023 – Via Teams Meeting**	
Present:	Neil Gammon	Independent Chair of HTF Trustees
	Susan Liburd	Non-Executive Director
	Gill Ponder	Non-Executive Director
	Jonathan Lofthouse	Group Chief Executive Officer
	Kate Wood	Chief Medical Officer
	Ellie Monkhouse	Chief Nurse
	Paul Marchant	Finance Accountant
	Simon Tighe	Deputy Director of Estates and Facilities
	Clare Woodard	Head of Smile Health
	Michelle Soar	HTF Community Champion
In attendance:	Lauren Short	Finance Admin (For the Minutes)
	Joanne Forward	Operational Matron for Medicine (Item 6.2)

Item 1 09/23 **Apologies for Absence**

Apologies for absence were received from: Lee Bond, Jug Johal (Simon Tighe), Lucy Skipworth (Michelle Soar), Jamie Lewis and Simon Leonard.

Item 2 09/23 **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 09/23 **Minutes of Meeting held on 7 July 2023**

The minutes from the meeting held on 7 July 2023 were approved.

Item 4 09/23 **Matters Arising**

All matters arising were covered within the action log.

Item 5 09/23 **Review of Action Log**

The action log was reviewed and updated accordingly, however Gill Ponder highlighted the following actions.

17th May, Item 10 - This item not being fully complete due to the progress update failing to mention fully completed papers / wishes. Clare Woodard confirmed that the HTF team are aware that wishes need to be fully completed before referring to this committee and will remind them at their next team meeting. Although it was noted that papers and/or wishes are sometimes approved to be

featured on the agenda through other means such as direct approach to Trustees' Chair.

Action: Clare Woodard

7th July, Item 5 – This action response did not reflect the reason for this being featured on the action log and concern was raised with the high admin percentage charge. It was felt that this rate needed to be challenged and negotiated if possible. Sue Liburd suggested that Clare Woodard could find out what other charities are charged when she attends the NHS Charities TogetherLeaders' Engagement Day on 28 September 2023.

Action: Clare Woodard

Item 6 09/23 **Items for Discussion / Approval**

6.1 NHS Charities Together Charity Leaders' Engagement Day Invitation

Neil Gammon thanked those who responded to the invitation and informed the Committee that Clare Woodard and Lucy Skipworth will be attending and will feedback to the committee at the next meeting.

Discussion took place regarding the Trustees being registered to receive emails and have their own log in for NHS Charities Together. Michelle Soar agreed to look into this and ensure all Trustees are set up correctly.

Action: Michelle Soar

6.2 AAU/SDEC Skylight Panels

Joanne Forward explained that this wish had previously been submitted one year ago but unfortunately no progress was made. All historic information and communication channels are currently being investigated.

Action: Clare Woodard / Michelle Soar

The wish was to have skylight panels fitted within the new assessment area of the AAU/SDEC roof of the building due to there being no natural light within the room (costing £55k). Although this would be a short stay area, it was felt that patients and staff would benefit from having natural light.

Trustees reviewed the costings on the paper provided and all felt it was extremely expensive. Simon Tighe agreed, however informed the Committee that the quote was more expensive due to the skylight panels not being factored into the original plan, and therefore extra planning and work would need to take place to complete this work.

Neil Gammon asked Jonathan Lofthouse for his thoughts. Jonathan expressed that although this is a nice thing for the hospital to have and can see that it will enhance patient experience, there are other areas within the Trust which are in disrepair and could arguably benefit from funding. With that being said,

Jonathan Lofthouse was happy to support the Committee's decision on this occasion.

Discussions took place and it was queried whether another installation supplier could fit the skylight panels, however this was not thought feasible due to a number of reasons. Simon Tighe agreed to discuss any potential further reduction in the quote with Kier when he next meets with them, due to it being charitable purchase.

Action: Simon Tighe

Paul Marchant shared that if this wish were to be approved, the funding would be drawn from the general fund and confirmation regarding not needing to pay the VAT was being clarified.

Trustees expressed their support for this wish for both DPOW and SGH as it would enhance patient experience but agreed more work needed to be done to reduce the costings.

It was confirmed that the build at DPOW will be completed just before Christmas 2023 and the build at SGH should be completed in April 2024.

It was agreed to await the outcome of Simon Tighe's meeting with Keir, after which Neil Gammon agreed to seek Trustees' final decision ex-committee and advise accordingly.

Action: Neil Gammon / Clare Woodard / Michelle Soar

Item 7 09/23 **Updates from Health Tree Foundation**

7.1 HTF Manager Update Report

Clare Woodard spoke to the report and highlighted the following key updates expanding the discussion where necessary:

- HTF was chosen as one of two recipients of the Mayor's Charity in May 2023, the HTF is working closely with Ian Lindley for events in 2023/2024 to raise funds for The Pink Rose Suite at DPOW.
- Community Diagnostic Centres at Scunthorpe and Grimsby - Lucy Skipworth and Lauren Henry attended a meeting with Craig Hodgson, Associate Director of Commercial Services, Mark Edgar, Associate Director of Estates Projects and Ellie Rogers, Capital Project Manager to discuss how best The Health Tree Foundation can be involved.
- Fairchild Legacy Update - Following planning meetings and involvement with trust staff, the Fairchild Legacy work has started on the dementia friendly wards at SGH. Whilst the initial target for completion of end December 22 could not be met due to operational pressures, Ward 16 has been confirmed as the first ward for work to commence.
- Trust Wide Staff Room Improvements - The rooms that will be completed first are SGH – Theatres, Goole – Ward 3 and DPOW – Stroke Unit. Following the approvals process, work was due to begin end of July 23

within Scunthorpe Theatres however due to staff pressures this has been postponed and we are hoping work will now commence start September 2023.
- The HTF team have already started with preparations for Christmas 2023.
- There are 139 active wishes, but the Committee were reassured that work is taking place to get these wishes finalised. Neil Gammon noted that he felt the need to highlight this at the HTF team meeting.
- HTF have submitted six grant funding applications within 2023 with two so far being successful.

Michelle Soar touched on the positive corporate partnership relationships HTF have and shared a number of ways the HTF is benefiting from those relationships.

Kate Wood took a deep dive into the wishes which weren't progressing and focused on the fan requests, and asked why these were now not being approved. Clare Woodard referred back to a decision which was agreed by this Committee to no longer fund fans due to a number of reasons but the main one being these were seen as disposable income due to the sheer number of fans ending up being condemned, especially during the winter months. Kate Wood highlighted that the reasoning for the fans being declined on the report were due to infection control, but this is not the case. Neil Gammon expressed his opinion of the fans not being value for money due to how they have been seen to be historically poorly treated. Kate Wood felt a blanket decision for this needed to be revisited and to investigate which wards are not treating the equipment with respect and whether or not another fan choice needed to be sort if they are continually breaking.

Neil Gammon advised Michelle Soar to take an action to review the fan wishes.

Action: Michelle Soar

Sue Liburd referred to key donors and asked whether there was a recognition scheme whereby the HTF hosts a thank you event at the Trust. All Trustees were in favour of this suggestion and Clare Woodard took the action to further investigate this and produce an outline plan at the November 2023 meeting for Trustees' consideration. Gill Ponder also added that it would be nice to invite key donors to see what their money has been spent on.

Action: Clare Woodard

Neil Gammon took a deep dive into the KPIs.

Clare Woodard focused and provided an update on amber KPIs :

- Income Generation and Investment (July 2023 figures) – Income is unfortunately lower than planned, however mitigation has been put in place to enhance fundraising and source income from other avenues.
- Fund Guardians – It's recognised that HTF is not a bank and the funds which have been raised need to be spent so the HTF team will be working with the fund guardians to encourage wishes to be submitted to benefit the staff and patients across the Trust.

- Impact Reports – The HTF team are working hard to ensure feedback from staff and patients relating to completed wishes is being gathered. This will also feature in the annual HTF report.
- Fund Raising Appeals – HTF is always looking for new appeals to raise funds and help support schemes happening within the Trust. The earlier HTF is informed about the Trust schemes, the better the team can find ways in which to support.
- Annual Survey – The survey is live now and will be re-issued toward the end of the year which will enable 2 reviews to take place. The findings will be presented to this committee in the new year, with the results being linked into the operational plan.
- Communications – HTF has a fantastic relationship with the NLAG Communications Team and use all the various communication and social media channels to engage and update patients and staff on current HTF activities.
- Local Businesses / Corporate Fundraising – It is great news to see new companies wanting to fundraise for HTF.
- Patient Stories – HTF are working with clinicians and patients who are the first to use HTF funded equipment to gain feedback and share news of improved positive experience.

Gill Ponder referred to the engagement numbers and raised her concern with regards to reporting retrospectively and then having no opportunity to pick something up that may have gone off track during the year. Gill thought it would be more helpful to have the report showing the end of year position but also the year-to-date position to monitor the KPIs. Clare Woodard to include this within future reports.

Action: Clare Woodard

Gill Ponder asked how the HTF advertise their social media platforms and Clare Woodard confirmed that any HTF correspondence includes all the social media tags, including QR codes being placed around the Trust's hospital sites. Gill Ponder suggested incorporating the social media tags and links to feature at the various events the Trust hold.

Neil Gammon welcomed any ideas of updating and changing the KPIs throughout the year to ensure continued progression.

Gill Ponder referred to the Little Lives KPI and asked what the fundraising appeal was for 2023. Clare Woodard confirmed that this is an ongoing appeal which was set up last year. It was queried why the KPI for the Little Lives appeal was marked as amber and after discussion this was agreed to be updated and marked as green.

Action: Clare Woodard

Neil Gammon agreed to raise the appeals with the HTF team when he attends their team meeting and ask Michelle Soar to provide the Trustees with an update.

Action: Michelle Soar

7.2 Risk Register

The Risk Register was noted.

Gill Ponder queried who the Corporate Trustee is, and Neil Gammon confirmed that it is the Trust Board. Item 1 of the risk register under sources of assurance needs to be updated to reflect this.

Action: Michelle Soar

Item 8 09/23 Sparkle Programme

8.1 Sparkle Update

The Sparkle Update was noted.

Neil Gammon asked for the captions of the pictures to be more informative.

Item 9 09/23 Finance Update

9.1 Finance Report

Paul Marchant presented the Finance report and highlighted the key points, including;

- Income for the year to August 2023 is £279k which is short of plan by £52k
- Expenditure fell below the plan of £599k and was recorded at £363k, however a significant number of commitments have been ordered and are yet to be goods received.
- The KPI of £0.76 spend on charitable activities (including commitments) compares to the target of £0.75.
- The CCLA investments will be revalued again on 30th September.

Individual donations have decreased due to the cost-of-living crisis, and this has been recognised across the board with other charities nationwide feeling the hit too.

Item 10 09/23 Any Other Business

Neil Gammon referred to the committee dates for next year and asked whether all in attendance were happy to alternate the meetings being via MS Teams and face to face. Kate Wood informed the committee, from an executive director perspective, the terms of reference will need to be reviewed following the group re-structure. It is not yet known who will be in post going forward.

Item 11 09/23 Matters for Escalation to the Trust Board

It was agreed that Neil Gammon would highlight the following to the Trust Board:

- Skypanels for AAU/SDEC at DPOW & SGH
- Donors Recognition
- Reduction in Individual Donations

Action: Neil Gammon

Item 12 09/23 **Date and Time of the next meeting:**

Thursday 9 November 2023
9.30am – 12.00pm
Via MS Teams

Attendance Record:

Name	Nov 2022	March 2023	May 2023	July 2023	Sept 2023
Neil Gammon	✓	✓	✓	✓	✓
Jonathan Lofthouse					✓
Peter Reading	✓	✓	✓		
Shaun Stacey				✓	
Terry Moran					
Linda Jackson					
Gill Ponder	✓	✓	Apols	✓	✓
Mike Proctor					
Maneesh Singh					
Lee Bond	Apols	✓	✓	Apols (Rep)	Apols
Jug Johal	✓	✓	✓	✓	Apols (Rep)
Kate Wood	Apols	Apols	Apols	✓	✓
Ellie Monkhouse	Apols (Rep)	Apols (Rep)	Apols (Rep)	Apols (Rep)	✓
Christine Brereton	-				
Paul Marchant	✓	✓	✓	Apols	✓
Andy Barber	-	-			
Victoria Winterton					
Clare Woodard	✓	✓	✓	Apols	✓
Adrian Beddow	-				
Ian Reekie (Governor)					
Tony Burndred	-	✓	✓	-	-
Susan Liburd	✓	Apols	✓	✓	✓
Simon Leonard	✓	✓	✓	✓	Apols
Lucy Skipworth	✓	✓	✓	Apols (Rep)	Apols (Rep)
Total	**8**	**10**	**10**	**7**	**8**

NLG(23)225

Name of the Meeting	**Trust Board of Directors – Public**	
Date of the Meeting	5 December 2023	
Director Lead	Wendy Booth, Interim Governance Advisor	
Contact Officer/Author	Wendy Booth, Interim Governance Advisor	
Title of the Report	**Trust Board & Board Committee Meetings Timetable**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a schedule of Trust Board & Board Committee Meetings for 2024/2025	
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.
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

MEETING SCHEDULE - 2024 - V11

	Quarter 4 (23/24)			Quarter 1 (24/25)			Quarter 2 (24/25)			Quarter 3 (24/25)			Quarter 1 (24/25)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**
Trust Board															
Public & Private (Thursdays - 9.00 am - 5.00 pm)		08.02.24		11.04.24		13.06.24		08.08.24		10.10.24		12.12.24		13.02.25	
Board Development (Tuesdays - 9.00 am - 5.00 pm)	02.01.24		05.03.24		07.05.24		02.07.24		03.09.24		05.11.24		07.01.25		04.03.25
Committees in Common															
Performance, Estates & Finance (Wednesdays - 9.00 am - 12.30 pm)	24.01.24	28.02.24	27.03.24	24.04.24	29.05.24	26.06.24	24.07.24	28.08.24	25.09.24	30.10.24	27.11.24	18.12.24	29.01.25	26.02.25	26.03.25
Group Development (Tuesdays - 9.00 am - 12.00 pm with exceptions as stated)	31.01.24 (Wednesday)	22.02.24 (Thursday)	26.03.24	23.04.24	28.05.24	25.06.24	30.07.24	27.08.24	24.09.24	22.10.24	26.11.24	11.12.24 (Wednesday)	28.01.25	25.02.25	25.03.25
Quality & Safety (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24 (1.30 pm - 5.00 pm)	29.02.24	28.03.24	25.04.24 (1.30 pm - 5.00 pm)	23.05.24	27.06.24	31.07.24 (Wednesday)	29.08.24	26.09.24	24.10.24	28.11.24	17.12.24 (Tuesday)	30.01.25	27.02.25	27.03.25
Remuneration (Thursdays - 9.00 am - 11.30 am)	11.01.24			04.04.24			11.07.24			03.10.24			09.01.25		
Workforce, Education & Culture (Thursdays - 1.30 pm - 5.00 pm with exceptions as stated)	30.01.24 (Tuesday - 9.00 am - 12.30 pm)	29.02.24	28.03.24	30.04.24 (Tuesday - 9.00 am - 12.30 pm)	23.05.24	27.06.24	25.07.24	29.08.24	26.09.24	24.10.24	28.11.24		30.01.25	27.02.25	27.03.25
Audit, Risk & Governance Committee (Thursdays - 9.00 am - 12.30 pm with exceptions as stated)	25.01.24			25.04.24		19.06.24 (Wednesday - 9.00 am - 10.30 am) **HUTH ONLY**	25.07.24	15.08.24 (9.00 am - 10.30 am) **NLAG ONLY**		31.10.24			23.01.25		
Charitable Funds															
NLAG (9.00 am - 12.00 pm)	10.01.24		07.03.24		01.05.24		04.07.24		05.09.24		14.11.24		22.01.25		13.03.25
HUTH (9.00 am - 12.00 pm)		21.02.24			30.05.24			22.08.24			13.11.24			06.02.25	
Executive Team Meetings															
Executive Team (Tuesdays - 2.00 pm - 5.00 pm)	09.01.24 16.01.24 23.01.24 30.01.24	06.02.24 13.02.24 20.02.24 27.02.24	12.03.24 19.03.24 26.03.24	02.04.24 09.04.24 16.04.24 23.04.24 30.04.24	14.05.24 21.05.24 28.05.24	04.06.24 11.06.24 18.06.24 25.06.24	09.07.24 16.07.24 23.07.24 30.07.24	06.08.24 13.08.24 20.08.24 27.08.24	10.09.24 17.09.24 24.09.24	01.10.24 08.10.24 15.10.24 22.10.24 29.10.24	12.11.24 19.11.24 26.11.24	03.12.24 10.12.24 17.12.24 24.12.24	14.01.25 21.01.25 28.01.25	04.02.25 11.02.25 18.02.25 25.02.25	11.03.25 18.03.25 25.03.25
Trust Management Board (TMB) (Mondays - 12.00 pm - 2.00 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24	20.01.25	17.02.25	17.03.25
Executive Management Committee (EMC) (Wednesdays - 2.30 pm - 4.30 pm)	17.01.24	21.02.24	20.03.24	17.04.24	15.05.24	19.06.24	17.07.24	21.08.24	18.09.24	16.10.24	20.11.24	18.12.24	15.01.25	19.02.25	19.03.25
Performance															
PRIMS - NLAG (Thursdays)	18.01.24	15.02.24	21.03.24	18.04.24	16.05.24	20.06.24	18.07.24	15.08.24	19.09.24	17.10.24	21.11.24	19.12.24	16.01.25	20.02.25	20.03.25
Performance - HUTH (Wednesdays)	03.01.24	07.02.24	06.03.24	03.04.24	08.05.24	05.06.24	03.07.24	07.08.24	04.09.24	02.10.24	06.11.24	04.12.24	08.01.25	05.02.25	05.03.25
Governors															
Council of Governors (Thursdays - Business Meetings - 2.00 pm - 5.00 pm, with the exception of ARM)	11.01.24			04.04.24		**Annual Review Meeting** 20.06.24 2.00 pm - 4.00 pm	11.07.24		**Annual Members Meeting** 12.09.24	31.10.24			09.01.25		
Governor Assurance Group (Thursdays - 5.30 pm - 7.00 pm with exception as stated)		15.02.24		18.04.24		24.06.24 (Monday)		15.08.24		17.10.24		19.12.24		20.02.25	
Appointments & Remuneration Committee (Thursdays - 1.30 pm - 3.00 pm)			14.03.24				04.07.24			03.10.24					06.03.25
NED & CEO Meetings															
NED & CEO Meetings (Thursdays - 2.00 pm - 4.00 pm - with exceptions as stated)	09.01.24 (Tuesday - 10.00 am-12.00 pm)	15.02.24	14.03.24 (10.00 am-12.00 pm)	18.04.24	16.05.24	18.06.24 (Tuesday - 10.00 am - 12.00 pm)	09.07.24 (Tuesday - 10.00 am - 12.00 pm)	15.08.24	10.09.24 (Tuesday - 10.00 am - 12.00 pm)	17.10.24	14.11.24	19.12.24	14.01.25 (Tuesday - 10.00 am - 12.00 pm)	20.02.25	13.03.25
Union Meetings															
JNCC - NLAG (Mondays - 2.30 pm - 4.30 pm)	15.01.24	19.02.24	18.03.24	15.04.24	20.05.24	17.06.24	15.07.24	19.08.24	16.09.24	21.10.24	18.11.24	16.12.24	20.01.25	17.02.25	17.03.25
JNCC - HUTH (Thursdays - 10.45 am - 12.45 pm)	04.01.24		07.03.24		02.05.24		04.07.24		05.09.24		07.11.24		02.01.25		06.03.25
Consultant Meetings															
JLNC - NLAG (Tuesdays - 1.00 pm - 3.00 pm)	16.01.24	20.02.24	19.03.24	16.04.24	21.05.24	18.06.24	16.07.24	20.08.24	17.09.24	15.10.24	19.11.24	17.12.24	21.01.25	18.02.25	18.03.25
LNC - HUTH (Wednesdays - 10.00 am - 12.00 pm)	17.01.24		20.03.24		15.05.24		17.07.24		18.09.24		20.11.24		15.01.25		19.03.25

Name of the Meeting	**Trust Board of Directors – Public**
Date of the Meeting	5/12/2023
Director Lead	Adrian Beddow, Associate Director of Communications
Contact Officer/Author	Charlie Grinhaff, Communications Manager
Title of the Report	**Communications Report**
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 September and October 2023 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.
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NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Communications Team update

December 2023

Kindness • Courage • Respect

Report period: September and October 2023

Contents

Headlines

4068 Members of the staff Facebook group

730+ Group staff attended Ask The Chief Executive

1374 Opens of the Members Newsletter

140 General enquiries dealt with

97% Of media coverage was positive or neutral

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%+ Freedom of Information requests (FOIs) within statutory time limits. • Taken over the remit of 'Membership communications' and started a new quarterly newsletter • Reviewed the content on our website, and that on the NHS website for our Trust • Introduced regular infographics on maternity stats, Emergency Department statistics and more recently patient feedback • Undertaken video training to enable to the team to produce more video content • Carried out a survey of our Foundation Trust Members to help shape member engagement going forward	**What we've already done** • Created a regular drumbeat for internal communications • 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 • Introduced Team Brief Live • Re-invigorated the way we share compliments on social media – swapping #ThankYouTuesday for #ThankYouNHS • Added the Trust Twitter feed to the home page of the Hub so staff not on social media can see our celebrating success content • Introduced a new managers email so we can target manager specific messages • Relaunched Ask Peter as Ask the Execs • Brought back the annual staff awards ceremony, Our Stars 2023, receiving a record number of nominations – over 1,000 • Aligned everything we do to the People's Promise – introducing the brand to relevant internal content • Recruited to a new role in the team – Lottery and Membership Coordinator
What we're working on • How we can work more closely with our local media, providing positive news stories • Reviewing our social media channels	**What we're working on** • Working with senior leaders on their approach to engagement and communication • Supporting the People division with the Health and Wellbeing and Culture Transformation work. • Establishing Group communication channels with HUTH

Supporting the Trust's priorities

Trust Priority – Our People
Staff survey – we have carried out a co-ordinated joint campaign with HUTH in promoting this year's NSS which has included weekly emails to managers, social media posts on our NLaG staff group, and on our other internal comms channels

Flu and Covid
We've been supporting the Flu and Covid Vaccination campaign encouraging staff to protect themselves.

Freedom to Speak Up
During October we launched a campaign to promote Speak Up Month and an appeal for Speak Up Champions. During the month, our Guardian received 41 concerns, 34 of which were closed in October and so far 10 people have come forward to be a champion. We also shared this infographic:

Supporting the Trust's priorities

Trust Priority – Collaborative and System working
We helped to promote the Humber and North Yorkshire Integrated Care Board led Humber Acute Services consultation programme.

The team shared 'Your Health, Your Hospitals' content on social media for the public, and internally for staff, to explain what the proposals are and what the impact will be and also to signpost to the consultation documents and questionnaire should anyone what to feed back their comments and thoughts.

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Trust priority The Green Agenda
We promoted Recycle Week in October and received national coverage from Greener NHS.

Campaigns and awareness weeks

AHP day
We celebrated AHP Day in October.

Conferences
We attended and promoted the Chief Nurse Conference and the Infection Control Conference - Bugs R Us.

Staff Lottery
We now have a new role in the team which is our Lottery and Membership Coordinator.

To inject a sense of fun and more opportunities to win prizes new monthly competitions have been launched where staff can show off their creativity. The first one was a pumpkin carving competition. The winner got a £50 voucher to spend on their team.

Improving staff morale and engagement

Keeping staff informed

3562
Opens of the Manager email

52,628
Opens of Building Our Future

All staff emails

Each week we send to all staff the Wednesday Weekly News (an e-news round-up of news and updated) on Thursdays we have a dedicated ‘Building Our Future’ update covering updates on the capital programmes in both estates and digital. A Chief Executive’s Briefing is also sent out across the Group.

Building Our Future was opened 52,628 times and generated 1,000 click throughs.

We also send out a monthly Manager Update to all our staff identified in ESR as being a manager/supervisor. Our September and October editions were opened 3,562 times and generated 556 click throughs.

Staff App

There were 666 downloads of the staff app in this period, with 527,881 page views and 147,709 sessions. The top pages were eRoster, webmail and ESR.

666
Downloads of the staff app

Improving staff morale and engagement

Giving staff a voice

Ask the Chief Executive

Ask The Execs has now been replaced with Ask the Chief Executive – live sessions on Teams held jointly with HUTH staff.

408 staff from across the group attended the September session (129 were NLaG staff). 385 joined on their computer, 23 on their phone. 37 questions were asked.

More than 330 staff attended the October session. 29 questions were asked.

738+
Group staff attended Ask the Chief Executive

Staff Thank Yous

Since the 'Thank you' system launched staff have sent more than 1,411 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.

"Big thank you to Natalie who is a fairly new recruit to the trust and is settling into her new role well, still getting to know people but went the extra mile (literally) to support AHP day and came along to run at the park run in Scunthorpe. Thank you and welcome to team Community Therapy NEL, Team AHP, Team NLAG."

Improving reputation through external communications

Media coverage

There were 90 stories about the Trust in the media during this period. 97 of media coverage was positive or neutral in tone. The majority of coverage was in print or online media.

Grimsby Live was the media outlet that published the most stories about the Trust.

We categorise the media coverage into themes – in this period '**pressures'** was the top theme, followed by 'service developments'

We issued 11 proactive news releases and the most covered was a story was 'Staff to climb mountain to raise money for equipment.'

Staff have been interviewed on the hospital at home service, new approach to surgery at Goole and he staff mountain climb.

97%
Of media coverage was positive or neutral

Media enquiries

34 media enquiries were handled in this time, 91% were dealt with within the requested timescale. The top theme was 'other' which was mainly due to enquires about RAAC . The majority of requests came from print/online outlets.

The main reason journalists got in touch was to request an interview. 5 reactive statements were issued in this period. It's worth noting that media enquiries received on the Humber Acute Services review in this period were forwarded to the Integrated Care Board (ICB) to respond.

91%
Of media enquiries dealt with on deadline

Social media

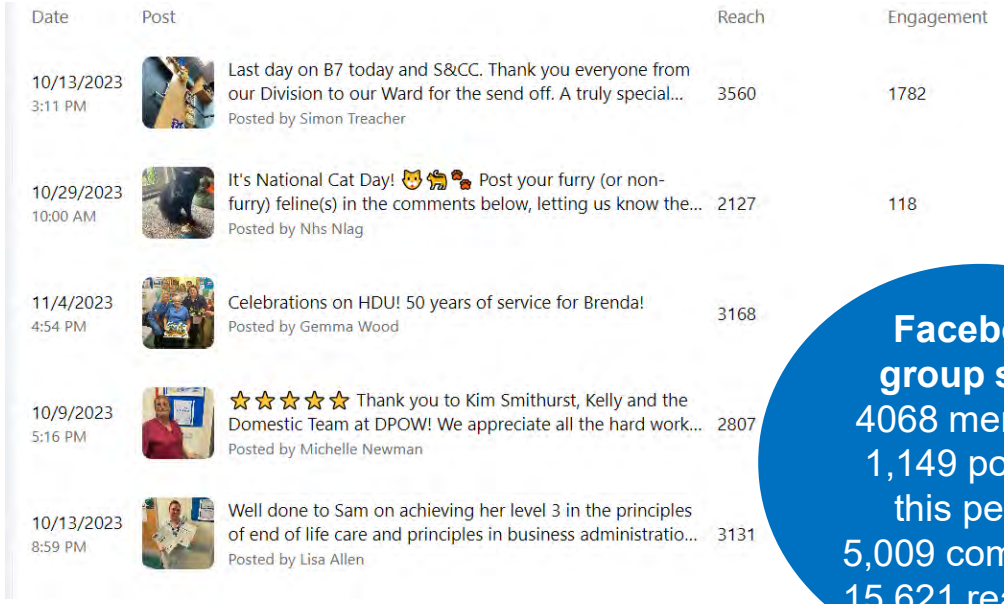
Social media overview
Followers update for the Trust's corporate accounts:

- 14,869 on the Trust's Facebook page (up by 1,115 from the last report)
- 5,568 followers on X (formerly Twitter)
- 5748 followers on LinkedIn
- We are rated 4.8 out of 5 stars on reviews on Facebook

We shared seven #ThankYouNHS posts and 25 #ThumbsUpFriday posts in this period

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 just over 4,000 staff members on there and popular post in this period included a retirement, National cat day, a celebration of 50 years service,, a thank you to the domestic team and recognising an academic achievement



Date	Post	Reach	Engagement
10/13/2023 3:11 PM	Last day on B7 today and S&CC. Thank you everyone from our Division to our Ward for the send off. A truly special... Posted by Simon Treacher	3560	1782
10/29/2023 10:00 AM	It's National Cat Day! 🐱🐈🐾 Post your furry (or non-furry) feline(s) in the comments below, letting us know the... Posted by Nhs Nlag	2127	118
11/4/2023 4:54 PM	Celebrations on HDU! 50 years of service for Brenda! Posted by Gemma Wood	3168	
10/9/2023 5:16 PM	☆☆☆☆☆ Thank you to Kim Smithurst, Kelly and the Domestic Team at DPOW! We appreciate all the hard work... Posted by Michelle Newman	2807	
10/13/2023 8:59 PM	Well done to Sam on achieving her level 3 in the principles of end of life care and principles in business administratio... Posted by Lisa Allen	3131	

Facebook group stats
4068 members
1,149 posts in this period
5,009 comments
15,621 reactions

Social media

X (formerly Twitter)
Our top post, and indeed top three posts on X in this period were all from our Nursing and Midwifery conference.

OCT 2023 SUMMARY

Tweet impressions	New followers
28.1K	8

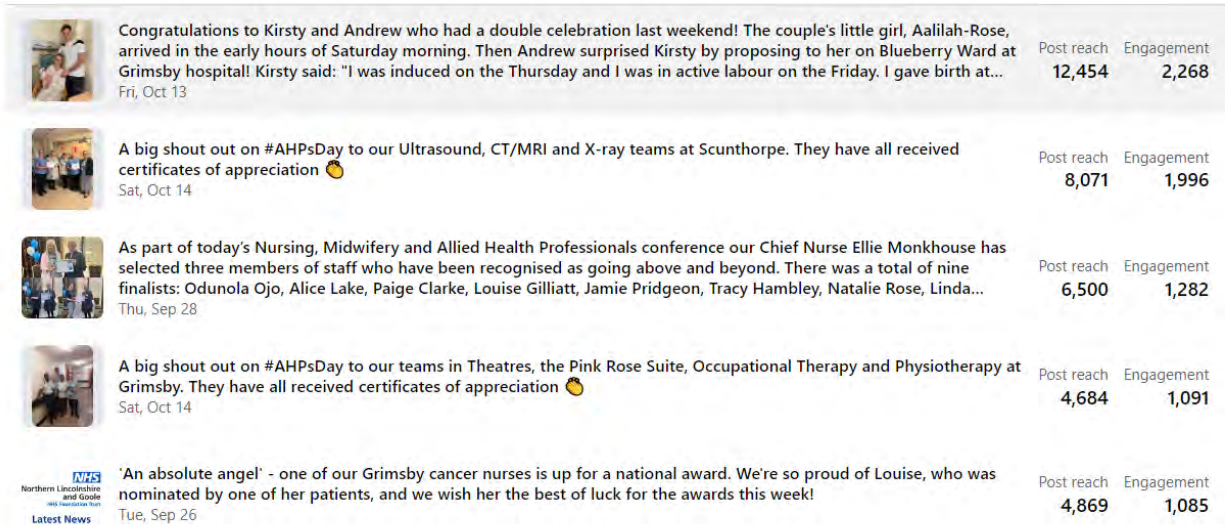
SEP 2023 SUMMARY

Tweet impressions	New followers
29.8K	9

Social media

Facebook page

The Facebook post with the highest engagement and reach was a heart-warming story of a couple who celebrated a new baby and a proposal at Grimsby hospital.
The top image is the top 5 posts ranked by reach, the bottom is the top 5 posts ranked by engagement.



Trust website

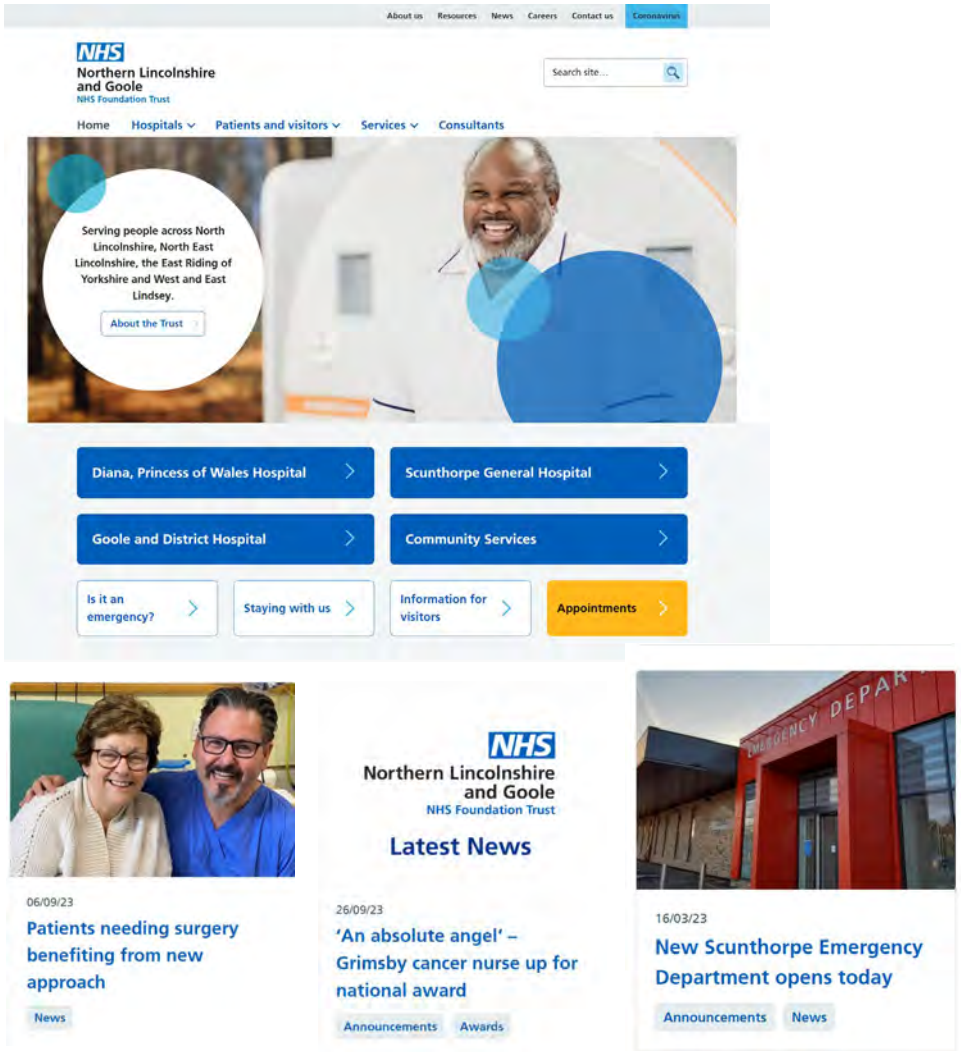
External website – www.nlg.nhs.uk

The Trust ranks in the top 25 of all NHS websites on the Silktide Web Accessibility Index which is a real accomplishment.

Key stats:

- 42,000 users 444,000 events including 158,628 page views
- Average engagement time was 1 min 31
- 6,695 forms submitted
- 366 file downloads
- Safari was the top browser used to access the site followed by Chrome. IOS was the top operating system followed by Android. 76% of users were mobile users
- Most visited pages: the Consultants A-Z, the staff page and Grimsby hospital home page were the top sections

The top three news releases viewed on the website were patients benefiting from new approach, absolute angel, and 'New Scunthorpe ED opens today', which was actually posted in March



Enquiries, information requests and membership

General enquiries

The team receives general enquiries via a form on the Trust website. In this period 140 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. The top themes in this period was ‘accessing services’ and ‘appointments’

140
General enquiries dealt with

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 59 submitted in September – of these 57 are closed, 0 are still in progress and 2 are awaiting a response from the requester.
There were 86 submitted in October – of these 71 are closed, 13 are still in progress and 2 are awaiting a response from the requester.

145
FOIs received

Membership

The September edition of the Members’ Newsletter had 1,374 opens.

.

1374
Opens of the Member newsletter

This report covers September and October 2023

Social media - update

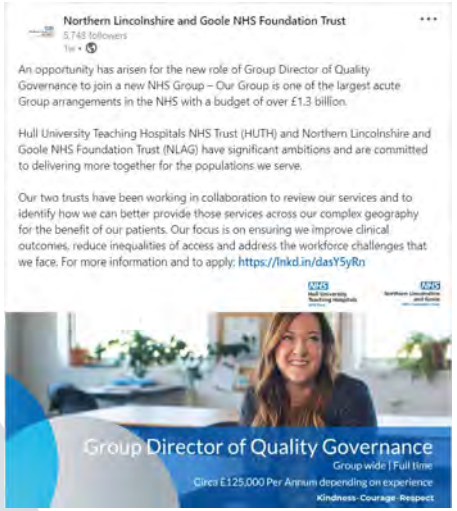
LinkedIn

Stats

166 page views
68 unique visitors
205 reactions
9 comments
26 reposts

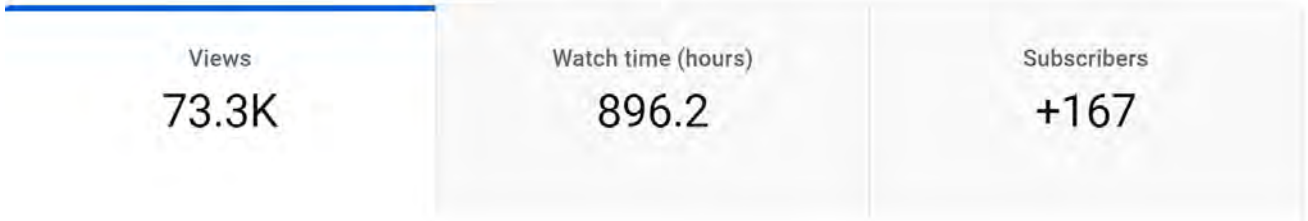
Content

Our top post, with 2,030 impressions and 127 clicks was a recruitment ad for our new Group Director of Quality Governance:

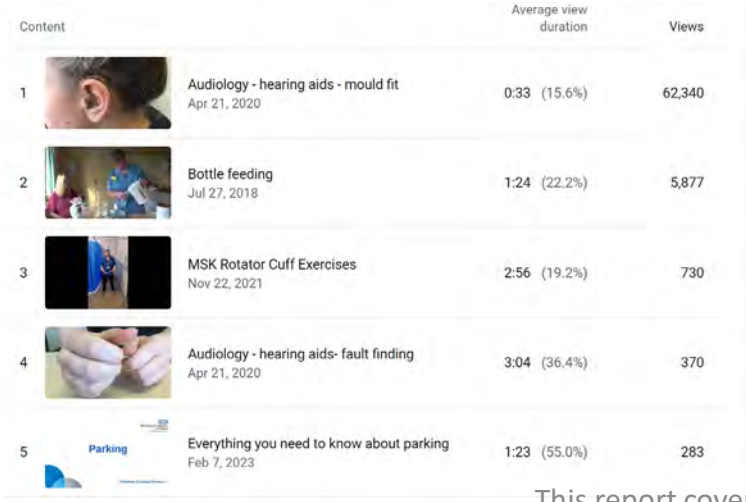


You Tube

Stats



Our top three videos were all instructional videos aimed at patients – one on hearing aids, advice from our Maternity services on bottle feeding and exercise demos from our Physiotherapy service.



	Content	Average view duration	Views
1	Audiology - hearing aids - mould fit Apr 21, 2020	0:33 (15.6%)	62,340
2	Bottle feeding Jul 27, 2018	1:24 (22.2%)	5,877
3	MSK Rotator Cuff Exercises Nov 22, 2021	2:56 (19.2%)	730
4	Audiology - hearing aids- fault finding Apr 21, 2020	3:04 (36.4%)	370
5	Everything you need to know about parking Feb 7, 2023	1:23 (55.0%)	283

NLG(23)227

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Alastair Pickering, Interim Chief Information Officer	
Contact Officer/Author	Shaun Stacey, Group Chief Delivery Officer Ellie Monkhouse, Chief Nurse Dr Kate Wood, Group Chief Medical Officer Simon Nearney, Director of People	
Title of the Report	**Integrated Performance Report (IPR)**	
Purpose of the Report and Executive Summary (to include recommendations)	The IPR aims to provide the Trust 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.	
Background Information and/or Supporting Document(s) (if applicable)	Access and Flow – IPR Quality and Safety – IPR Workforce – IPR	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
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IPR EXECUTIVE SUMMARY **Date: November 2023**

1. ACCESS & FLOW – Shaun Stacey

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

- Diagnostic Procedures Waiting Times – 6 Week Breach Date (DM01)
- Patient Initiated Follow Up
- Cancer – Two Week Wait

Lowlights: (share 3 areas of challenge/struggle)

- Incomplete RTT Pathways 65 Weeks
- % of Extended Stay Patients 21+ Days
- Cancer Waiting Times – 104+ Day Backlog

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Incomplete RTT Pathways 65 Weeks	Displace lower 52ww specialties and increase Orthopaedics to tackle backlog	This will allow long waiting Orthopaedic patients to be treated in theatre and reduce the longer waiters.
% of Extended Stay Patients 21+ Days	System wide multi agency MADE event for 7 days	The MADE event will bring the system partners closer together to help discharge patients who no longer have a right to reside.
Cancer Waiting Times – 104+ Day Backlog	Timely removal of patients from cancer tracking once non-malignancy confirmed	Timely removal will reduce the number of patients on the waiting list

1. QUALITY & SAFETY – Kate Wood & Ellie Monkhouse

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

- Falls - The number of reported falls has decreased for the third consecutive month a range.
- No Methicillin Susceptible Resistance Staphylcoccus Aureus (MRSA) reported this month- (following x1 reported the previous month)
- The number of Community pressure ulcer incidents reported has slightly decreased.
- The SHMI rate of patients that died with an infection related cause continues to be 96.18 which is below the England average 100 and remains within the expected range.
- The percentage of SJRs sighting problems in care/negative learning associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation is reducing with 16% reported in August 2023 compared to 20% in April 2023.
- There has been a successive improvement in the percentage of adult observations recorded on time over the past 9 months, achieving 92.9% in October 2023 against 90% target as well as sustained achievement of the CQUIN target for recording, escalation and response to NEWS2 score for unplanned critical care admissions.

Lowlights: (share 6 areas of challenge/struggle)

- Decline in Complaints closed on time from previous month of 83% to 63%.
- There is an upward trend in Methicillin Susceptible Staphylcoccus Aureus (MSSA) Bacteraemia hospital acquired cases
- There has been a slight increase in the number of reported acute pressure ulcers- in category 2 (low harm)
- Compliance with MCA assessments and best interest recording that meet the legal requirements continued to be low with 13% and 0% in August, respectively.
- Risk related to access to future MCA data sets due to malfunction of the server that the data is held on.
- Delay in development of software bot to feed information from WebV to ePMA to record patient's weight.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Decline in closed complaints on time	The number and complexity of complaints has increased significantly - increasing td workloads and availability from the complaints team and Divisions. Complaints Manager has weekly meetings with Divisional Leads.	Weekly Support & Challenge Meetings continue which provide a real focus and appropriate challenge when identified. Positive work continues with Chief of Staff to identify complaints that are moving towards the 60-day mark to ensure these receive additional focus and rapid turnaround times on sign off completion.
MSSA- Initial findings indicate this to be associated to peripheral cannula care.	Further investigation and action plan in progress.	Outcome will be completed, and action plan completed and learning widely shared.
Increase in reported Pressure Ulcers	All pressure ulcers reported with moderate harm are now reviewed weekly, as a result, supportive actions can be implemented in a timely	No new root causes were identified during the review process and local actions are in place to share the learning.

Compliance with MCA assessments and best interest recording that meet the legal requirements.	MCA resource folders have been rolled out to all Surgery & CC wards. The MCA DoLS Lead is continuing to provide support to ward B6 staff and has introduced bespoke feedback forms for staff who have completed MCA assessment and best interest forms. Staff from the Medicine division have recently undertaking Applying QI training and have selected mental capacity as their QI projects to improve practice on their ward areas - Ward 23, Ward 24/IAAU and the Stroke ward at SGH.	Improved patient/carers experience due to compliance with MCA.
Risk related to access to future MCA assessment data sets due to malfunction of the server that the data is held on.	The Web V team are aware of the issue and are working towards reinstating access to the data but may not be available for December's IPR.	Targeted QI work once data sets reinstated.
Delay in development of software bot to feed information from WebV to ePMA to record patient's weight.	A monthly summary report continues to be shared with ward leaders displaying compliance levels per division per site per ward to encourage improvement. Medicine ward staff have completed Applying QI training resulting in improvements in compliance on Ward 25 and ED at DPoW. The surgery & CC division are also undertaking spot checks on all wards to improve compliance. Implementation of a bot remains a priority.	Improve safety of weight related prescribing.

1. WORKFORCE – Simon Nearney

Highlights:

- The Turnover position has decreased again, this is now at 10.6% and the lowest it has been since recording via the IPR
- The Sickness rate has reduced again, this has now fallen for three consecutive months and is now at 5% against a target of 4.1%
- Core Mandatory Training remains above target at 90.5% against a target of 85%

Lowlights:

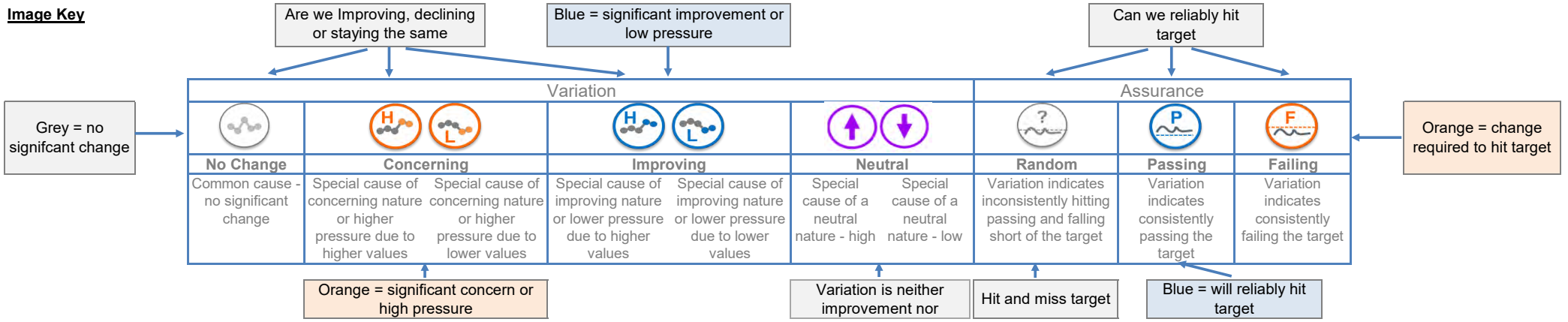
- Role Specific Mandatory Training remains below target at 80.1% against a target of 85% but has seen a 1% increase this month.
- The Medical Vacancy rate for consultants remains high at 19.8% against a target of 15%, this month we have seen a 1.4%
- increase.
- Registered Nurse Vacancy rate is at 10.6% against a target of 8%, for three consecutive months we have seen slight decreased however this remains high.

Key Issue to Address this period:	What improvement Action was implemented?	Expected Outcome & What opportunities can we leverage?
Role Specific Mandatory Training Role specific compliance has improved by approximately 0.7% since the previous report, reverting to an upward trajectory for the first time since July 2023.	**Role Specific Mandatory Training** Moving and Handling and Resuscitation remain key areas for improvement within role specific mandatory training. Supported by the Head of Education, Training and Development, both training teams have reviewed and adapted their delivery models for the remainder of the year up to March 2024 to ensure they maximise training spaces available.	**Role Specific Mandatory Training** Additional sessions have been planned across all areas of resuscitation to support demand, including the use of full safety training days where higher volumes of staff can be trained at Level 2. Moving and Handling modules continue to be impacted by wasted spaces with a further 137 staff withdrawing from or not attending planned sessions in October 2023. Further Moving and Handling Cascade Trainer training has been completed this month to increase capacity of qualified trainers supporting in clinical areas. This has been particularly effective in GDH where the offer of Moving and Handling training is less frequent so having qualified cascade trainers is beneficial to all staff on site. As with core mandatory training, monthly reports are cascaded to directorates via HRBPs providing key information on areas of concern for mandatory training. Current areas reported in detail are - Moving and Handling, Resus, Deteriorating Patient, Safeguarding Adults Level 3, Safeguarding Children Level 3, Fire Safety, Corporate Induction and Information Governance and Data Security (latter 3 being core mandatory and previous being role specific).

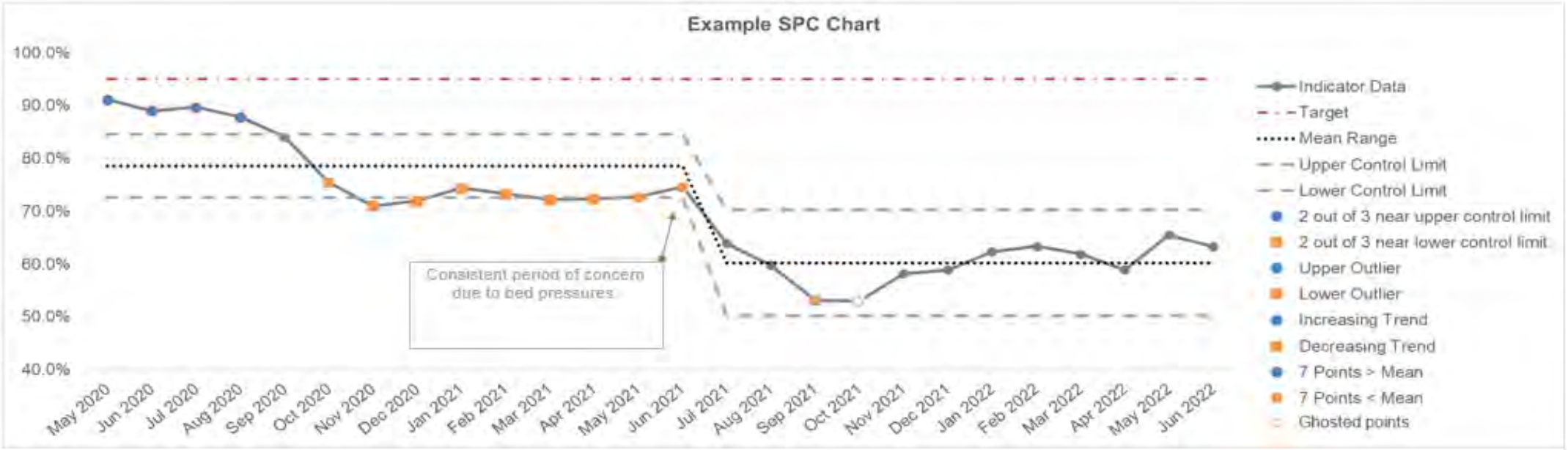
Medical Vacancy Rate Sourcing of senior medical staff via the Talent Acquisition Team has commenced with an initial focus upon Emergency Medicine and Acute Medicine as high spend areas with higher vacancy factors in senior grades.	**Medical Vacancy Rate** Work continues to design and implement a CESR support programme to support employees towards being granted specialist GMC Registration and appointment into substantive Consultant roles.	**Medical Vacancy Rate** Recruitment of Radiologists is planned in Kerala in November 2023, and in addition to direct recruitment relationship building and visits to various hospitals is planned for Acute and Emergency Medicine, Surgery, and Radiology. These will allow NLAG clinical staff to view training and facilities and develop longer term pipelines of medical staff, alongside exploring opportunities for partnership working with institutions in Kerala.
Registered Nursing Vacancy Ongoing engagement with international nurses sourced in Kerala is ongoing with arrivals in November and an additional cohort now planned for January 2024.	**Registered Nursing Vacancy** NQNs starting this year are expected to exceed targets, with the majority of NQNs now allocated wards, which has resulted in planned over establishments in some areas to reduce withdrawal rates.	**Registered Nursing Vacancy** Discussions are now underway to design the recruitment plan for NQNs for 2024. Recruitment of further international nurses will take place in Kerala in November 2023, with the aim of recruiting circa 20 - 30 international nurses. Work with hospitals and educational providers will also take place in Kerala to develop relationships to facilitate longer term pipelines. Please note the vacancy position shown relates to registered nurses in all grades

Northern Lincolnshire and Goole NHS Foundation Trust

Image Key



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



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

Notes on Process Limits Re-Calculation

Process limits will be affected when there has been a change in an operational process or procedure that has resulted in a change to the data, for example a process improvement or impact.

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.

Re-calculation, when appropriate, allows us to see whether we are likely to consistently achieve any target and will still allow us to see of improvement or deterioration is occurring.

The following principles apply when deciding whether to re-calculate:-

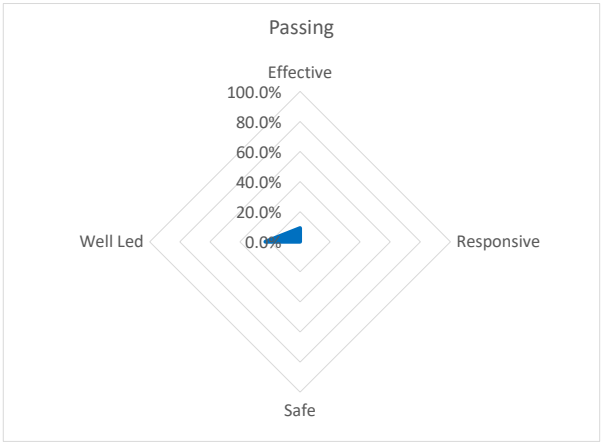
- There should be an identifiable real process change that resulted in the above.
- The change must have been sustained for an appropriate number of data points.

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

Consistently Passing

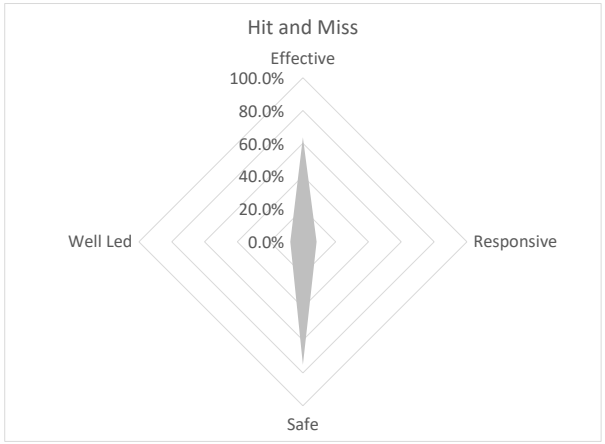
Total: 4



% Discharge Letters Completed Within 24 Hours of Discharge
Core Mandatory Training Compliance Rate
Medical Staff PADR Rate
Medical Vacancy Rate - Other *

Hit and Miss

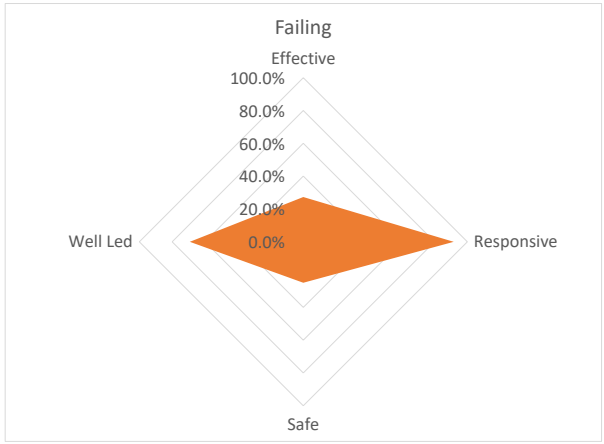
Total: 12



% Outpatient Non Face To Face Attendances
% Patients Discharged On The Same Day As Admission (excluding daycase)
Bed Occupancy Rate (G&A)
Duty of Candour Rate
Mixed Sex Accommodation Breaches
Total Inpatient Waiting List Size
Venous Thromboembolism (VTE) Risk Assessment Rate
% of Extended Stay Patients 21+ days
Inpatient Elective Average Length Of Stay
Inpatient Non Elective Average Length Of Stay
Complaints Responded to on time
Medical Vacancy Rate *

Consistently Failing

Total: 24



% Inpatient Discharges Before 12:00 (Golden Discharges)
Ambulance Handover Delays - Number 60+ Minutes
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
PADR Rate
Percentage Under 18 Weeks Incomplete RTT Pathways*
Role Specific Mandatory Training Compliance Rate
Turnover Rate
Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*
Sickness Rate
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
Cancer Request To Test In 7 Days*
Community Acquired Pressure Ulcers (Number)
Unregistered Nurse Vacancy Rate *
Registered Nurse Vacancy Rate *
Trustwide Vacancy Rate *
Medical Vacancy Rate - Consultants *
Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission

			Assurance		
			Pass	Hit and Miss	Fail
Variance	Special Cause Improvement		% Discharge Letters Completed Within 24 Hours of Discharge Medical Vacancy Rate - Other *	% Patients Discharged On The Same Day As Admission (excluding daycase) Inpatient Non Elective Average Length Of Stay Duty of Candour Rate	Emergency Department Waiting Times (% 4 Hour Performance) Turnover Rate PADR Rate Combined AfC and Medical Staff PADR Rate Role Specific Mandatory Training Compliance Rate Sickness Rate Unregistered Nurse Vacancy Rate * Trustwide Vacancy Rate *
	Common Cause		Medical Staff PADR Rate Core Mandatory Training Compliance Rate	Bed Occupancy Rate (G&A) % of Extended Stay Patients 21+ days Inpatient Elective Average Length Of Stay Complaints Responded to on time Venous Thromboembolism (VTE) Risk Assessment Rate Mixed Sex Accommodation Breaches Medical Vacancy Rate *	% Inpatient Discharges Before 12:00 (Golden Discharges) Outpatient Did Not Attend (DNA) Rate Ambulance Handover Delays - Number 60+ Minutes Cancer Waiting Times - 104+ Days Backlog* Cancer Waiting Times - 62 Day GP Referral* Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)* Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge Cancer Request To Test In 7 Days* Community Acquired Pressure Ulcers (Number) Registered Nurse Vacancy Rate *
	Special Cause Concern			% Outpatient Non Face To Face Attendances Total Inpatient Waiting List Size	Number of Overdue Follow Up Appointments (Non RTT) Number of Incomplete RTT pathways 52 weeks* Percentage Under 18 Weeks Incomplete RTT Pathways* Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38* Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission Medical Vacancy Rate - Consultants *

Scorecard - Access and Flow

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. '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 for Assurance/Variation when the data is not presented as an SPC chart.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Planned	% Under 18 Weeks Incomplete RTT Pathways*	Oct 2023	61.0%	92.0%	Alert		
	Number of Incomplete RTT pathways 52 weeks*	Oct 2023	818	0	Alert		
	Total Inpatient Waiting List Size	Oct 2023	12,387	11,563	Alert		
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Oct 2023	26.8%	1.0%	Alert		
	Number of Incomplete RTT pathways 65 weeks	Oct 2023	119	No Target	Alert		n/a
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Oct 2023	37,834	9,000	Alert		
	Outpatient Did Not Attend (DNA) Rate	Oct 2023	6.3%	5.00%	Alert		
	% Outpatient Non Face To Face Attendances	Oct 2023	21.9%	25.00%	Alert		
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Oct 2023	50.0%	85.0%	Alert		
	Cancer Waiting Times - 104+ Days Backlog*	Oct 2023	29	0	Alert		
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Oct 2023	14.3%	75.0%	Alert		
	Cancer - Request To Test In 7 Days*	Oct 2023	52.7%	100.0%	Alert		
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2023	60.8%	95.0%	Alert		
	Number Of Emergency Department Attendances	Oct 2023	14,669	No Target	Alert		n/a
	Ambulance Handover Delays - Number 60+ Minutes	Oct 2023	659	0	Alert		
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Oct 2023	996	0	Alert		
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Oct 2023	541	0	Alert		
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Oct 2023	44.6%	40.0%	Highlight		
	% of Extended Stay Patients 21+ days	Oct 2023	13.7%	12.0%			
	Inpatient Elective Average Length Of Stay	Oct 2023	2.0	2.5			
	Inpatient Non Elective Average Length Of Stay	Oct 2023	3.3	3.9			
	% Discharge Letters Completed Within 24 Hours of Discharge	Oct 2023	97.6%	90.0%			
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Oct 2023	16.8%	30.0%	Alert		
	Bed Occupancy Rate (G&A)	Oct 2023	95.4%	92.0%			

Scorecard - Quality and Safety

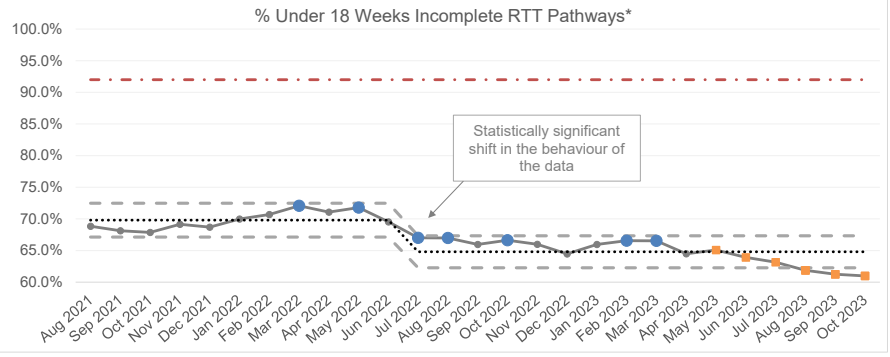
Note 'Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target
Note 'Highlight' is stated when either Variation is showing special cause improvement for the first time or Assurance indicates passing the target for the first time
n/a is stated when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

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Sep 2023	0.00	see analysis			n/a
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Sep 2023	0.21	see analysis			n/a
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Sep 2023	0.00	see analysis			n/a
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Sep 2023	0.26	see analysis			n/a
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Sep 2023	0.47	see analysis			n/a
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected	Alert		As expected
	Summary Hospital level Mortality Indicator (SHMI)	May 2023	103.0	As expected			As expected
	SHMI diagnosis groups outcome risk percentage (infections)	May 2023	96.2%	No target			n/a
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Aug 2023	16.0%	No target		n/a	n/a
Safe Care	Patient Safety Alerts actioned by specified deadlines	Sep 2023	100.0%	100%			n/a
	Number of Serious Incidents raised in month	Sep 2023	4	No target			n/a
	Occurrence of 'Never Events' *(Number)*	Sep 2023	0	0		n/a	n/a
	Duty of Candour Rate	Sep 2023	100.0%	100%			
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2023	3.8	No target			n/a
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2023	4.0	No target			n/a
	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 2023	95.1%	95.0%			
	Care Hours Per Patient Day (CHPPD)	Sep 2023	8.5	No target			n/a
	Mixed Sex Accommodation Breaches	Sep 2023	3	0			
	Community Acquired Pressure Ulcers (Number)	Sep 2023	52	0	Alert		
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Oct 2023	6.4	No target			n/a
	Complaints Responded to on time	Oct 2023	63.0%	85.0%			
	Friends & Family Test: Inpatient Score Percentage Positive	Sep 2023	98.9%	No target	Highlight		n/a
	Friends & Family Test: A&E Score Percentage Positive	Sep 2023	77.8%	No target			n/a
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Sep 2023	4.0	No target			n/a
Mental Capacity	Number of contacts with the MCA/DoLS team	Oct 2023	0.0	No target		n/a	n/a
	Percentage of MCA assessments that meet the legal requirements	Aug 2023	13.0%	No target		n/a	n/a
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Aug 2023	0.0%	No target		n/a	n/a
Prescribing	Harm impact for weight related medication prescribing incidents	Oct 2023	2	No target			n/a
Maternity	Robson Scores - Group 1	Oct 2023	23.1%	No target			n/a
	Robson Scores - Group 2	Oct 2023	29.0%	No target			n/a
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Oct 2023	16	No target			n/a
	Still Birth Rate per 1000	Oct 2023	3.3	No target			n/a
	Spontaneous 3rd or 4th Degree Tear	Oct 2023	0.6%	No target			n/a
	Instrumental 3rd or 4th Degree Tear	Oct 2023	5.3%	No target			n/a

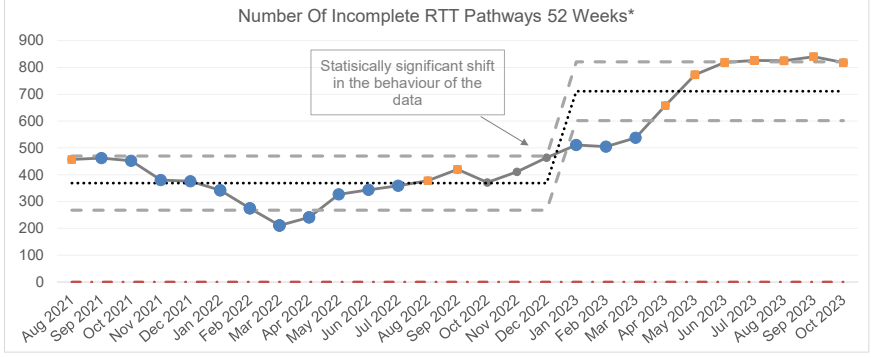
Scorecard - Workforce

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. '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 for Assurance/Variation when the data is not presented as an SPC chart.

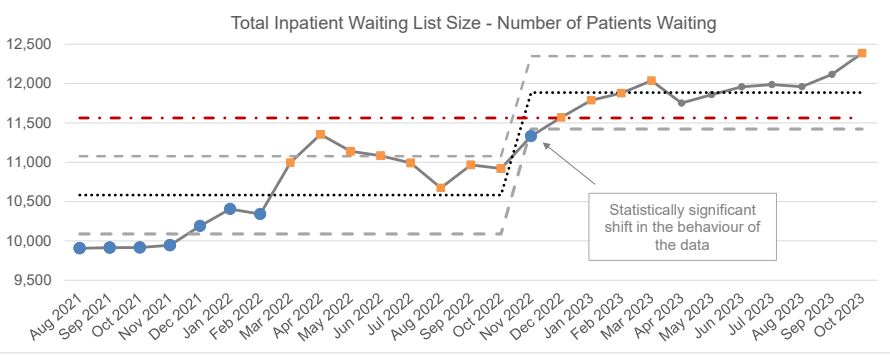
Category	Indicator	Period	Actual	Target	Action	Variation	Assurance
Vacancies	Unregistered Nurse Vacancy Rate*	Oct 2023	10.3%	8.0%	Alert		
	Registered Nurse Vacancy Rate*	Oct 2023	10.6%	8.0%	Alert		
	Medical Vacancy Rate*	Oct 2023	13.2%	15.0%			
	Trustwide Vacancy Rate*	Oct 2023	9.1%	8.0%	Alert		
	Medical Vacancy Rate - Consultants*	Oct 2023	19.8%	15.0%	Alert		
	Medical Vacancy Rate - Other*	Oct 2023	5.3%	15.0%	Highlight		
Staffing Levels	Turnover Rate	Oct 2023	10.6%	10.0%	Alert		
	Sickness Rate	Sep 2023	5.0%	4.1%	Alert		
Staff Development	PADR Rate	Oct 2023	83.9%	85.0%	Alert		
	Medical Staff PADR Rate	Oct 2023	93.0%	85.0%			
	Combined AfC and Medical Staff PADR Rate	Oct 2023	85.4%	85.0%	Alert		
	Core Mandatory Training Compliance Rate	Oct 2023	90.5%	85.0%			
	Role Specific Mandatory Training Compliance Rate	Oct 2023	80.1%	85.0%	Alert		



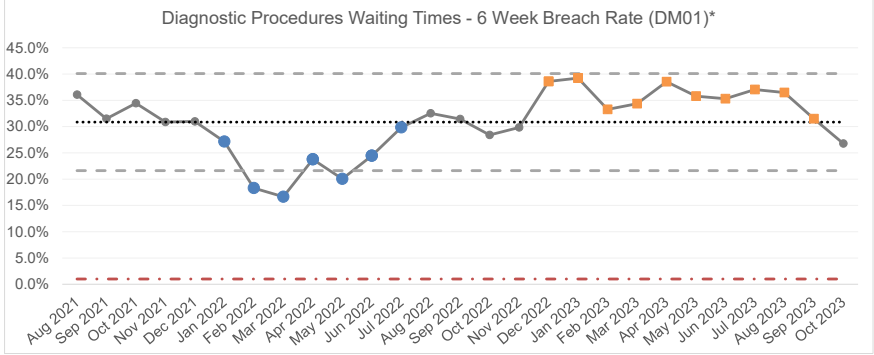
Oct 2023	Target	Variance	Assurance
61.0%	92.0%	Special cause of concerning nature or higher pressure due to lower values	Consistently falling short of the target



Oct 2023	Target	Variance	Assurance
818	0	Special cause of concerning nature or higher pressure due to higher values	Consistently falling short of the target



Oct 2023	Target	Variance	Assurance
12,387	11,563	Special cause of concerning nature or higher pressure due to higher values	Inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
26.8%	1.0%	Common cause - no significant change	Consistently falling short of the target

Data Analysis:

Under 18 weeks incomplete*: Following a stable period of expected behaviour the indicator is currently indicating concern. However, more data is needed to determine whether this will continue. Current data indicates that the target will not be met without action, planned actions outlined below.

Incomplete 52 weeks*: Since spring of 2022 52-week delays has slowly climbed and has been registering concern for seven months. Current data indicates that the target will not be met without action, planned actions outlined below.

Inpatient waiting list: The number of waiters has recorded a general increase for the past 12 months and as such is registering concern. Target assurance suggests that the target will achieve and fail at random, although the target has not been achieved for almost a year.

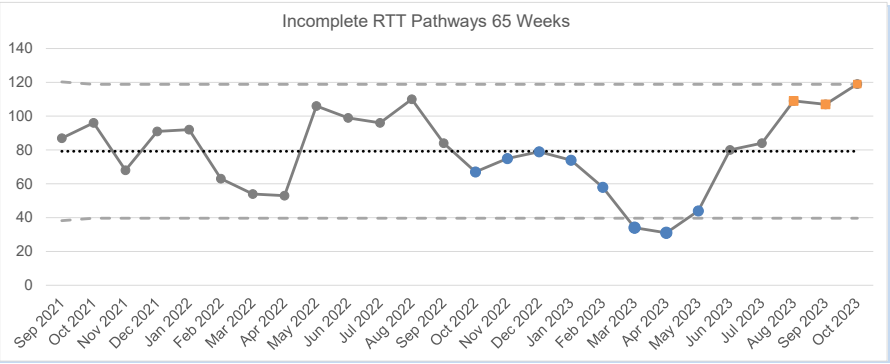
Diagnostics 6 Week Wait (DM01)*: Performance remains within the expected range although for ten of the previous twelve months the figures have registered on the high side of the mean. Current data indicates that the target will not be met without action, see below.

Challenges:

Key Risks:

Actions:

Mitigations:



Oct 2023
119

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

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Data Analysis:
Incomplete RTT pathways 65 weeks: Although performance remains largely within the process limits, the figures have increased on an almost month on month basis. The most recent three months are close to the upper process limit and as such are registering concern.

Challenges:
- Reduced CT & MRI capacity due to Community Diagnostic Centre constraints
- Reporting capacity for CT / MRI
- Workforce vacancies resulting in reduced capacity for Outpatients, subsequent increase in 52 week waits, delays in diagnostics including MRI impacting on increased waits
- Balancing the risk of patient flow versus elective activity
- Acceptance of Mutual Aid
- Diagnostic Demand is greater than capacity for Echo
- Independent sector delays have impacted on incomplete pathways with no provision currently for Gastroenterology throughout October
- Theatre capacity affected by short notice sickness, issues with theatre estates and an influx of acute activity causing elective activity to be converted
- Significant pressures in anaesthetic assessment capacity due to pathways and sickness, vacancy and leave position
- Delivery of additional £13m - activity needs to increase to support delivery.
- Chellenges around joint pathways with Primary Care - current shared care agreements (Rheumatology)

Key Risks:
- Ageing diagnostic equipment across mulitple modalities - loss of service provision if failures occur and clinical harm potential with assocaited delays
- Diagnostic recruitment and retention / workforce skill mix
- Impact on operational delivery due to ongoing industrial action
- Impact of ability to fill consultant vacancies in hard to fill specialties

Actions:
- Recruitment of Radiogrpahers and Radiologists (Dec '23)
- Establish additional sessions to support delivery of Divisional activity plans (Ongoing)
- Displace lower 52ww specialties and increase Orthopaedics to tackle backlog (Nov '23)
- Requested Independent sector provider to look further afield than own area to identify clinicians able to support Gastroenterolgy
- Waiting list Initiatives to recover lost activity due to Industrial action (Ongoing)

Mitigations:
- Diagnostic equipment maintainance contracts in place, equipment risks on risk register and escalated via PRIM
- Weekly performance review in place
- Monitoring of reporting times and utilising out-sourced capacity where available
- Robust processes in place to regularly review waiting lists and focus on long waiting and high-risk patients.
- Locum staff in place where able, to maintain services
- Activity plans reviewed weekly
- Clinical risk stratification to ensure allocation of all appointments is led by clinical priority of patients
- Contract negotiations underway to secure on-going use of the Independent Sector with sign off expected with commencement of new contract
- Waiting List Initiatives have been utllised in a number of specialties to address the current long over due and patients >52 weeks, this has been done as desktop review, rather than follow up, to good effect
- Mobilisation of Community Diagnostic Centre CT/MRI vans on alternative pad locations

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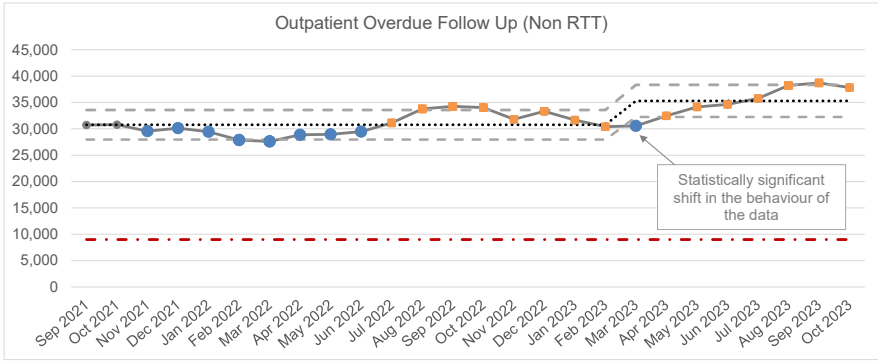


Oct 2023
37,834

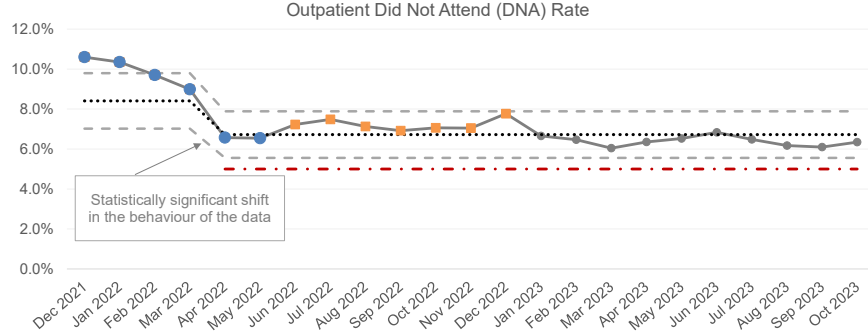
Target
9,000

Variance

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

Assurance

Consistently falling short of the target



Oct 2023
6.3%

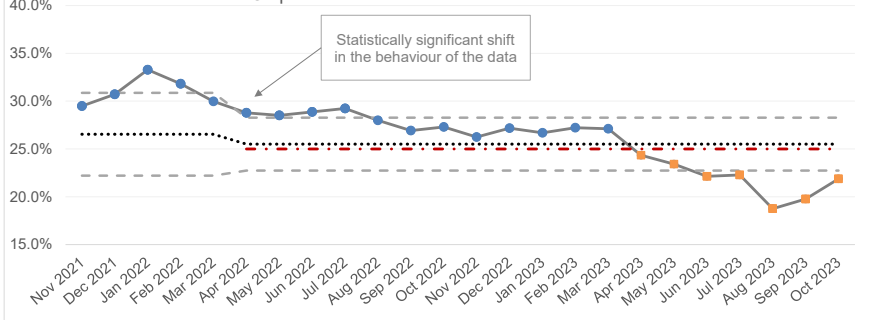
Target
5.0%

Variance

Common cause - no significant change

Assurance

Consistently falling short of the target



Oct 2023
21.9%

Target
25.0%

Variance

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

Assurance

Inconsistently hitting passing and falling short of the target

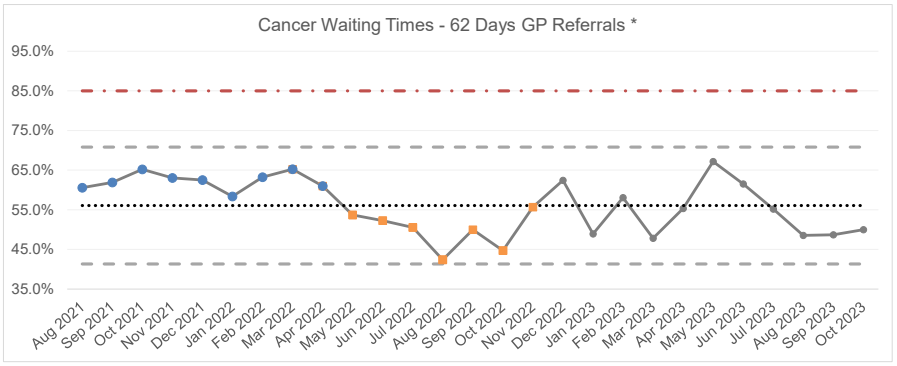
Data Analysis:
Outpatient Overdue follow up: This indicator has recorded concern for the past seven months. The indicator is failing the target by some margin. Current data indicates that the target will not be met without action, planned actions outlined below.
Outpatient DNA rate: The indicator is stable and within the expected range of the data. Current data indicates that the target will not be met without action, planned actions outlined below.
Non Face to Face Outpatient: The past few months have recorded a decrease in performance and as such the indicator is registering concern. The target is within the process limits and may therefore be achieved at random unless the downwards trend continues.

Challenges:
- The 25% reduction in follow-up activity continues to have a significant impact on the overdue follow-up waiting list, as we try to balance the conversion of follow-up activity to new. Despite the work invested to date, patients continue to be added to the follow-up list, and our numbers of overdue patients continues to rise.
- There has been little progress on the patient validation to reduce overdue follow-ups (via a direct communication to the patient), clinical sign-up to this initiative is proving very challenging.
- Management resource to the OP Programme is limited, due to long term sickness, and the Lorenzo Project is consuming signficant amounts of operational leadership resource.
- A lack of funding to continue roll-out of the CHN network at pace is causing some frustration. Roll-out has been on hold since April 2023

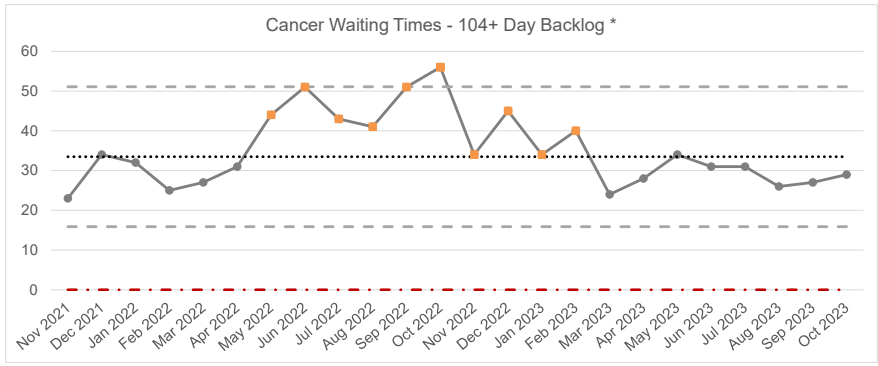
Key Risks:
- Clinical buy-in across some specialities to deliver the 25% reduction. Risk to delivery without radical change, particularly as regards validation and PIFU.
- Inability to secure a long-term finance model for CHN as pump prime funding expired in March 2023.
- Impact on operational delivery due to ongoing industrial action
- The increase of the overdue follow-up waiting list, as follow-up activity is taken out and converted to new.
- Non face to face attendance rates will fall due to the contract for video consulting ending in March will no further funding secured to extend.

Actions:
- Within the GIRFT action plans a number of initiatives have been agreed including changes to pathways and consideration of PIFU in pathways where clinically appropriate. Work on delivery will continue for the remainder of the year (Oct - March 24)
- Working with Divisional Medical Directors to explore options for delivering the 25% reduction in follow-ups (Dec 23). Pilots agreed with ENT, Paeds and Gynae for direct communication patient validation.
- Work continues to encourage clinicians to utilise the various options available to manage follow-ups and prevent patients being added to the follow-up list
- Getting It Right First Time (GIRFT) for Outpatients is underway across 14 specialities. There are 78 actions in total, being monitored via the GIRFT Steering Group and action plan
- Discussions on CHN future finance model is progressing with NLAG and ICB finance leads, some TIF funding is being utilised as an interim arrangement to complete Cardiology roll-out across all the PCN's in Northern Lincolnshire (March 2024)
- Data Packs are being developed to support specialties in reducing follow-up, highligting good/poor practice and showing inconsistencies across the specialty workforce. Gastro is the first pilot area to use the pack.
- Review of specialties where overdue follow-ups are increasing and action trackers to manage improvements (Oct '23)

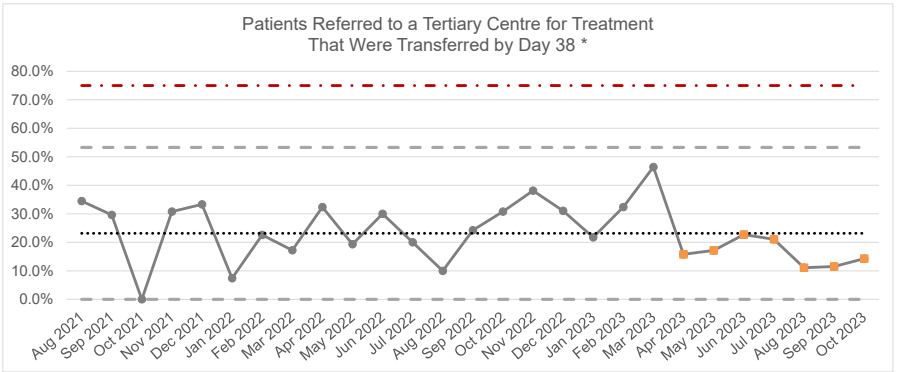
Mitigations:
- Clinicians engaged through GIRFT to support PIFU adoption and OP Follow-up Patient Validation. Oversight via the GIRFT Steering Group
- DMD's engaged in discussions and proposals to validate follow-up patients (via direct correspondence with patients). Proposal supported by Exec Team
- Discussions continue on future finance options for CHN, interim arrangements in place to finalise Cardiology roll-out. CHN Evalution paper developed, final draft is being considered by COO.
- Specialty level trajectories in place within the activity plans for 2023-24 for reducing Follow-up activity, although hitting trajectories for follow-up activity, this is having an adverse impact on the overdue follow-ups.



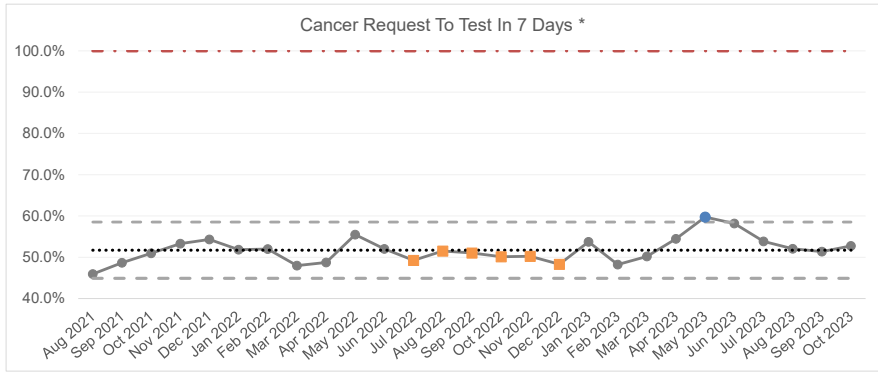
Oct 2023	50.0%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Oct 2023	29
Target	0
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Oct 2023	14.3%
Target	75.0%
Variance	Special cause of concerning nature or higher pressure due to lower values
Assurance	Consistently falling short of the target



Oct 2023	52.7%
Target	100.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target

Data Analysis:

62 days GP referral*: From July 2023 this indicator includes breast symptomatic referrals. Performance is stable and as expected. This target 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.

104+ day backlog*: Performance is as expected. The indicator is consistently failing the target 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 for the past seven months has fallen below the average and is therefore registering concern. Current data indicates that the target will not be met without action, planned actions outlined below.

Request to test 7 days*: Performance is stable and as expected. The data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- All tumour sites are affected by the increasing waiting times for oncology consultant appointments (62-day pathway)
- 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 pathology turnaround times, patient choice
- Notable increase in Urological Cancer referrals over last 3 months and increase in 62 day breaches due to TURBT no longer being classed nationally as a first treatment
- Increase in Urology patients awaiting surgery at HUTH due to Urology Renal consultant vacancy
- Patient unavailability - patients not always aware they are on a suspected cancer pathway
- Increase in 104+ day patients due to a number of factors including access to diagnostics, surgery, oncology

Key Risks:

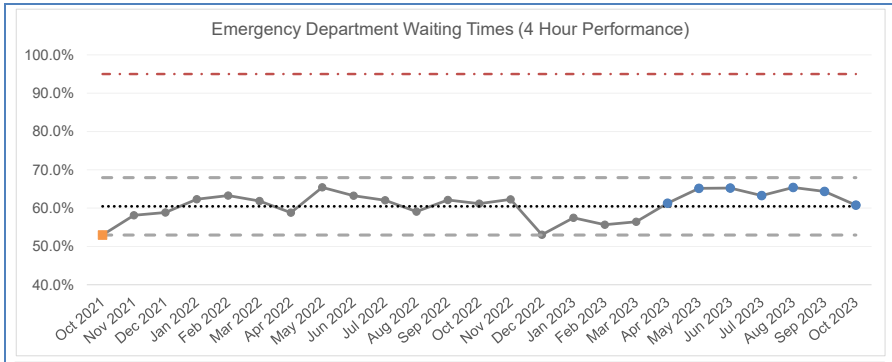
- Request to Test (14 days) requires reduction to 7 calendar days to meet 28-day Faster Diagnosis Standard
- Upper GI pathway includes HUTH, currently significant delay due to demand on services
- There are issues related to visiting consultant services for Oncology referrals for tertiary based staging scans (EUS, PET CT) and associated wait for results affect the ability to transfer for treatment by Day 38 - when patients are transferring to Hull.

Actions:

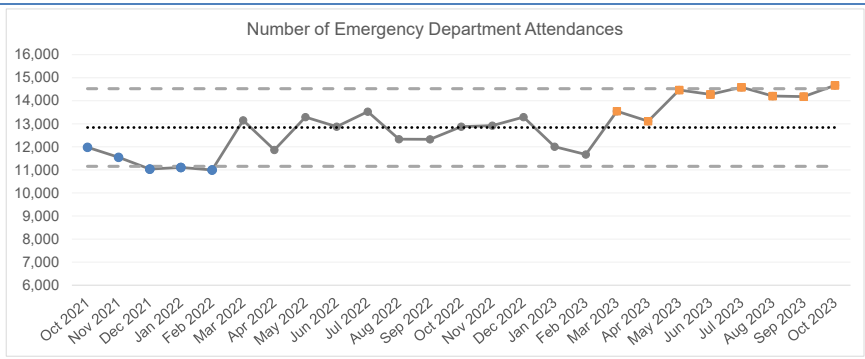
- Timely removal of patients from cancer tracking once non-malignancy confirmed (Ongoing)
- Regular review with HUTH of demand and capacity for Oncology (Ongoing)

Mitigations:

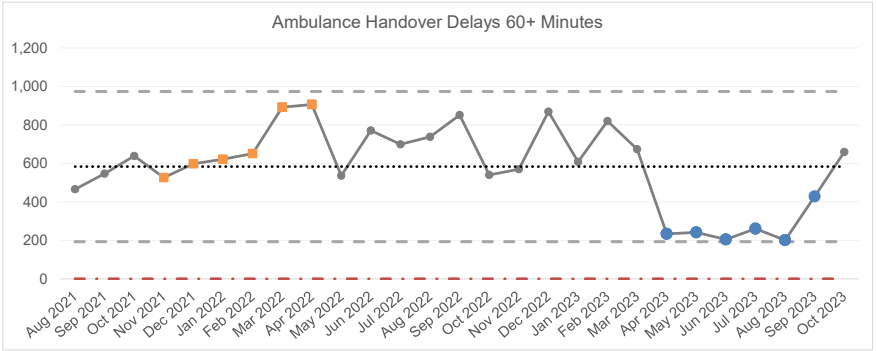
- 62-day performance is being reviewed and managed weekly.
- Joint weekly PTL review between Medicine and Surgery Upper GI
- Cancer Improvement Plans developed for each cancer tumour site
- Micro-management of the completion of cancer packs with any incomplete after 5 working days is now being overseen at senior divisional level
- Funding now approved to recruit to administrative support roles
- The joint transformation pathway work with HUTH will help with the transfer of patients between NLaG/ HUTH to identify areas where the pathway can be accelerated
- Review of all 104+ day patients on PTL by Divisions to remove where possible or chase up appointment times to eliminate any 104+ waiters



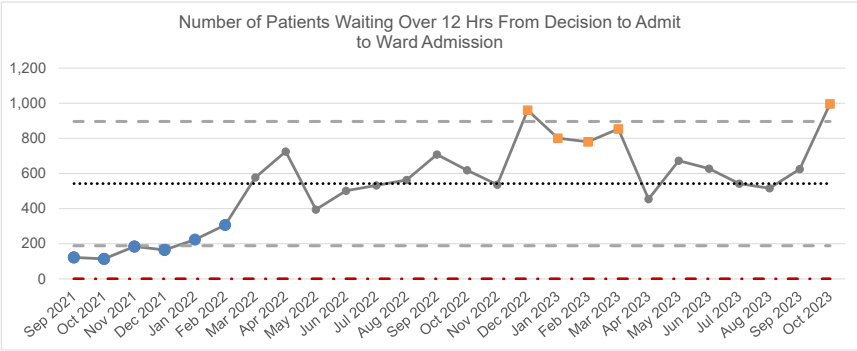
Oct 2023
60.8%
Target
95.0%
Variance
Special cause of improving nature or lower pressure due to higher values
Assurance
Consistently falling short of the target



Oct 2023
14,669
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



Oct 2023
659
Target
0
Variance
Common cause - no significant change
Assurance
Consistently falling short of the target



Oct 2023
996
Target
0
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently falling short of the target

Data Analysis:

ED 4 hour waiting: Performance is within the expected range of the data and is registering improvement due to recording values higher than the mean for the past six months. Current data indicates that the target will not be met without action, planned actions outlined below.

ED Attendances: Performance has largely been within the process limits. The past eight months have registered concern due to a consistent run of values above the mean.

Ambulance handover 60+ minutes: Performance continues to register within the expected range of the data. The indicator continues to fail the target. Current data indicates that the target will not be met without action, planned actions outlined below.

DTA 12 hours: Performance has registered outside the expected range triggering concern. More data is needed before this can be taken to indicate a trend. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:

- Pressure created within the community due to demand for ambulances which may be held up in hospital handover process
- Elevated level of acuity resulting in pressures within Resus and delays for walk in patients
- Same Day Emergency Care (SDEC) regularly running at full capacity
- Plan to increase the Urgent Care Service to 24-hours a day if funded
- Demand on services impacts on hospital flow and delays in admission resulting in regular escalation of OPEL status
- Continued rise in attendances at ED

Key Risks:

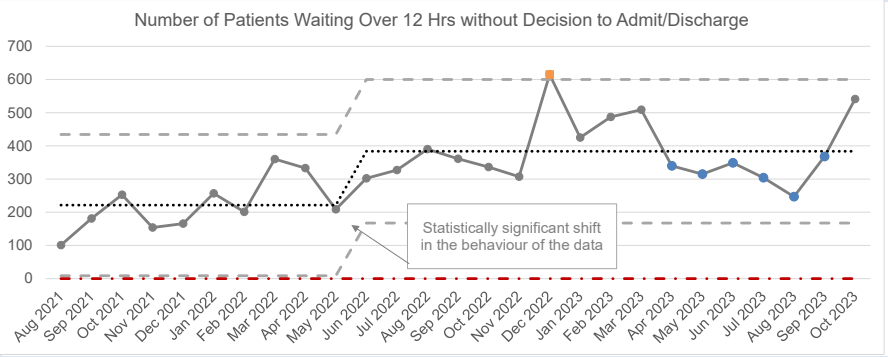
- Inability to meet the Royal College of Emergency Medicine staffing requirements in the Emergency Department
- Gaps in both medical and nurse staffing resulting in high levels of agency and locum staff
- Challenge to achieve Ambulance Handover targets due to lack of flow within the hospital - however progress being made against current targets set
- Inability to meet waiting times in Emergency department due to demand
- Staff burnout and maintaining morale through ongoing pressures - impacting on recruiting and retention

Actions:

- Junior doctor rota is being revisited with involvement of the BMA (Ongoing)
- Review of all Urgent Care Services across Northern Lincolnshire (Ongoing)
- QI project has commenced in relation to 4 hour performance with the meetings taking place that include leads from Radiology, Urgent & Emergency Care and Acute Care (Ongoing)
- Expansion of the Virtual Ward services (Ongoing)
- QI project is in place to improve the flow within the department (Oct '23)
- Process improvement has been carried out in relation to Ambulance Handover to ensure achievement of 30 minute Mean time (Ongoing)
- Work being carried out in relation to system issues that are leading to 12 hour breaches (Ongoing)

Mitigations:

- Senior clinician reviews taking place in ambulances when delays to off loading occur
- New structure in place within ED with senior decision makers identified daily 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
- 2-hourly board rounds with EPIC and Clinical Coordinator with nursing care needs, monitored through care round document
- SDEC nurse-in-charge attends 08:00am ED board round to support identification of patients suitable for SDEC
- Direct electronic referrals to SDEC for GP/EMAS via SPA now in place to support alternative pathways and direct SDEC access.
- Virtual ward, Outpatient Parenteral Antimicrobial Therapy (OPAT) and Home first now implemented
- Consultants hours have been revisited with a Group Job Planning Session organised to support an even 7/7 cover including UCS shifts.
- The Patient Flow Improvement and Ambulance Handover Group have now been restructued into an oversight meeting and a Task & Finish Meetings.
- Focus work being carried out in relation to criteria to admit.



Oct 2023	**541**
Target	**0**
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target

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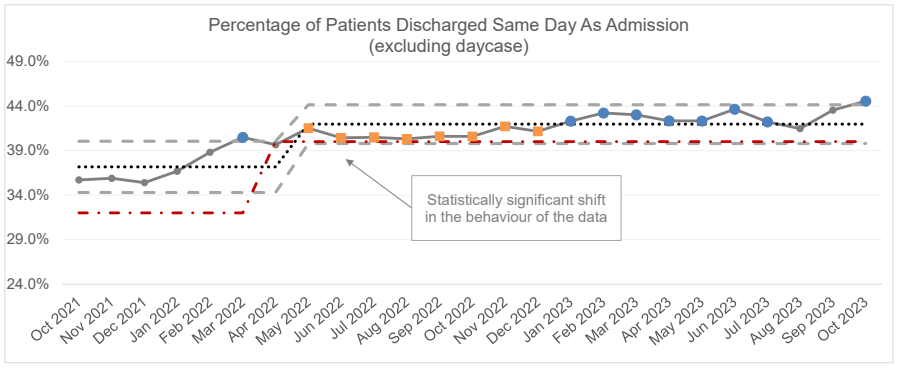
Data Analysis:
Patients waiting 12h+ without decision: Performance is within the expected range of the data. Current data indicates that the target will not be met without action, planned actions outlined below.

Challenges:
• Number of patients with a Decision to admit continues to rise - impacting on the ability to move patients from Emergency Department to Integrated Acute Assessment Unit (IAAU)
• Regularly running at capacity in SDEC, impacting Patient Flow within the department
• Use of urgent care service (UCS) rooms overnight to bed patients down resulting in a lack of rooms to see patients the following day

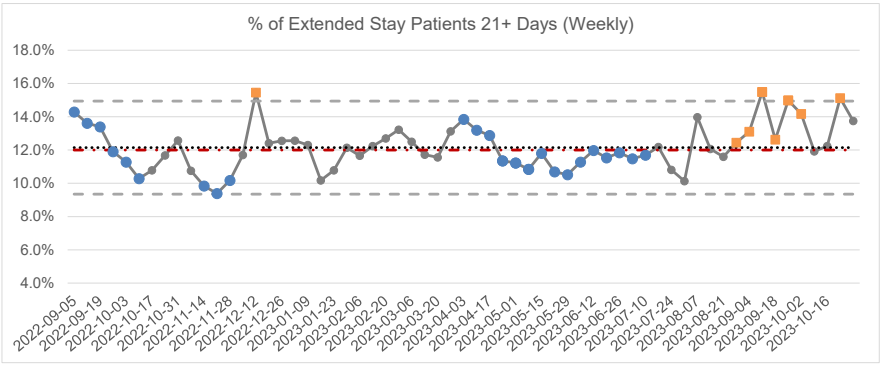
Key Risks:
• Lack of rooms to be able to see new patients that arrive within the department due to lack of flow out of ED
• Staff burnout and maintaining morale through ongoing pressures - impacting retention and recruitment
• Number of red flag (higher risk) patients in the Waiting Room
• Failure to meet triage targets
• Lack of flow through ED due to lack of timely discharges from all in-patient wards.

Actions:
• QI project initiated to improve the flow within the department (Oct '23)
• Progress the work to enable Live review and validation of 12 hour DTAs (Ongoing)
• The review of all Urgent Care Services across Northern Lincolnshire continues further meetings scheduled. Discussions are taking place between the Finance Director and ICB place leads in relation to future plans (Ongoing)
• Reiteration of the criteria to admit to all grades of clinicians within ED as part of the MADE Event (nov 23)
• Daily report produced for ED SMT and Medicine Quad to look at capacity, flow and performance (Nov 23 and ongoing)
• New process to be introduced in relation to admissions to Medicine (led by Clinical Leads for UEC and Acute) whereby all admissions will be signed off by ED consultant 0800-0000 and Medicine Registrar 0000-0800 (Nov 23 and onoing)

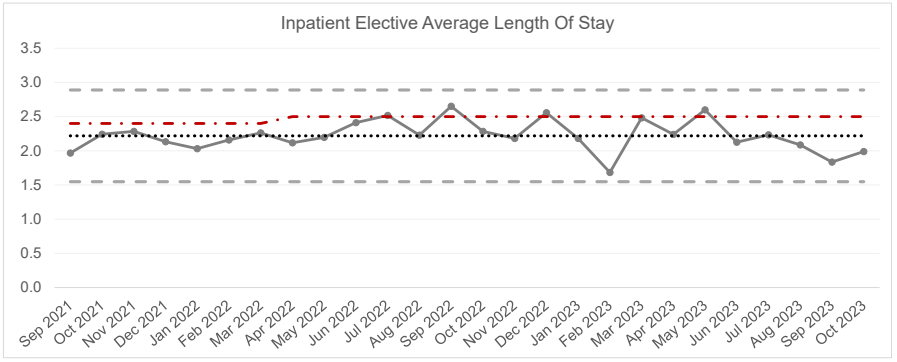
Mitigations:
• Care standards are in place to ensure that the patients are reviewed regularly
• Two hourly Board Rounds in place and patients are reviewed where necessary
• Critical Medication Sheets are in place where required to ensure patients are receiving the medication they require whilst waiting for admission
• Position statements given at all Operational Meetings in relation to flow and bed status in ED
• In reach from relevant services is taking place daily
• Live monitoring of patients to ensure that there are no delays when there are available beds on the wards is in place
• Virtual ward, OPAT and Home First service now implemented
• Continued review of the patient numbers considering alternative pathways to ensure patients are seen and treated by the appropriate service
• Criteria to admit followed in ED to review appropriateness of admission and consideration of all alternative pathways



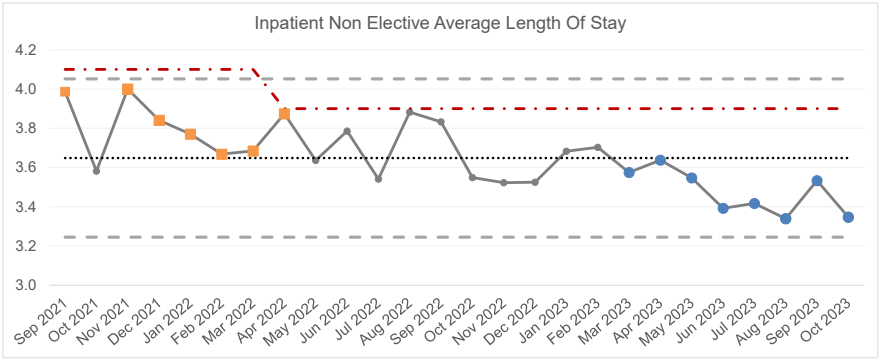
Oct 2023	Target	Variance	Assurance
44.6%	40.0%	Special cause of improving nature or lower pressure due to higher values	Inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
13.7%	12.0%	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
2.0	2.5	Common cause - no significant change	Inconsistently hitting passing and falling short of the target



Oct 2023	Target	Variance	Assurance
3.3	3.9	Special cause of improving nature or lower pressure due to lower values	Inconsistently hitting passing and falling short of the target

Data Analysis:
Discharged same day as admission: Performance is largely as expected. The most recent figure is recorded as improvement. More data is needed before this can be taken to indicate a trend. The indicator can be expected to achieve and fail the target at random.
% 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: Performance is stable and within the expected range. The target can be expected to achieve and fail at random.
Non elective length of stay: Performance is within the expected range and registering improvement due to the past eight months recording values lower than the mean. The indicator can be expected to achieve and fail the target at random.

Challenges:
- Consultant vacancies impacting on service delivery
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself well to the creation of escalation beds
- Infection prevention constraints remain
- Increased medical staff sickness
- Impact of industrial action on patient pathways and batching of D2A referrals to system partners post strikes

Key Risks:
- Space and capacity issues within SDEC/IAAU continues
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge

Actions:
- System wide action plan in place to support patient flow (ongoing)
- Delivery of new IAAU/SDEC New Builds (Q3 DPoW, Q4 SGH)
- System wide multi agency MADE event for 7 days (Nov '23)
- Choice policy has been to TMB, training to commence prior to roll out 27th November
- "get up, get dressed, get moving" programme commenced to prevent deconditioning
- Planning "describe not prescribe" workshop to improve quality of referrals and to support with pathway decisions
- Piloting Discharge Facilitation form at North Lincs, to improve referrals to care homes
- Discharge lounge consultation commenced, to close 21st November
- PSC conducting deep dive of NLAG to investigate why NLAG productivity is so high compared to England average

Mitigations:
- Admission avoidance/SPA developments continue to perform well
- Community Frailty team working within care homes and operating direct referral from UCS and SPA
- Single Point of Access available with 2-hour community response in place
- Acute and Community joint working group established between Medicine and Community & Therapies
- Community Response Team GP supporting Category 3 & 5 calls
- Daily meetings led by the Programme Director Home First Transformation weekdays and site senior team Sat and Sun's, who work with system partners to have a clear delayed discharge and escalation plan
- 7-Day Services for equipment provision to support discharge at both North and Northeast Lincolnshire
- Work taking place with system partners to understand the current constraints and agree actions to alleviate exit block from the acute Trust

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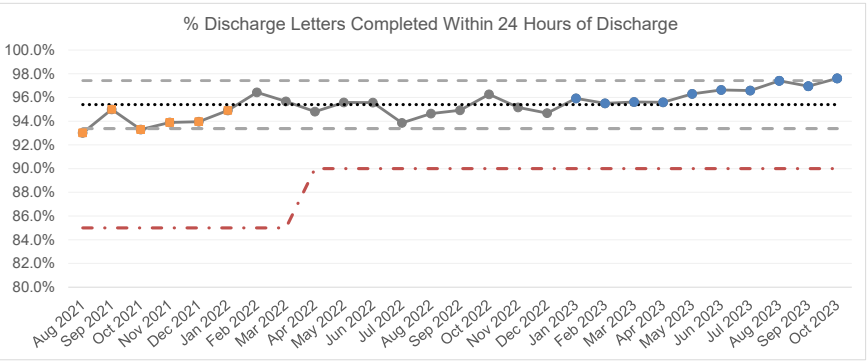
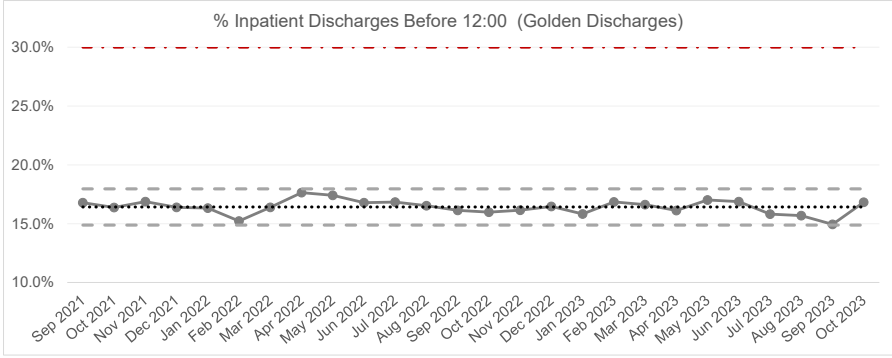
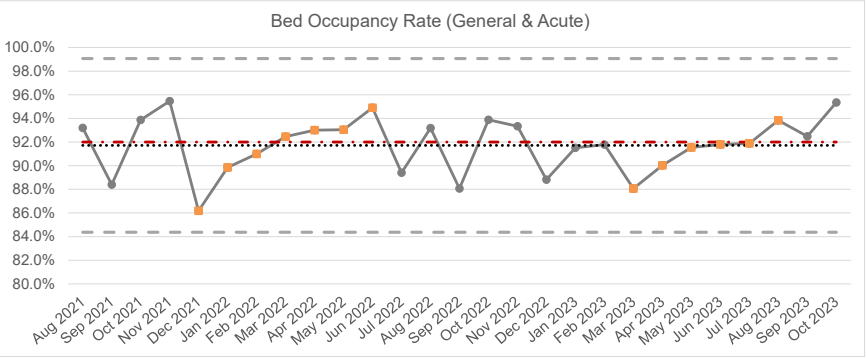


Oct 2023	97.6%
Target	90.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently passing the target



Oct 2023	16.8%
Target	30.0%
Variance	Common cause - no significant change
Assurance	Consistently falling short of the target



Oct 2023	95.4%
Target	92.0%
Variance	Common cause - no significant change
Assurance	Inconsistently hitting passing and falling short of the target

Data Analysis:
Inpatient discharge letters: Performance has registered improvement for the past ten months. The indicator can be expected to achieve the target.
Inpatient discharges before 12:00: Performance has been stable and largely within the expected range. The target will not be met without action, planned actions outlined below.
G&A Bed Occupancy: Performance is within the expected range albeit with the occasional short-lived run of month on month increases which trigger concern. The target can be expected to achieve and fail at random.

Challenges:
- Consultant vacancies impacting on service delivery
- Exit block due to Social Care constraints (staffing, interim bed availability, lack of packages of care availability)
- The hospital environment and staff availability and layout does not lend itself well to the creation of escalation beds
- Infection prevention constraints remain
- Increased medical staff sickness
- Impact of industrial action on patient pathways and batching of D2A referrals to system partners post strikes

Key Risks:
- Space and capacity issues within SDEC/IAAU continues
- Shortages in available workforce to meet service needs which results in inconsistency and delays in patient pathways
- High acuity levels and patients means more patients require further support on discharge

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- PSC conducting deep dive of NLAG to investigate why NLAG productivity is so high compared to England average

Mitigations:
- Admission avoidance/SPA developments continue to perform well
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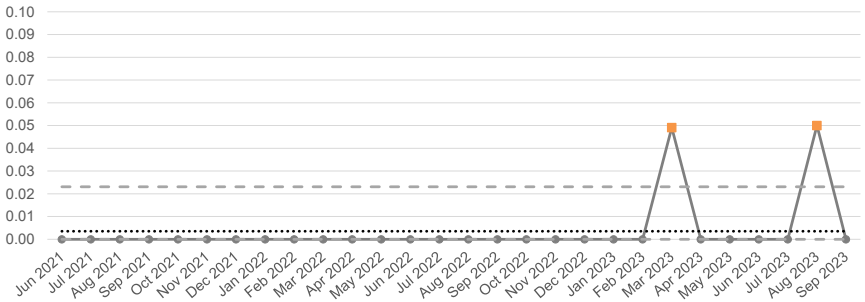
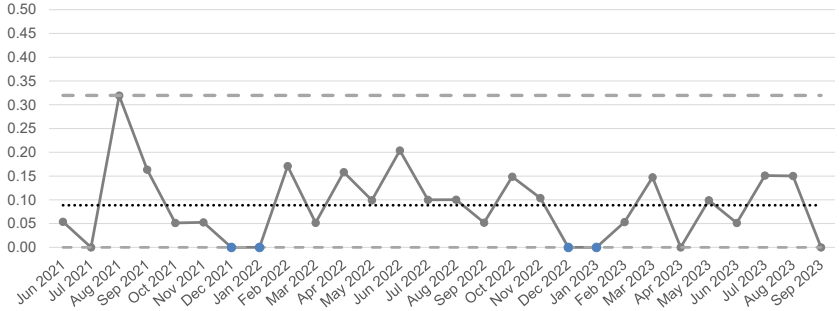
- 7-Day Services for equipment provision to support discharge at both North and Northeast Lincolnshire
- Work taking place with system partners to understand the current constraints and agree actions to alleviate exit block from the acute Trust

Number of MRSA Infections (Rate Per 1000 Bed Days)



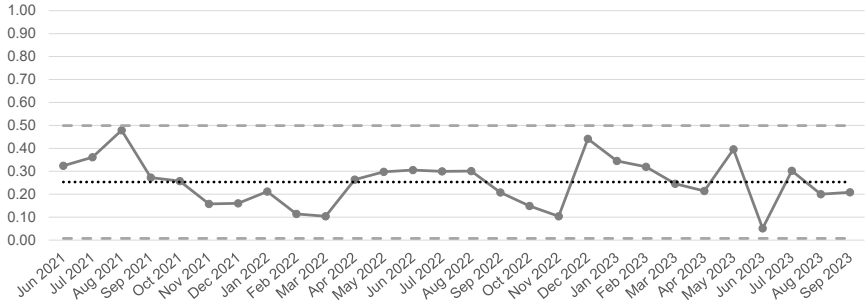
Sep 2023
0.00
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

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



Sep 2023
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 E Coli Infections (Rate Per 1000 Bed Days)



Sep 2023
0.21
*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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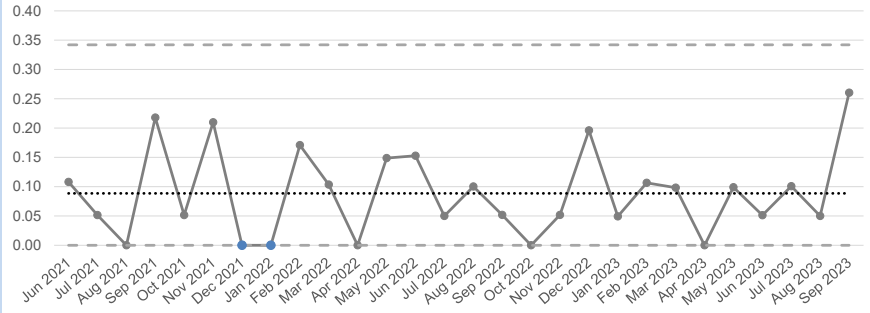
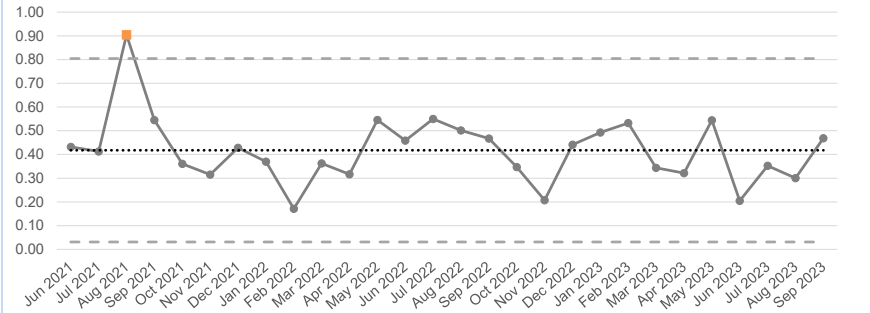
Data Analysis:
MRSA: Performance is stable and within the expected range of the data. The YTD figure is 1 against an annual target of 1.
C Diff: Performance is stable and within the expected range of the data. The YTD figure is 11 against an annual target of 20.
E Coli: Performance is stable and within the expected range of the data. The YTD figure is 27 against an annual target of 46.

Commentary:
The Trust is performing as expected and are currently below national average on all alert organisms



Sep 2023
0.26
*Target
see analysis below
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Sep 2023
0.47
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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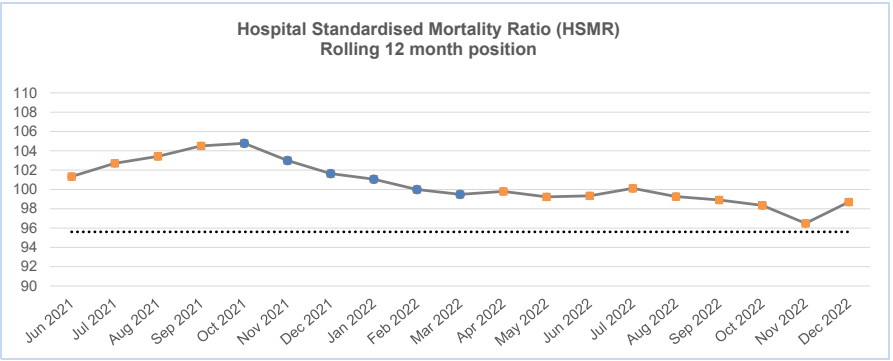
Data Analysis:
MSSA: Performance is stable and within the expected range of the data. The YTD figure is 11, there is no annual target.
Gram Neg: Performance is stable and within the expected range of the data. The YTD figure is 41 against an annual target of 75.

Commentary:
The Trsut is below average on bacteraemai rates



Dec 2022
98.7

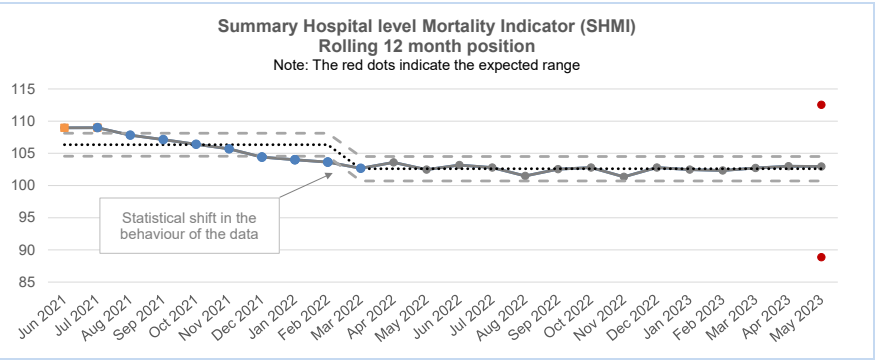
Target
As expected

Variance

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

Assurance

Within 'as expected' range



May 2023
103.0

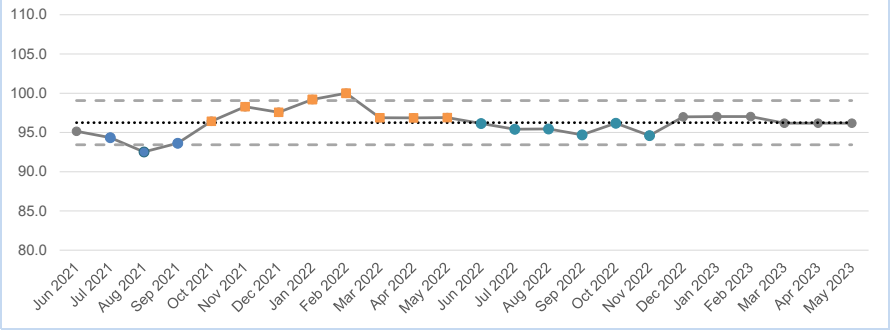
Target
As expected

Variance

Common cause - no significant change

Assurance

Within 'as expected' range



May 2023
96.18%

Target
No target

Variance

Common cause - no significant change

Assurance

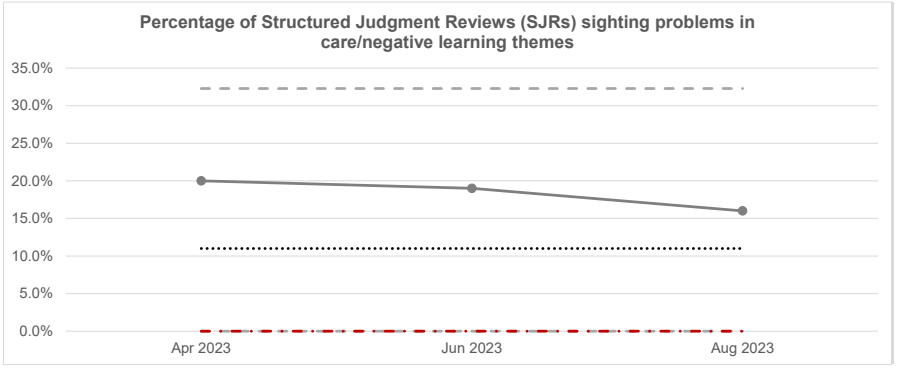
There is no target therefore target assurance is not relevant

This space is intentionally blank

Data Analysis:
HSMR: The new CHKS contract is now in place. Updated figures and SPC will be available from December 2023.
SHMI: Performance is stable and continues within the expected range. The data represents a rolling 12 month position.
SHMI diagnosis: The data is stable and has been within the expected range for over a year.

Commentary:
The rolling 12 month SHMI remains within the 'as expected' banding with the latest value of 103 for the period June 2022-May 2023.
HSMR data extracted from the new CHKS benchmarking system shows the Trust's HSMR value as 97.47 in July 2023 and a rolling 12 month value of 106.12.Variance in HSMR data is being explored and monitored through the Mortality Improvement Group. In particular COPD, Gastroinestinal hemorrhage and complication of device; implant or graft have been identified for further review. It should be noted that data quality issues with the new CHKS system have been identified and escalated to CHKS. Full benefits realisation of the CHKS system will not be available until after the Lorenzo/PAS migration as data feeds are limited. We will however have access to national peer data sets.

SHMI Diagnosis Groups (outcome measure linked to Sepsis quality priority):
The SHMI rate of patients that died with an infection related cause continues to be 96.18 which is below the England average 100 and remains within the expected range.



Aug 2023
16.0%

Target
No target

Variance

There is insufficient data for variance and assurance

Assurance

There is insufficient data for variance and assurance

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Data Analysis

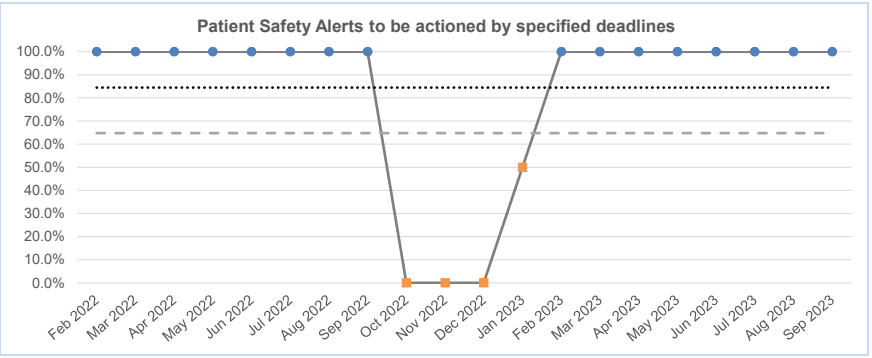
SJRs: This figure is not available every month. August 2023 is the latest date for which data is available. The figures have ranged from 16% to 20%.

Commentary

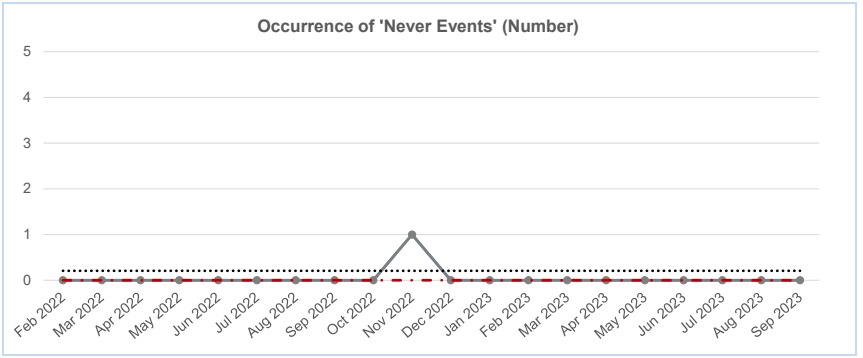
The percentage of SJRs sighting problems in care/negative learning associated with recognition of end of life pathway at earlier stage and the quality of ReSPECT/advanced care planning documentation is reducing with 16% reported in August 2023 compared to 19% in June 2023 and 20% in April 2023.

Collaborative working with Care Plus Group to enable an integrated palliative care and end of life team at SGH and DPoW. A joint end of life and palliative care referral form has been introduced and this went live on 16 October 2023. A morning huddle has been embedded to reduce duplication and ensure patients and staff receive the support they require. Joint working with Lindsey Lodge Hospice developing a Single Point of Referral for specialist palliative care. A trial week was completed w/c 9 October 2023 with teams from the MacMillan Specialist Palliative Care team from Community triaging calls alongside colleagues from Linsey Lodge Hospice. As a result of the trial a single point of referral has been agreed and went live w/c 16 October 2023.

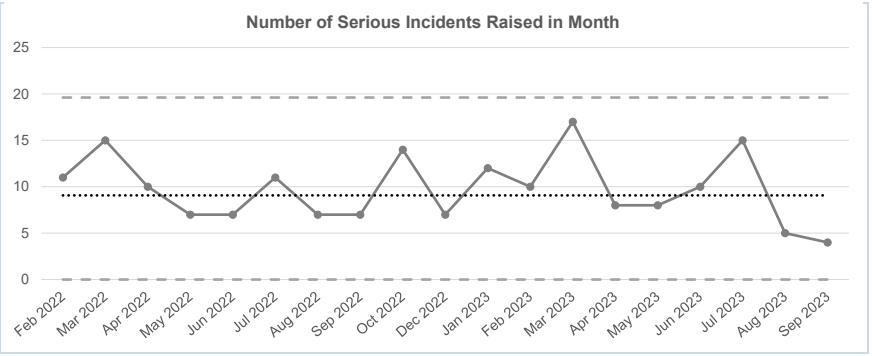
Next steps in the EOL QI project will be to undertake a patient survey and develop a training video for doctors to help recognition of end of life pathway at an earlier stage.



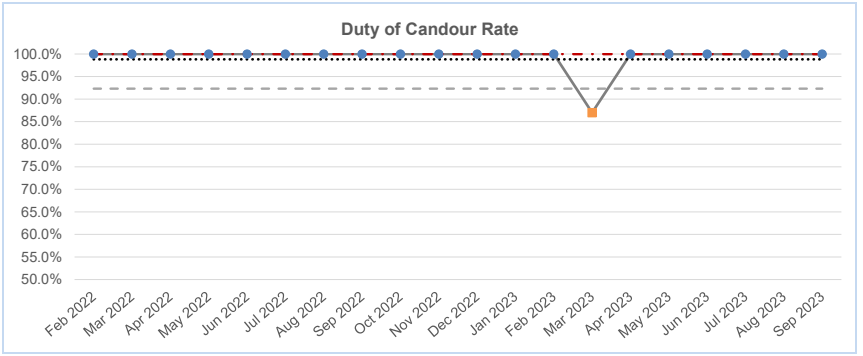
Sep 2023
100.0%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant



Sep 2023
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



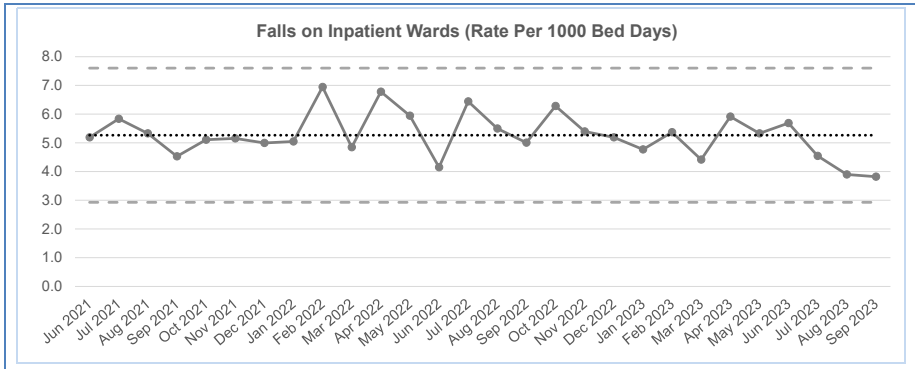
Sep 2023
4
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



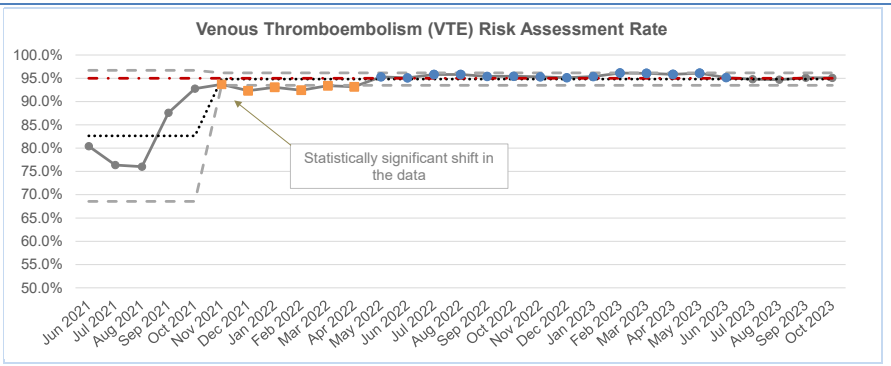
Sep 2023
100.0%
Target
100.0%
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
Inconsistently hitting passing and failing the target

Data Analysis:
Patient Safety Alerts: Performance is within the expected range and registering improvement. The numbers involved are low.
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.
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: Following a low figure in March the indicator has returned to regularly recording 100%

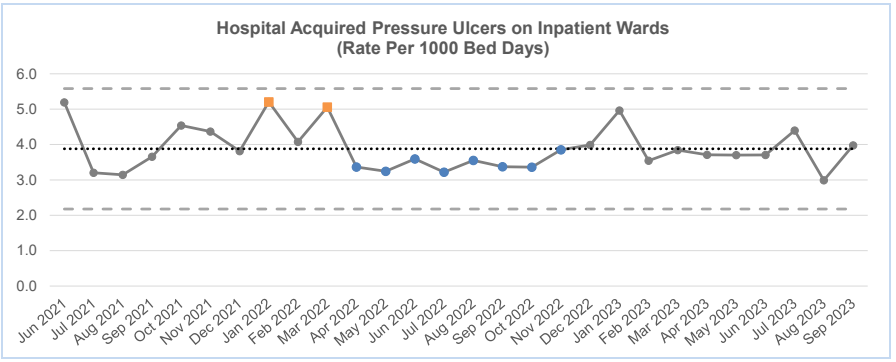
Commentary:
We continue to manage patient safety alerts, meeting national deadlines for the past 8 months.
Serious incidents reported are within common cause variation and duty of candour rate is maintained at 100%.



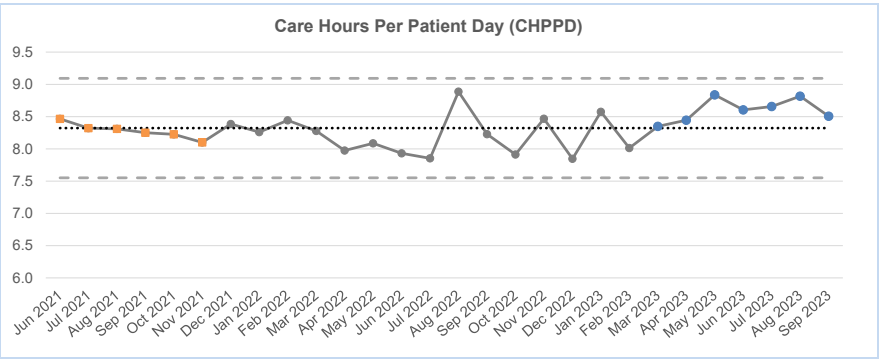
Sep 2023
3.8
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Oct 2023
95.1%
Target
95.0%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Sep 2023
4.0
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore target assurance is not relevant



Sep 2023
8.5
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target therefore target assurance is not relevant

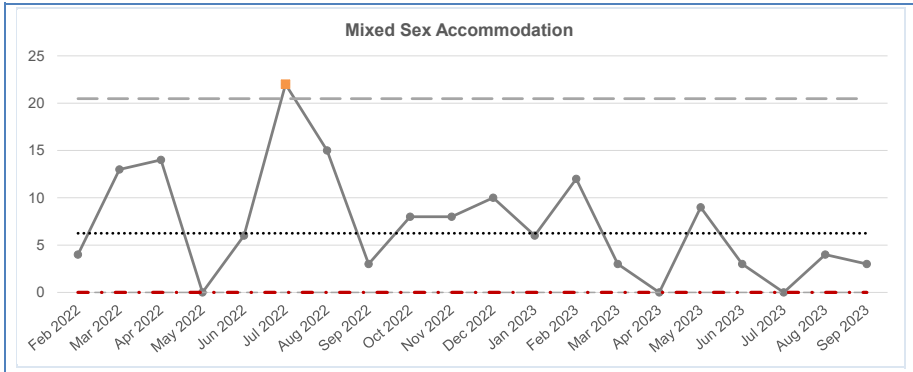
Data Analysis:

Falls on Inpatient Wards: Performance is stable and as expected.
VTE Risk Assessment: Performance is within the expected range but has moved out of improvement due to falling below the average of the data. The target has continued to be met since April 2022.
Hospital Acquired Pressure Ulcers: Performance is consistently within the expected range for the data.
Care Hours Per Patient Day: Over the past seven months, performance has shown improved and has remained within the data's expected range.

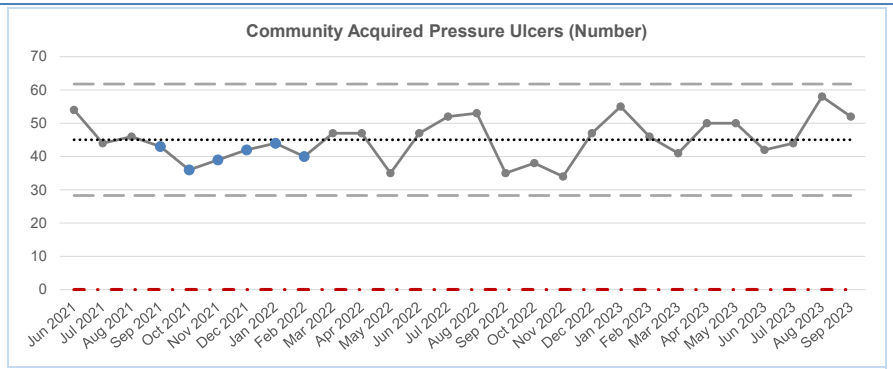
Commentary:

VTE risk assessment rate remains within common cause variation maintaining 95.1% in October 2023 against the Trust's 95% target.

Falls - The number of reported falls per 1000 Bed Days has decreased for the third consecutive month and remains within the "as expected" range. Huddles for repeat falls continue to be facilitated by Matrons with actions and learning shared locally and at the Trust's Strategic Falls Group. Huddles for falls with moderate, or greater, harm are facilitated by the Lead Nurse Patient Safety.
Hospital Acquired Pressure Ulcers - There has been a slight increase in the number of reported pressure ulcers however this remains within the "as expected" range. All pressure ulcers reported with moderate harm are now reviewed weekly, as a result, supportive actions can be implemented in a timely manner.



Sep 2023
3
Target
0
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Sep 2023
52
Target
0
Variance
Common cause - no significant change
Assurance
Consistently failing the target

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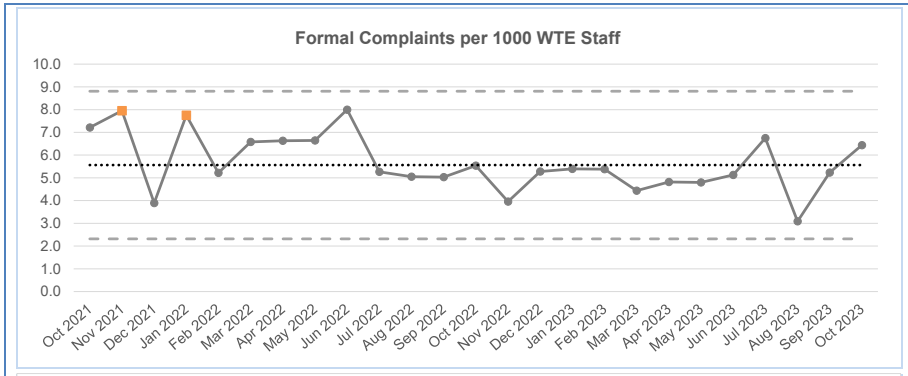
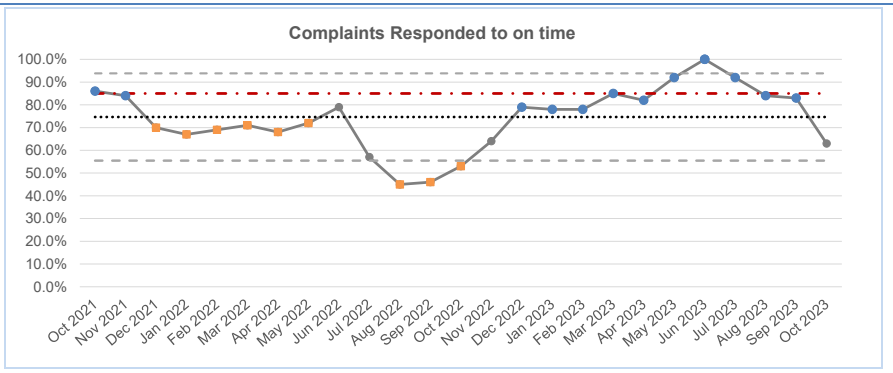
Data Analysis:
Mixed sex accommodation: Performance is within the expected range of the data and will achieve and fail the target at random.
Community Acquired Pressure Ulcers (Number): Performance is within the expected range of the data. However, the target is unlikely to be met without action.

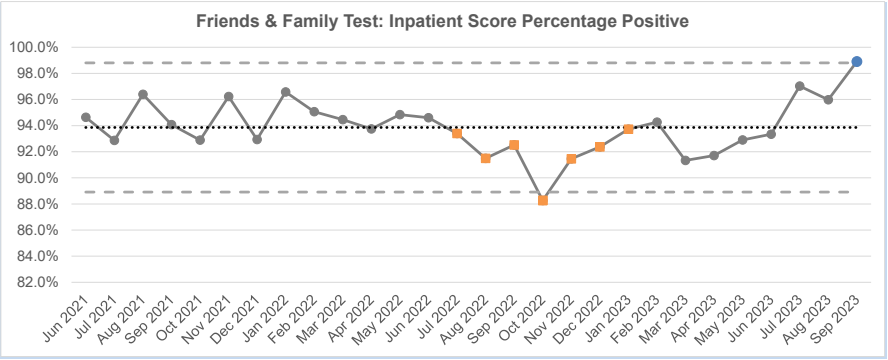
Commentary:



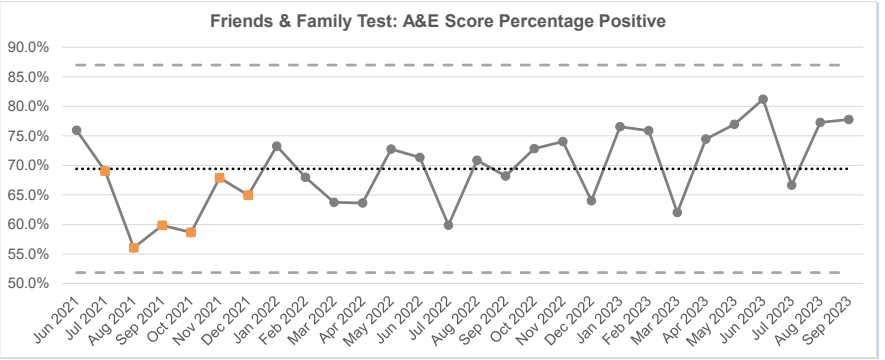
Oct 2023
6.4
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target therefore assurance is not relevant



Oct 2023
63.0%
Target
85.00%
Variance
Common cause - no significant change
Assurance
Inconsistently hitting passing and failing the target



Sep 2023
98.9%
Target
No target
Variance
Special cause of improving nature or higher pressure due to higher values
Assurance
There is no target, therefore target assurance is not relevant



Sep 2023
77.8%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:

Formal Complaints: Performance is stable and continues within the expected range of the data.

Complaints Responded to on time: Performance has registered improvement for the past ten months. October's performance has deteriorated slightly but remains within the expected range. The indicator will achieve and fail the target at random.

FFT Inpatient: The majority of respondents continue to provide positive feedback. The data continues within the expected range with this month registering improvement for the first time.

FFT A&E: The majority of respondents continue to provide positive feedback. The data continues within the expected range.

Commentary:

Action 1: Decline in Complaints closed on time from previous month of 83% to 63%.

Risk: Trust potential fall from below KPI, which had been maintained, and patient / complainant dissatisfaction at not maintaining our preferred within 60 Day response time.

Mitigation: Number and complexity of complaints has increased significantly - increasing the pressure around workloads and availability from both the complaints team and Divisions respectively.

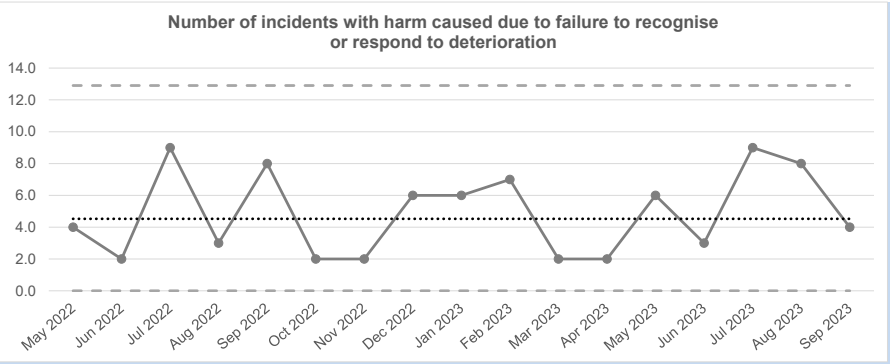
Complaints Manager has weekly meetings with Heads of Nurisng to maintain oversight and drive from Divisional level. Weekly Support & Challenge Meeting(s) continue for our complaint handlers and will provide a re-focus on turn around times with appropriate challenge when identified. Positive work continues with Chief of Staff to identify complaints that are moving towards the 60 day mark to ensure these receive additional focus and rapid turn around times on sign off completion. Weekly Meetings with Lead Nurse and the Complaints Manager are now in place to ensure complete oversight of complaints position - this information will then be disseminated back to the complaint handers to ensure focus is maintained on the 60 day response time; with escalation highlighted at Support & Challenge and Lead Nurse / Complaint Manager Meetings.

Action 2: FFT implementation within ECC & Maternity due November / December - response numbers have increased with an interim paper data collection plan.

Risk: The Trust has procured a new provider for FFT upon completion of contract with previous provider, this is with the intention of improving the service provided to patients in gathering their feedback.

Mitigation: The implementation has been delayed due to the Trusts resources being required on other essential IT system work, however we do now have an estimated date/month for commencing the new FFT going forward. This is currently phase 1 (ECC/Maternity) implementation - further phases may experience similiar delay due to Trust priorites with other IT System demands.

The interim paper data collection will continue in place until the new system is intergrated and fully operational.



Sep 2023
4.0

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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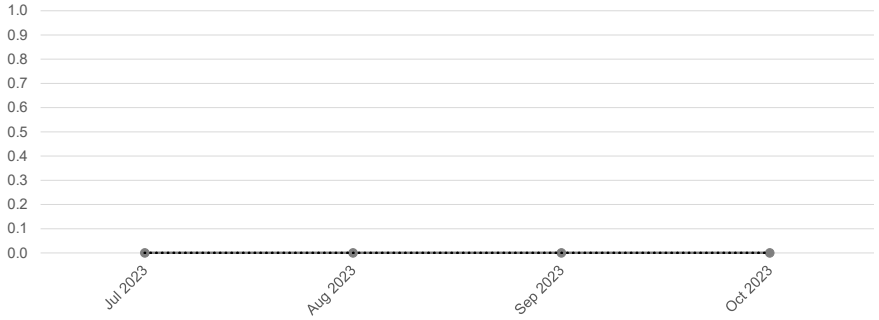
Data Analysis

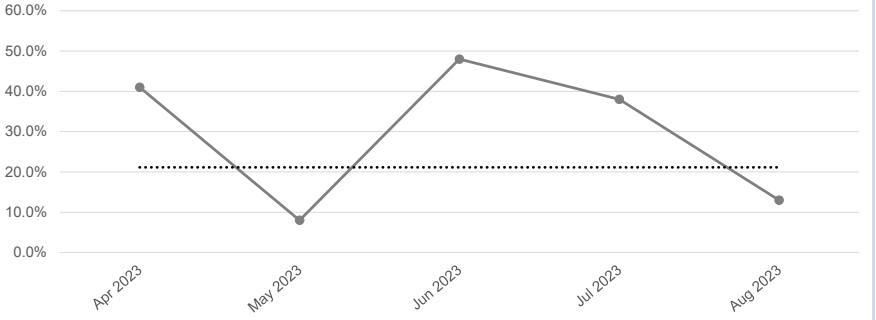
Harm caused deterioration: Performance is as expected and within the expected range of the data.

Commentary

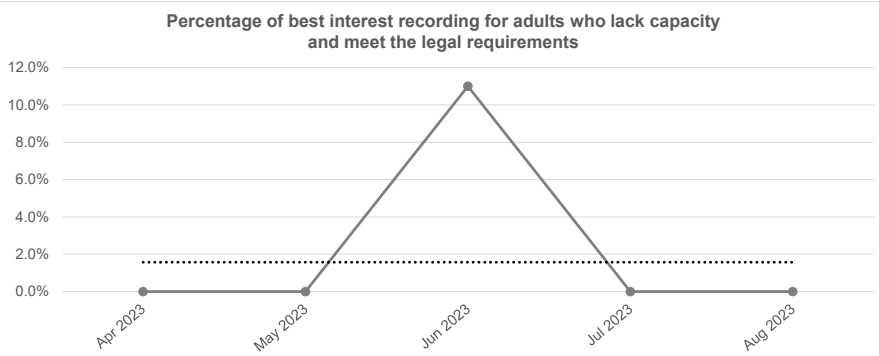
4 incidents with low/minor harm were reported in September 2023. The data is within the expected range with common cause variation. Deteriorating patient incidents continue to be monitored through the Deteriorating patient/sepsis group to identify themes and learning. All clinical sisters and ward managers are undertaking applying QI training to focus on deteriorating patient and escalation.



Oct 2023
0
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant



Aug 2023
13.0%
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant



Aug 2023
0.0%
Target
No target
Variance
There is insufficient data for variance and assurance
Assurance
There is no target, therefore target assurance is not relevant

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Data Analysis

MCA/DoLS contacts: This indicator has more than three months of data and as such a line chart has been added. Performance has remained at 0 since July 2023.
MCA Assessments: Performance has varied from 8% to 48%.
Best interests: Performance has varied from 0% to 11%.

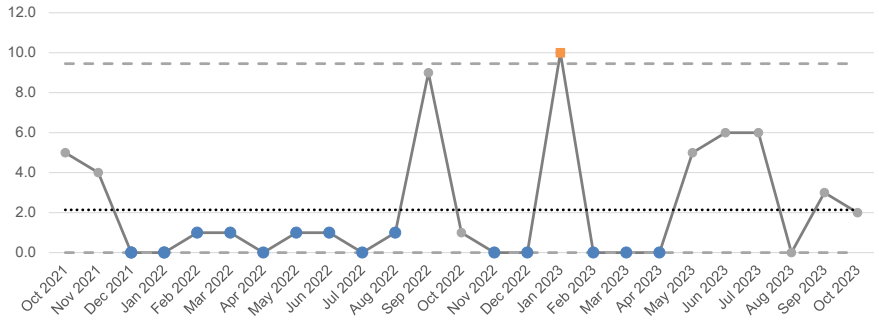
Commentary

The Surgery & CC division have rolled out yellow Mental Capacity resource folders to all wards. The Medicine and Family Services divisions are being supported to replicate the roll out of the resource folders to their ward areas. The Community & Therapy Services division have undertaken an audit on Mental Capacity Act (MCA) assessment in community nursing to determine how many patients admitted to adult nursing caseload have had an MCA assessment undertaken when risk identified. Results were poor, 4% compliance. A robust action plan is underway.

Staff from the Medicine division have recently undertaking Applying QI training and have selected mental capacity as their QI projects to improve practice on their ward areas - Ward 23, Ward 24/IAAU and the Stroke ward at SGH.

The MCA DoLS Lead is continuing to provide support to ward B6 staff and has introduced bespoke feedback forms for staff who have completed MCA assessment and best interest forms.

Risk related to access to future data sets due to malfunction of the server that the data is held on. The Web V team are aware of the issue and are working towards reinstating access to the data but may not be available for December's IPR.



Oct 2023
2

Target
No target

Variance

Common cause - no significant change

Assurance

There is no target, therefore target assurance is not relevant

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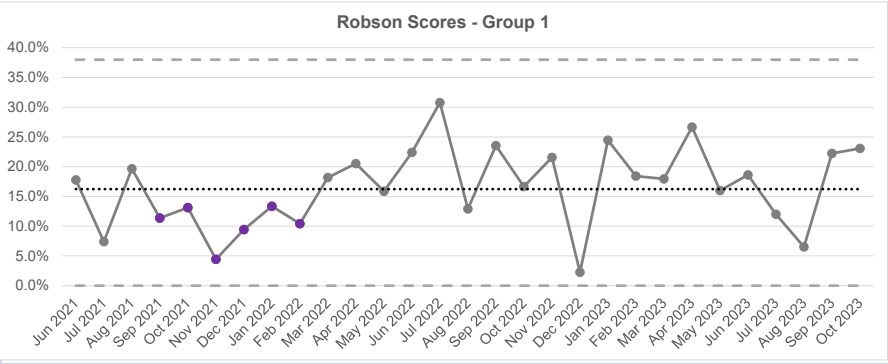
Data Analysis

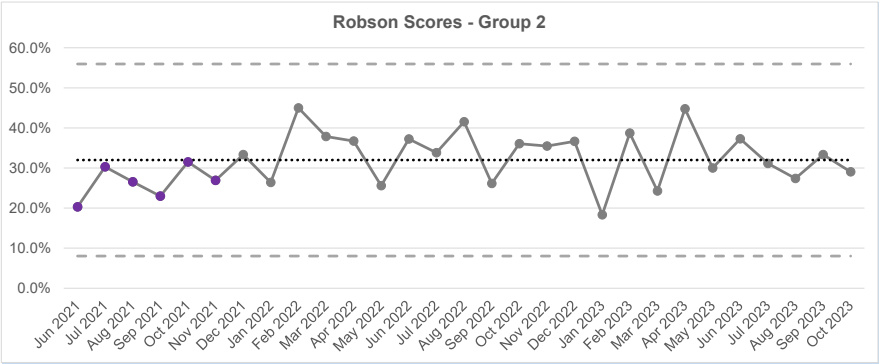
Harm impact: Performance continues to be sporadic ranging from zero to 10 over the past two years.

Commentary

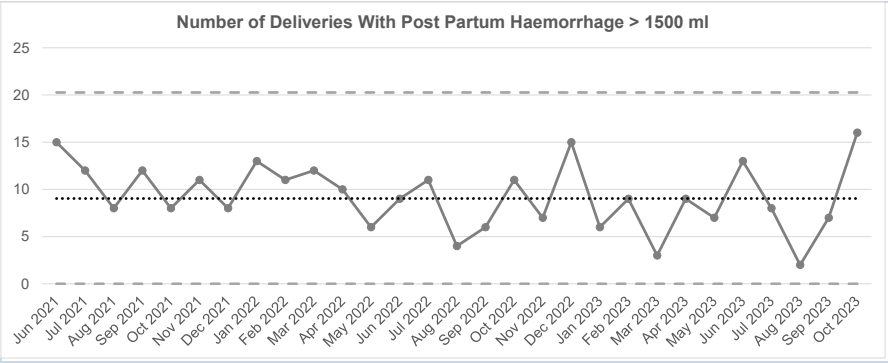
In October 2023 there were 2 no harm incidents. All medication related incidents are discussed at the Safer Medication Group to raise awareness and share learning.



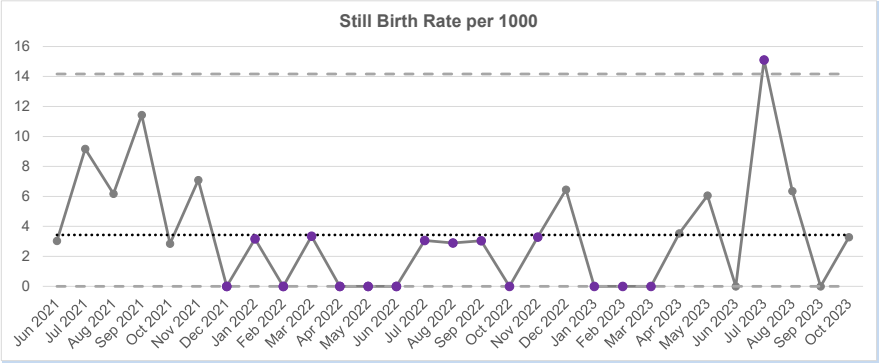
Oct 2023
23.1%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



Oct 2023
29.0%
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



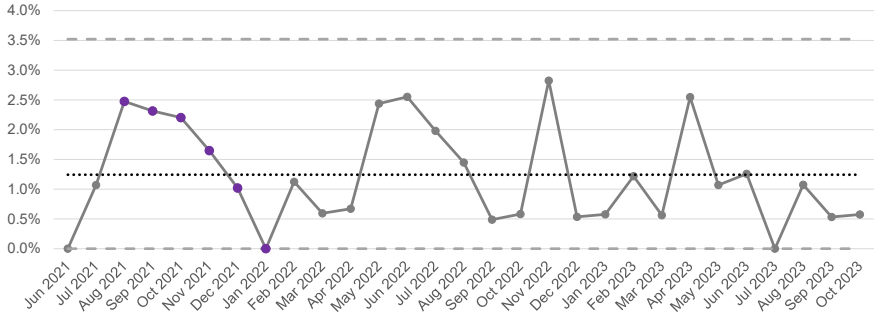
Oct 2023
16
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant



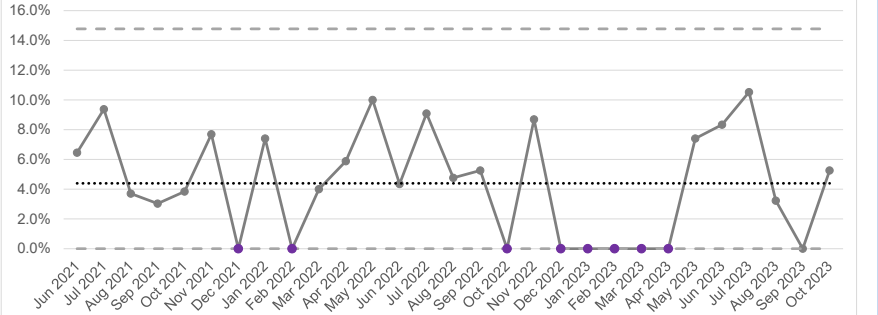
Oct 2023
3.3
Target
No target
Variance
Common cause - no significant change
Assurance
There is no target, therefore target assurance is not relevant

Data Analysis:
Robson Scores 1: Performance is within the expected range of the data.
Robson Scores 2: Performance is within the expected range of the data
PPH > 1500 ml: Performance is within the expected range of the data
Still birth rate per 1000: Although several months record a value of zero, performance continues to be sporadic ranging from zero to 15 over the past two years.

Commentary:



Oct 2023	Target	Variance	Assurance
0.6%	**No target**	Common cause - no significant change	There is no target, therefore target assurance is not relevant



Oct 2023	Target	Variance	Assurance
5.3%	**No target**	Common cause - no significant change	There is no target, therefore target assurance is not relevant

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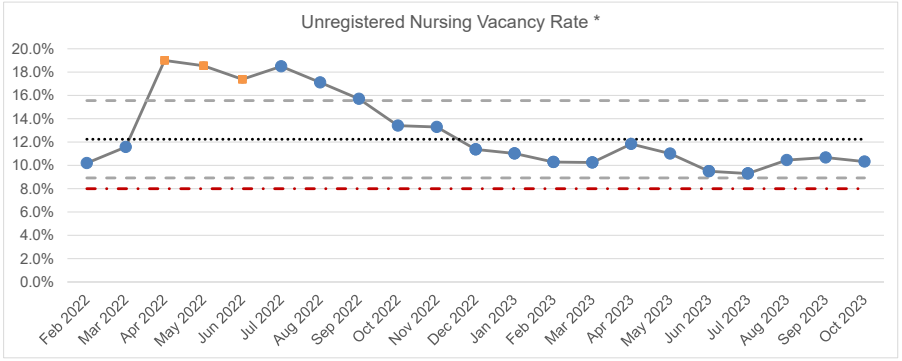
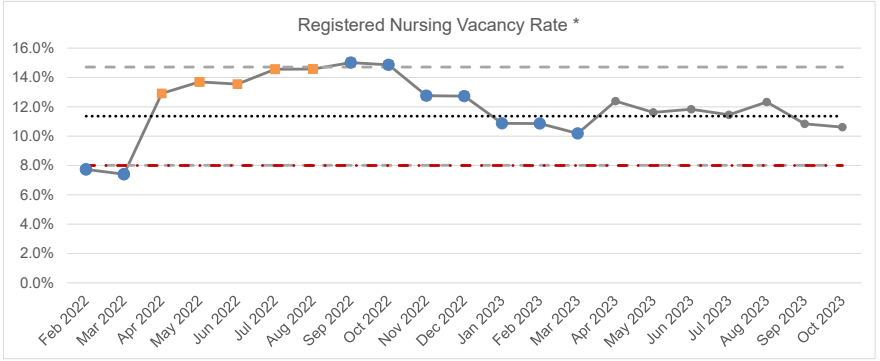
Data Analysis:
Spontaneous 3rd or 4th degree tear: Performance is stable and within the expected range.
Instrumental 3rd or 4th degree tear: Performance is stable and within the expected range.

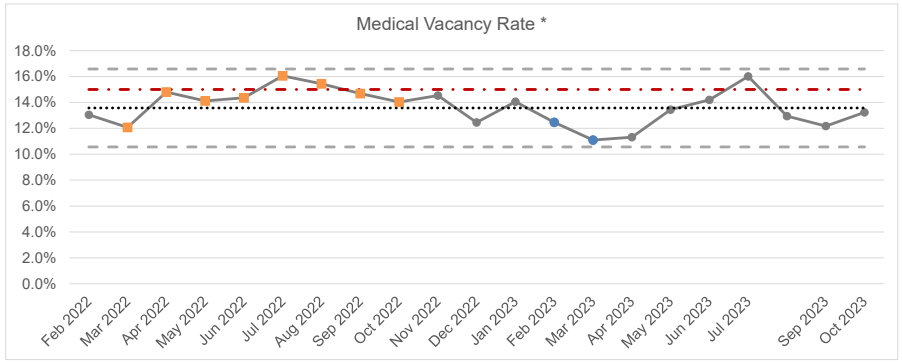
Commentary:



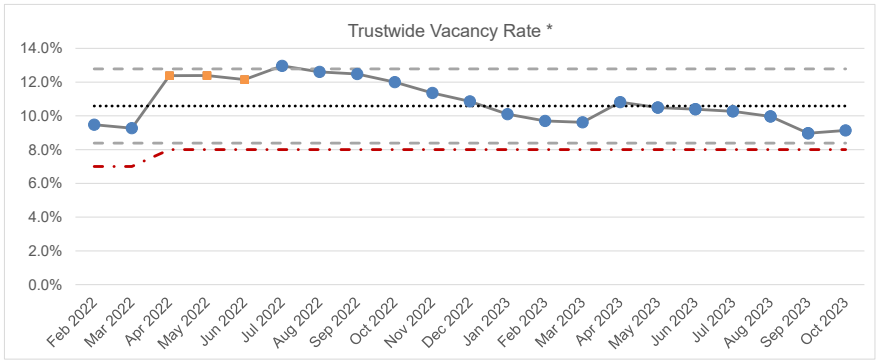
Oct 2023	Target	Variance	Assurance
10.3%	8.0%	Special cause of improving nature or lower pressure due to lower values	Consistently failing the target



Oct 2023	Target	Variance	Assurance
10.6%	8.0%	Common cause - no significant change	Consistently failing the target



Oct 2023	Target	Variance	Assurance
13.2%	15.0%	Common cause - no significant change	Inconsistently hitting passing and failing the target



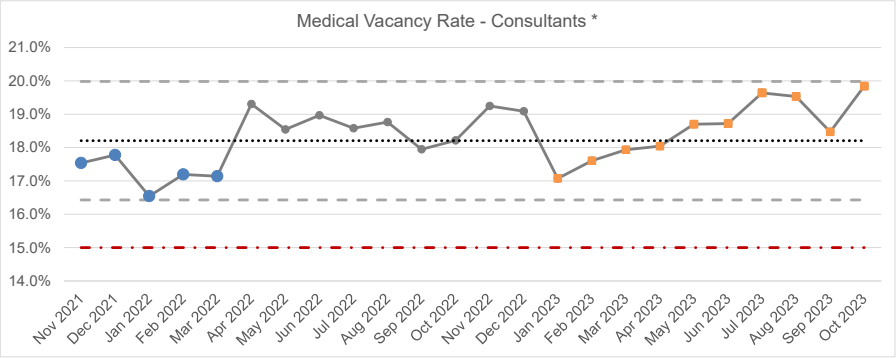
Oct 2023	Target	Variance	Assurance
9.1%	8.0%	Special cause of improving nature or lower pressure due to lower values	Consistently failing the target

Data Analysis:
Unregistered Nursing Vacancies: The last 16 months have shown an improvement in performance, which is still within the data's expected range. The available data suggests that without intervention, the target will not be reached.
Registered Nursing Vacancies: Over the past two months, performance has improved; the present data is within the predicted range and below the average. Current data suggests that the target is unlikely to be met without action.
Medical Vacancy Rate: Performance is stable and within the expected range of the data. The indicator can be expected to achieve and fail the target at random.
Trustwide Vacancy Rate: Performance has improved over the past 16 months and is within the expected range. Current data indicates that the target will not be met without action.

Commentary:
This month shows a slight decrease in the vacancy position for Unregistered Nursing. This month has seen an increase in the establishment of 14.93 for unregistered nursing. Division's are continually advertising Health Care support worker roleswith good response. Work to widen participation and engage with underrepresented groups is ongoing, including work with DWP. Regular meetings with the NHSI/E HCSW Programme Lead for support and accountability are ongoing.

Ongoing engagement with international nurses sourced in Kerala is ongoing with arrivals in November and an additional cohort now planned for January 2024. NQNs starting this year are expected to exceed targets, with the majority of NQNs now allocated wards, which has resulted in planned over establishments in some areas to reduce withdrawal rates. Discussions are now underway to design the recruitment plan for NQNs for 2024. Recruitment of further international nurses will take place in Kerala in November 2023, with the aim of recruiting circa 20 - 30 international nurses. Work with hospitals and educational providers will also take place in Kerala to develop relationships to facilitate longer term pipelines. Please note the vacancy position shown relates to registered nurses in all grades.

Commentary Vacancies Cont/d: The vacancy position remains within target. A robust pipeline of medical staff is established, with 7 scheduled to start in November. In addition engagement with the existing pipeline of a further 42 medical staff is ongoing to facilitate starts as soon as possible. Sourcing of senior medical staff via the Talent Acquisition Team following the appointment of an additional Recruitment Specialist has commenced initially focussing upon Emergency Medicine and Acute Medicine Consultant and Specialty Doctor roles, as identified as the highest spend areas. Methodology will be reviewed and refined from this initial work. In addition, some joint working with HUTH is scheduled taking advantage of BMJ advertising to supplement sourcing of senior roles. Recruitment of Radiologists is planned in Kerala in November 2023, and in addition to direct recruitment relationship building and visits to various hospitals is planned for Acute and Emergency Medicine, Surgery, and Radiology. These will allow NLAG clinical staff to view training and facilitites and develop longer term pipelines of medical staff, alongside exploring opportunities for partnership working with institutions in Kerala.	Despite a 20.52 WTE establishment increase in month an improving vacancy position is shown again in month and continues the trend in an improving Trustwide position. Various staff group-specific projects are underway to impact Registered Nursing, Unregistered Nursing, and Medical Staff. Trustwide recruitment continues at an elevated level with the recruitment team supporting by making 207 offers in month and starting 224 new starters. In October there were 173 active vacancies being recruited to, and 3278 applications received and processed.



Oct 2023
19.8%
Target
15.0%
Variance
Special cause of concerning nature or higher pressure due to higher values
Assurance
Consistently failing the target

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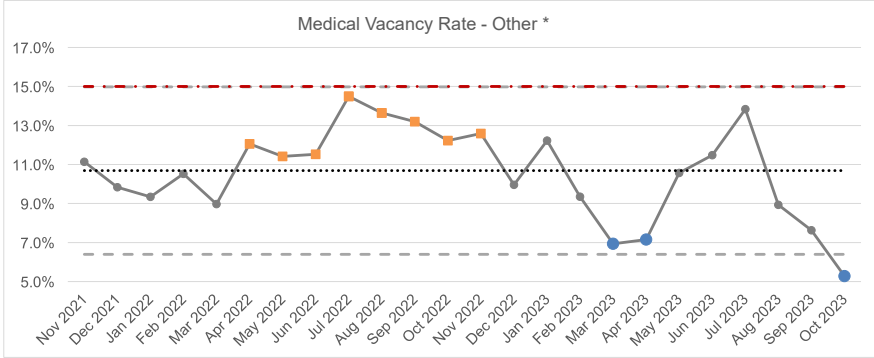

Oct 2023
5.3%
Target
15.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently passing the target

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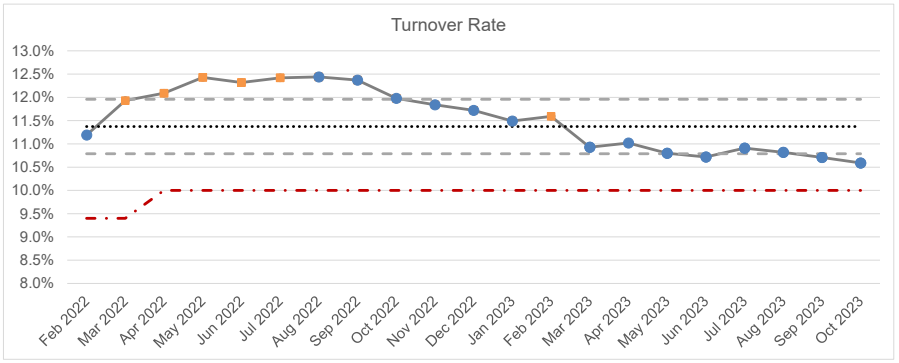
Data Analysis:
Medical Vacancy Rate - Consultants: For the past ten months, the indicator has been consistently trending towards the upper process limit, indicating a special cause for concern. Current data suggests the target will not be met without action.
Medical Vacancy Rate - Other: Current data has fallen below the lower process limit, the indicator is showing an improving nature and is consistently achieving the target.

Commentary:
Sourcing of senior medical staff via the Talent Acquisition Team has commenced with an initial focus upon Emergency Medicine and Acute Medicine as high spend areas with higher vacancy factors in senior grades. Work continues to design and implement a CESR support programme to support employees towards being granted specialist GMC Registration and appointment into substantive Consultant roles. Recruitment of Radiolgoists is planned in Kerala in November 2023, and in addition to direct recruitment relationship building and visits to various hospitals is planned for Acute and Emergency Medicine, Surgery, and Radiology. These will allow NLAG clinical staff to view training and facilitites and develop longer term pipelines of medical staff, alongside exploring opportunities for partnership working with institutions in Kerala.

The vacancy position has increased in month. 5 other medical grades are scheduled to start in November, and a pipeline of a further 35 other medical staff has been established awaiting start dates. Specialty Doctors will be targeted for Acute Medicine and Emergency Medicine as part of the Talent Acquisition Team sourcing work which has now commenced.



Oct 2023
10.6%
Target
10.0%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target

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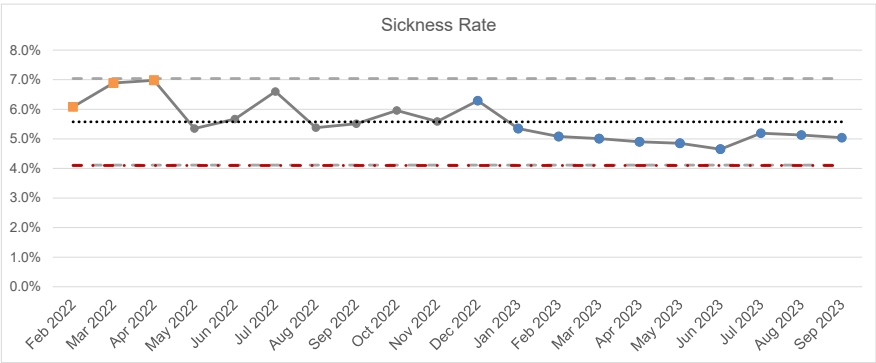

Sep 2023
5.0%
Target
4.1%
Variance
Special cause of improving nature or lower pressure due to lower values
Assurance
Consistently failing the target

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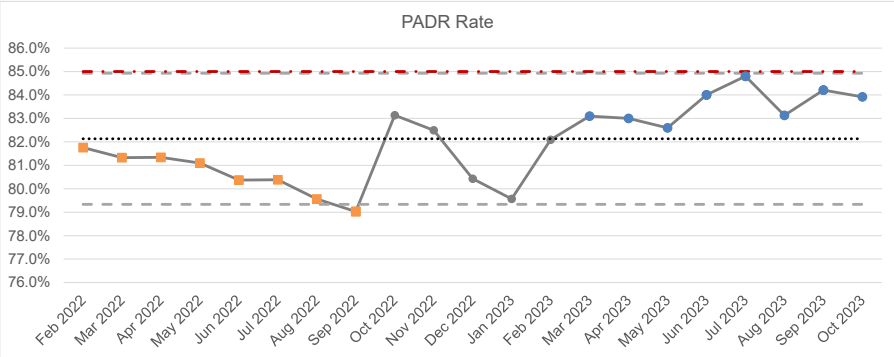
Data Analysis:
Turnover Rate: Performance has fallen outside of the lower process limit and is currently registering improvement due to recording values below the average. However, the target is unlikely to be met without action.
Sickness Rate: Over the past ten months the indicator has registered improvement. As a result the target is now within the process limits, suggesting the target may achieve and fail at random.

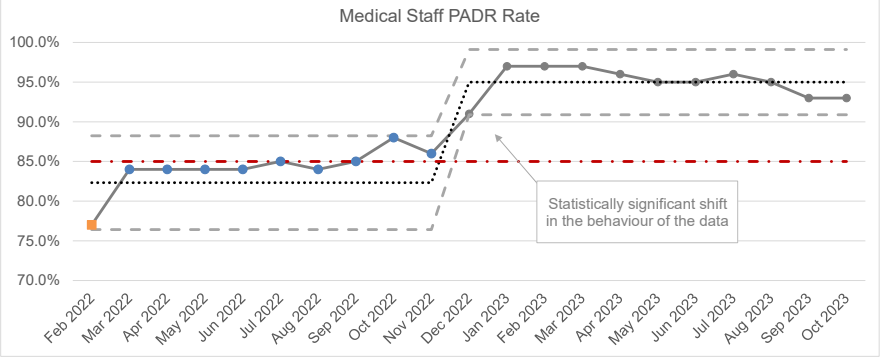
Commentary:

•**C&T** holding "listening events" senior leadership team visited staff at various locations to hear about any issues they experience, ideas to solve these and any positives they wish to share. feedback used to solve issues feeds into our "you said, we did". ;•analysis of exit questionnaire data.; •Stress Risk assessments completed for staff who identify potential issues, producing action plans.; •Promoting all Trust HWB initiatives to ensure staff can access appropriate support. ; •Continuing to explore ways of facilitating flexible working – Joined HSJ Webinar to gain insights into flexible working initiatives for rostering. ;•Star of the Month continues within the division with some great nominations and showcasing fantastic work.; •Promoting learning and development opportunities internal and external to the Trust, including the Values Based Leadership course.; •Significant reduction in nursing vacancies to ensure safe staffing levels and support positive work experience and retention.
Medicine are focusing on the "People Promise in action" : •**Compassionate & Inclusive** – Star of the Months, Ward Check in's with Matron and HR . •**Recognised & Rewarded** – Ward engagements with freebies, chocolates and thank you cards. •**A voice that counts** – Holding monthly Quad engagement sessions with all of Medicine, promoting the Freedom to Speak up Guardian, Staff Survey and having "You said, we did" •**Safe & Healthy** – Ensuring all our colleagues are supported and have access to the Trust wellbeing resources E.g. Vivup, Maximus etc. Managers also complete Stress Risk Assessments •**Always Learning** – At Boards, Governance and SMT Workforce we actively promote learning, coaching and the qualifications and apprenticeships we have on offer. •**Flexibility** – Promoting and completing the Carers Passport when applicable, for all staff medical,clinical and non clinical •**Team** – revamped the Dr's induction and for all interviews we have an honest conversation of what the areas is life, offering tours, meets and greets and really helping the new starter get a real feel for what it's like to work here. Nurse's induction booklets, Dr's induction/department packs ; exit interview analysis, reasons for leaving and trying to improve on the not so well feedback.

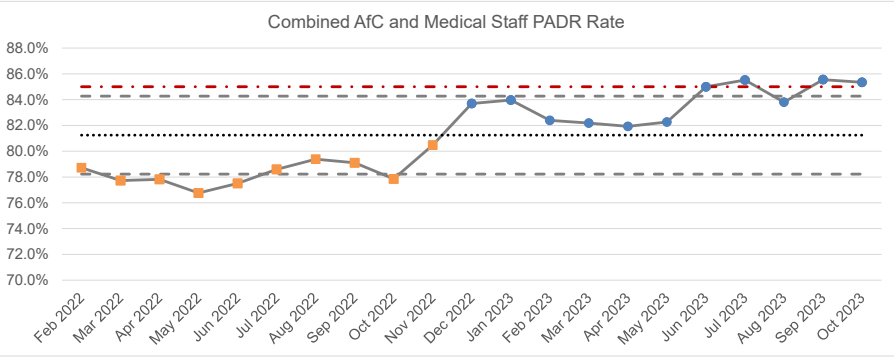
We are seeing a gradual decline in sickness % following a slight increase in July 23. The HR team continue to support and advise managers on cases to robustly manage these in accordance with Trust policy, exploring all options in order to facilitate early return to works. The managing attendance line manager training is being reviewed to ensure this remains fit for purpose alongside the 'how to' videos.



Oct 2023	83.9%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently failing the target



Oct 2023	93.0%
Target	85.0%
Variance	Common cause - no significant change
Assurance	Consistently passing the target



Oct 2023	85.4%
Target	85.0%
Variance	Special cause of improving nature or lower pressure due to higher values
Assurance	Consistently failing the target

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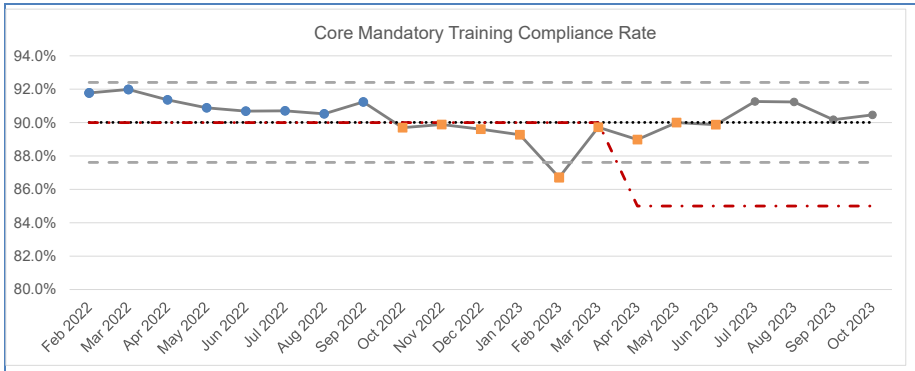
Data Analysis:
PADR Rate: The indicator has registered improvement for the last eight months. The current data indicates that the target is unlikely to be met without action.
Medical Staff PADR Rate: There has been significant improvement over the last ten months. Performance remains in the expected range and has achieved the target for the past year.
Combined AfC and Medical Staff PADR Rate: The indicator has registered improvement for the last eleven months. The target has been achieved on four occassions but this is not yet reliable.

Commentary:
The Trust AFC PADR compliance rate has reduced by 0.3% and is below target. This is due to the amount of Agenda for Change PADR's due to come out of compliance in October.The combined AFC and Medical staff PADR rate remains above target at 85.4%. The ESR Team continue to support managers around PADR compliance with myth busting, gentle reminders and education.

The data above for Medical staff PADR compliance reflects that the local processes that underpin medical PADR are capable. Processes which include dedicated support for all non-training grade doctors through the Revalidation and Medical Appraiser coordinator, Clinical lead for Appraisal, Appraisers and the Chief Medical Officer taking an active and supportive role as Responsible Officer (for example, being key note speaker at appraiser training events), an efficient and well maintained IT solution for the documentation management of appraisals, a formalised cohort of Medical Appraisers (training, network meetings, integration renumeration of role, and status of obtaining the role), and a robust communication processes when doctors are significantly delayed with appraisal.
The Chief Medical Officer directorate continued to horizon scan to ensure that capability can be sustained, for example, increase in medical staff. Next appraisal year there will 480 doctors which will be eligible for appraisal which will require more resources such as additional trained appraisers. A business case is currently being developed for the next round of planning to be proactive about the increase in medical staff who will require appraisal.



Oct 2023
90.5%

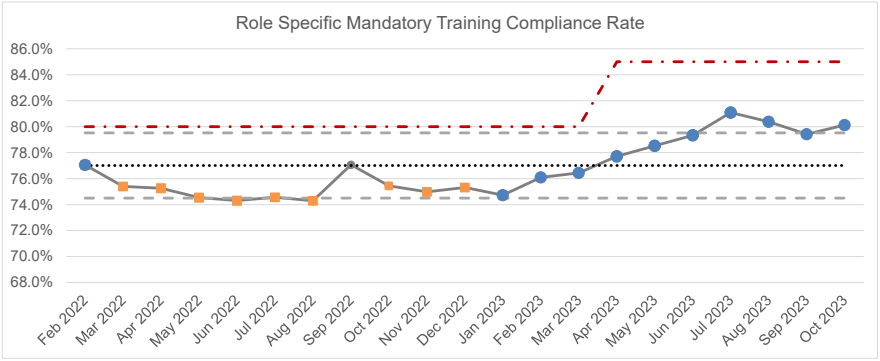
Target
85.0%

Variance

Common cause - no significant change

Assurance

Consistently passing the target



Oct 2023
80.1%

Target
85.0%

Variance

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

Assurance

Consistently failing the target

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Data Analysis:
Core Mandatory Training: Performance is stable and within the expected range of the data. The target will reliably be achieved.
Role Specific Mandatory Training: The indicator has registered improvement for the past ten months. However current data indicates that the target will not be met without action.

Commentary:

Core mandatory training compliance has improved by approximately 0.5% since the previous report, maintaining its position 5% above the Trust target. Preventing Radicalisation - Advanced Prevent Awareness compliance continues on an upward trajectory, improving by 2.71% since the previous report, now only 1.1% below the Trust target. Fire Safety remains the lowest compliance for all core mandatory training, with a further 2.15% decline since the previous report. Work is in progress to provide additional safety training sessions between now and the end of March 2024 to address the high volumes out of compliance for Fire Safety, though room availability has restricted some sessions. The number of wasted spaces through staff not attending or withdrawing from booked Fire Safety sessions in October was 175, 54 fewer than the previous month. Details on these wasted spaces continue to be cascaded to divisions via the HRBPs in monthly reports from the Head of Education, Training and Development. Targeted communication also continues to those employees out of compliance for Information Governance and Data Security as compliance for this competency @ 7.11.23 was 88%, 7% below its target of 95%

Role specific complaince has improved by approximately 0.7% since the previous report, reverting to an upward trajectory for the first time since July 2023. Moving and Handling and Resuscitation remain key areas for improvement within role specific mandatory training. Supported by the Head of Education, Training and Development, both training teams have reviewed and adapted their delivery models for the remainder of the year up to March 2024 to ensure they maximise training spaces available. Additional sessions have been planned across all areas of resuscitation to support demand, including the use of full safety training days where higher volumes of staff can be trained at Level 2. Moving and Handling modules continue to be impacted by wasted spaces with a further 137 staff withdrawing from or not attending planned sessions in October 2023. Further Moving and Handling Cascade Trainer training has been completed this month to increase capacity of qualified trainers suppoting in clinical areas. This has been particularly effective in GDH where the offer of Moving and Handling training is less frequent so having qualified cascade trainers is beneficail to all staff on site. As with core mandatory training, monthly reports are cascaded to directorates via HRBPs providing key information on areas of concern for mandatory training. Current areas reported in detail are - Moving and Handling, Resus, Deteriorating Patient, Safeguarding Adults Level 3, Safeguarding Children Level 3, Fire Safety, Corporate Induction and Information Governance and Data Security (latter 3 being core mandatory and previous being role specific).

IPR Appendix A - National Benchmarked Centiles

Northern Lincolnshire and Goole NHS Foundation Trust

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

The Centile is calculated from the relative rank of an organisation within the total set of reporting organisations. The number can be used to evaluate the relative standing of an organisation within all reporting organisations. 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 21/11/2023

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

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

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Access & Flow	Planned	% Under 18 Weeks Incomplete RTT Pathways	Oct 23	61.0%	92.0%	59	75 / 171	Jul 23
	Planned	Number of Incomplete RTT pathways 52 weeks	Oct 23	818	0	59	71 / 161	Jul 23
	Planned	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)	Oct 23	26.8%	1.0%	18	115 / 156	Jun 23
	Cancer	Cancer Waiting Times - 62 Day GP Referral	Oct 23	50.0%	85.0%	21	107 / 132	Jul 23
	Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 23	60.8%	95.0%	14	116 / 144	Jul 23
	Urgent Care	Number Of Emergency Department Attendances	Oct 23	14,669	No target	45	80 / 144	Jul 23
	Urgent Care	Decision to Admit - Number of 12 Hour Waits	Oct 23	996	0	9	143 / 153	Jul 23
	Flow	Bed Occupancy Rate (General & Acute)	Oct 23	95.4%	92.0%	37	98 / 156	Q1 23/24
	Outpatients	Outpatient Did Not Attend (DNA) Rate	Oct 23	6.3%	5.0%	62	54 / 158	Jul 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Quality & Safety	Infection Control	Number of MRSA Infections	Sep 23	0.00	No target	64	82 / 135	Jul 23
	Infection Control	Number of E Coli Infections	Sep 23	0.21	No target	72	39 / 135	Jul 23
	Infection Control	Number of Trust Attributed C-Difficile Infections	Sep 23	0.00	No target	96	6 / 135	Jul 23
	Infection Control	Number of MSSA Infections	Sep 23	0.26	No target	76	34 / 135	Jul 23
	Mortality	Summary Hospital level Mortality Indicator (SHMI)	May 23	103.0	As expected	39	73 / 119	Jun 23
	Safe Care	Number of Serious Incidents Raised in Month	Sep 23	4	No target	Old data unsuitable for comparison		
	Safe Care	Care Hours Per Patient Day (CHPPD)	Sep 23	8.5	No target	40	98 / 188	Jul 23
	Safe Care	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 23	95.1%	95.0%	Old data unsuitable for comparison		
	Patient Experience	Formal Complaints - Rate Per 1000 wte staff	Oct 23	6.4	No target	Old data unsuitable for comparison		
	Patient Experience	Friends & Family Test - Percentage Positive Inpatient Scores	Sep 23	98.9%	No target	73	5 / 132	Jul 23

			Local Data (IPR)			National Benchmarked Centile		
IPR Section	**Category**	**Indicator**	**Period**	**Actual**	**Target**	**Centile**	**Rank**	**Period**
Workforce	Staffing Levels	Sickness Rate	Sep 23	5.0%	4.1%	50	107 / 212	Jun 23

IPR Appendix B

Scorecard - Access and Flow (F&P Committee)

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. '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 for Assurance/Variation when the data is not presented as an SPC chart.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Planned	Percentage Under 18 Weeks Incomplete RTT Pathways*	Oct 2023	61.0%	92.0%	Alert			Board
	Number of Incomplete RTT pathways 52 weeks*	Oct 2023	818	0	Alert			Board
	Total Inpatient Waiting List Size	Oct 2023	12,387	11,563	Alert			Board
	Diagnostic Procedures Waiting Times - 6 Week Breach % (DM01)*	Oct 2023	26.8%	1.0%	Alert			Board
	Number of Incomplete RTT pathways 65 weeks	Oct 2023	119	No Target	Alert		n/a	Board
	Number of Incomplete RTT Pathways*	Oct 2023	40,364	No Target	Alert		n/a	FPC
	DM01 Diagnostic Waiting List Size - Submitted Waiters (Live)	Oct 2023	16,025	No Target			n/a	FPC
	% of Inpatient Live Waiting List Overdue Risk Strat Date	Oct 2023	45.8%	37%	Alert			FPC
Outpatients	Number of Overdue Follow Up Appointments (Non RTT)	Oct 2023	37,834	9,000	Alert			Board
	Outpatient Did Not Attend (DNA) Rate	Oct 2023	6.3%	5.0%	Alert			Board
	% Outpatient Non Face To Face Attendances	Oct 2023	21.9%	25.0%	Alert			Board
	% Outpatient summary letters with GPs within 7 days	Sep 2023	58.4%	50.0%	Alert			FPC
	Advice and Guidance as a Percentage of all Referrals	Oct 2023	9.2%	No Target			n/a	FPC
	% of Outpatient Waiting List Risk Stratified (New and Review)	Oct 2023	83.7%	99.0%	Alert			FPC
	% of Outpatient Waiting List Overdue Risk Strat Date (New and Review)	Oct 2023	30.8%	23.0%	Alert			FPC
	Patient Initiated Follow Up	Oct 2023	4.1%	5.0%	Highlight			FPC
Cancer	Cancer Waiting Times - 62 Day GP Referral*	Oct 2023	50.0%	85.0%	Alert			Board
	Cancer Waiting Times - 104+ Days Backlog*	Oct 2023	29	0	Alert			Board
	Patients Referred to a Tertiary Centre for Treatment That Were Transferred By Day 38*	Oct 2023	14.3%	75.0%	Alert			Board
	Cancer Request To Test In 7 Days*	Oct 2023	52.7%	100.0%	Alert			Board
	Cancer Waiting Times - 2 Week Wait*	Oct 2023	95.1%	93.0%				FPC
	Cancer Waiting Times - 2 Week Wait for Breast Symptoms*	Oct 2023	82.2%	93.0%				FPC
	Cancer Waiting Times - 28 Day Faster Diagnosis*	Oct 2023	72.4%	75.0%				FPC
	Cancer Request To Test In 14 Days*	Oct 2023	84.2%	100.0%	Alert			FPC
	Cancer Waiting Times - 31 Day First Treatment*	Oct 2023	91.7%	96.0%				FPC
	Cancer Waiting Times - Cancer 62-day backlog	Oct 2023	109	No Target			n/a	FPC
	Cancer Waiting Times - 62 day Screening*	Oct 2023	33.3%	90.0%	Alert			FPC
Urgent Care	Emergency Department Waiting Times (% 4 Hour Performance)	Oct 2023	60.8%	95.0%	Alert			Board
	Number Of Emergency Department Attendances	Oct 2023	14,669	No Target	Alert		n/a	Board
	Ambulance Handover Delays - Number 60+ Minutes	Oct 2023	659	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs From Decision to Admit to Ward Admission	Oct 2023	996	0	Alert			Board
	Number of Patients Waiting Over 12 Hrs without Decision to Admit/Discharge	Oct 2023	541	0	Alert			Board
	Number of UCS Attendances	Oct 2023	5,781	No target	Alert		n/a	FPC
	% UCS Waiting Times (4 Hour Performance)	Oct 2023	99.4%	92.0%				FPC
	Ambulance Handover Delays - Number 30-60 Minutes	Oct 2023	467	No Target			n/a	FPC
Flow	% Patients Discharged On The Same Day As Admission (excluding daycase)	Oct 2023	44.6%	40.0%	Highlight			Board
	% of Extended Stay Patients 21+ days	Oct 2023	13.7%	12.0%				Board
	Inpatient Elective Average Length Of Stay	Oct 2023	2.0	2.5				Board
	Inpatient Non Elective Average Length Of Stay	Oct 2023	3.3	3.9				Board
	% Discharge Letters Completed Within 24 Hours of Discharge	Oct 2023	97.6%	90.0%				Board
	% Inpatient Discharges Before 12:00 (Golden Discharges)	Oct 2023	16.8%	30.0%	Alert			Board
	Bed Occupancy Rate (G&A)	Oct 2023	95.4%	92.0%				Board
	Percentage of patients re-admitted as an emergency within 30 days	Oct 2023	8.6%	No Target			n/a	FPC
	Percentage of Daycase Spells From Elective Activity	Oct 2023	91.4%	No Target			n/a	FPC
	% of Extended Stay Patients 7+ days	Oct 2023	46.9%	No Target			n/a	FPC
	% of Extended Stay Patients 14+ days	Oct 2023	24.8%	No Target			n/a	FPC
	% Inpatient Discharges Before 17:00	Oct 2023	67.5%	80.0%	Alert			FPC
Theatre	Theatre Session Utilisation (Core Capacity)	Oct 2023	52.6%	No Target			n/a	FPC
	Theatre In Session Capped Utilisation	Oct 2023	80.2%	No Target			n/a	FPC
	Theatre In Session Non-Capped Utilisation	Oct 2023	81.2%	No target			n/a	FPC

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)

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Infection Control	Number of MRSA Infections *(Rate per 1,000 bed days)*	Sep 2023	0.00	see analysis			n/a	Board
	Number of E Coli Infections *(Rate per 1,000 bed days)*	Sep 2023	0.21	see analysis			n/a	Board
	Number of Trust Attributed C-Difficile Infections *(Rate per 1,000 bed days)*	Sep 2023	0.00	see analysis			n/a	Board
	Number of MSSA Infections *(Rate per 1,000 bed days)*	Sep 2023	0.26	see analysis			n/a	Board
	Number of Gram Negative Infections *(Rate per 1,000 bed days)*	Sep 2023	0.47	see analysis			n/a	Board
Mortality	Hospital Standardised Mortality Ratio (HSMR)	Dec 2022	98.7	As expected	**Alert**	H	As expected	Board
	Summary Hospital level Mortality Indicator (SHMI)	May 2023	103.0	As expected			As expected	Board
	SHMI diagnosis groups outcome risk percentage (infections)	May 2023	96.2%	No target			n/a	Board
End of Life	Percentage of Structured Judgment Reviews (SJRs) sighting problems in care/negative learning themes	Aug 2023	16.0%	No target		n/a	n/a	Board
	Percentage of in hospital deaths with anticipatory medication prescribed	Mar 2023	10.7%	No target		L	n/a	Q&S
Safe Care	Patient Safety Alerts to be actioned by specified deadlines	Sep 2023	100.0%	No target		H	n/a	Board
	Number of Serious Incidents raised in month	Sep 2023	4	No target			n/a	Board
	Occurrence of 'Never Events' *(Number)*	Sep 2023	0	0		n/a	n/a	Board
	Duty of Candour Rate	Sep 2023	100.0%	100.0%		H	?	Board
	Falls on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2023	3.8	No target			n/a	Board
	Hospital Acquired Pressure Ulcers on Inpatient Wards *(Rate per 1,000 bed days)*	Sep 2023	4.0	No target			n/a	Board
	Venous Thromboembolism (VTE) Risk Assessment Rate	Oct 2023	95.1%	95.0%			?	Board
	Care Hours Per Patient Day (CHPPD)	Sep 2023	8.5	No target		H	n/a	Board
	Mixed Sex Accommodation Breaches	Sep 2023	3	0			?	Board
	Community Acquired Pressure Ulcers (Number)	Sep 2023	52.0	0	**Alert**		F	Board
Patient Experience	Formal Complaints *(Rate Per 1,000 wte staff)*	Oct 2023	6.4	No target			n/a	Board
	Complaints Responded to on time	Oct 2023	63.0%	85.0%			?	Board
	Friends & Family Test: Inpatient Score Percentage Positive	Sep 2023	98.9%	No target	**Highlight**	H	n/a	Board
	Friends & Family Test: A&E Score Percentage Positive	Sep 2023	77.8%	No target			n/a	Board
Observations	Number of incidents with harm caused due to failure to recognise or respond to deterioration	Sep 2023	4.0	No target			n/a	Board
	Percentage of Adult Observations Recorded On Time (with a 30 min grace)	Oct 2023	92.9%	90.0%		H	?	Q&S
	Recording of and response to NEWS2 score for unplanned critical care admissions	Jun 2023	61.5%	30.0%		n/a	n/a	Q&S
Mental Capacity	Number of contacts with the MCA/DoLS team	Oct 2023	0.0	No target		n/a	n/a	Board
	Percentage of MCA assessments that meet the legal requirements	Aug 2023	13.0%	No target		n/a	n/a	Board
	Percentage of best interest recording for adults who lack capacity and meet the legal requirements	Aug 2023	0.0%	No target		n/a	n/a	Board
Sepsis	Percentage of paediatric primary sepsis screenings using national risk stratification criteria	Oct 2023	47.5%	No target		n/a	n/a	Q&S
	Percentage of Adult Sepsis screening completed within 15 minutes in response to elevated NEWS2 score	Oct 2023	27.0%	90.0%	**Alert**	H	F	Q&S
Prescribing	Harm impact for weight related medication prescribing incidents	Oct 2023	2	No target			n/a	Board
	Actual weight recorded on Web V within 24 hours of admission	Oct 2023	No Data	No target		n/a	n/a	Q&S
	Weight recorded on EPMA matches actual weight recorded in Web V	Oct 2023	No Data	No target		n/a	n/a	Q&S
Maternity	Robson Scores - Group 1	Oct 2023	23.1%	No target			n/a	Board
	Robson Scores - Group 2	Oct 2023	29.0%	No target			n/a	Board
	Number of Deliveries With Post Partum Haemorrhage > 1500 ml	Oct 2023	16	No target			n/a	Board
	Still Birth Rate per 1000	Oct 2023	3.3	No target			n/a	Board
	Spontaneous 3rd or 4th Degree Tear	Oct 2023	0.6%	No target			n/a	Board
	Instrumental 3rd or 4th Degree Tear	Oct 2023	5.3%	No target			n/a	Board

Scorecard - Workforce

Alert' is stated when either Variation is showing special cause concern or Assurance indicates failing the target. '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 for Assurance/Variation when the data is not presented as an SPC chart.

Category	Indicator	Period	Actual	Target	Action	Variation	Assurance	Audience
Vacancies	Unregistered Nurse Vacancy Rate *	Oct 2023	10.3%	8.0%	Alert			Board
	Registered Nurse Vacancy Rate *	Oct 2023	10.6%	8.0%	Alert			Board
	Medical Vacancy Rate *	Oct 2023	13.2%	15.0%				Board
	Trustwide Vacancy Rate *	Oct 2023	9.1%	8.0%	Alert			Board
	Medical Vacancy Rate - Consultants *	Oct 2023	19.8%	15.0%	Alert			Board
	Medical Vacancy Rate - Other *	Oct 2023	5.3%	15.0%	Highlight			Board
Staffing Levels	Turnover Rate	Oct 2023	10.6%	10.0%	Alert			Board
	Sickness Rate	Sep 2023	5.0%	4.1%	Alert			Board
Staff Development	PADR Rate	Oct 2023	83.9%	85.0%	Alert			Board
	Medical Staff PADR Rate	Oct 2023	93.0%	85.0%				Board
	Combined AfC and Medical Staff PADR Rate	Oct 2023	85.4%	85.0%	Alert			Board
	Core Mandatory Training Compliance Rate	Oct 2023	90.5%	85.0%				Board
	Role Specific Mandatory Training Compliance Rate	Oct 2023	80.1%	85.0%	Alert			Board
Disciplinary	Number of Disciplinary Cases Live in Month	Oct 2023	6	No Target			n/a	WFC
	Average Length of Disciplinary Process (Weeks)	Oct 2023	20	12	Alert			WFC
	Number of Suspensions Live in Month	Oct 2023	3	No Target			n/a	WFC
	Average Length of Suspension (Weeks)	Oct 2023	5	No Target			n/a	WFC
Culture	Staff Survey - Advocacy	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Involvement	Jul 2023	5.8	6.8		n/a	n/a	WFC
	Staff Survey - Motivation	Jul 2023	6.6	7.0		n/a	n/a	WFC

Appendix C - Glossary

A&E	Accident and Emergency
A&F	Access and Flow
ACN	Associate Chief Nurse
ADQG	Associate Director Quality Governance
AfC	Agenda for Change
CDI	Clostridioides difficile infection
CESR	Certificate of Eligibility for Specialist
CHPPD	Care hours per patient day
CMO	Chief Medical Officer
DM01	Diagnostic Waiting Times and Activity
DNA	Did not attend
DOLS	Deprivation Of Liberty Safeguards
DPOW	Diana Princess of Wales Hospital
DWP	Department of Work and Pension
ED	Emergency Department
EMAS	East Midlands Ambulance Service
EPIC	Emergency Physician in Charge
EPMA	Electronic Prescribing and Medicines
FFT	Friends and Family Test
GMC	General Medical Council
GP	General Practitioner
HCSW	Health Care Support Worker
HEE	Health Education England
HIT	High Intensity Theatre
HR	Human Resources
HSMR	Hospital Standardised Mortality Ratio
HUTH	Hull University Teaching Hospital
IAAU	Integrated Acute Assessment Units
ICS	Integrated Care Systems
IPC	Infection Prevention and Control
KPI	Key Performance Indicators
LOS	Length of Stay
MCA	Mental Capacity Act
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-susceptible Staphylococcus aureus
NEWS	National Early Warning System
NG	National Guidance
NHSE/I	NHS England and Improvement
NL	North Lincolnshire
NLAG	Northern Lincolnshire and Goole NHS Trust
OD	Organisational Development
OOH	Out of Hospital
OP	Outpatient
OPAT	Outpatient Parenteral Antimicrobial Therapy
OPEL	Operational Pressures Escalation Levels
PADR	Performance Appraisal and Development
PALS	Patient Advice and Liaison Service
PBI	Power BI, a Microsoft software
PE	Patient Experience
PIFU	Patient Initiated Follow Ups
PTL	Patient Tracking List
Q&S	Quality and Safety
QI	Quality Improvement
RDC	Rapid Diagnostics Centre
RTT	Referral to Treatment
SAS	Specialist and Specialty
SGH	Scunthorpe General Hospital
SHMI	Summary Hospital Mortality Index
SJR	Structured Judgement Reviews
SPA	Single Point of Access
SPC	Statistical Process Charts
T&D	Training and Development
UCS	Urgent Care Centre
VTE	Venous Thromboembolism
WLIs	Waiting List Initiative's
WTE	Whole Time Equivalent
YTD	Year to Date

NLG(23)228

Name of the Meeting	**Trust Board – Public**	
Date of the Meeting	5 December 2023	
Director Lead	Jonathan Lofthouse, Group Chief Executive	
Contact Officer/Author	As Above	
Title of the Report	**Documents Signed Under Seal**	
Purpose of the Report and Executive Summary (to include recommendations)	The report below provides details of documents signed under Seal since the date of the last report (October 2023 – NLG(23)193).	
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.
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

Introduction

Standing order 60.3 requires that the Trust Board receives reports on the use of the Trust Seal.

60.3 Register of Sealing

"An entry of every sealing shall be made and numbered consecutively in a book provided for that purpose, and shall be signed by the persons who shall have approved and authorised the document and those who attested the Seal. (The report shall contain details of the seal number, the description of the document and date of sealing)".

The Trust's Seal has been used on the following occasions:

Seal Register Ref No.	**Description of Document Sealed**	**Date of Sealing**
277	Engrossment Deed Plan – re-routing gas pipe on the South West Corner of the DPOW Site	01.11.2023
278	NEL/NLaG Early Access Licence for site investigations, Shopping Centre, Freshney Place, Grimsby	01.11.2023

Action Required

The Trust Board is asked to note the report.

NLG(23)236

Name of the Meeting	**Trust Board of Directors**	
Date of the Meeting	5 December 2023	
Director Lead	Lee Bond, Group Chief Financial Officer	
Contact Officer/Author	Ellie Monkhouse, Chief Nurse: Joint Clinical Champion Dr Kate Wood, Chief Medical Officer: Joint Clinical Champion Neil Gammon, Independent Chair of Health Tree Foundation Trustees' Committee: Author	
Title of the Report	**Health Tree Foundation (HTF) Annual Report 2022/2023**	
Purpose of the Report and Executive Summary (to include recommendations)	The attached HTF Annual Report 2022/2023 is submitted to the Trust Board for information as noted in the Health Tree Foundation Trustees' Committee (HTF) Highlight Report – 9 November 2023	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
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)	Only on Health Tree Foundation Charitable Funds	
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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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

Contact

Email: hello@healthtreefoundation.org.uk
Telephone: 03033 304514
Website: www.healthtreefoundation.org.uk

Goole:

The Health Tree Foundation
Goole & District Hospital,
Woodland Avenue, Goole,
DN14 6RX

Scunthorpe:

The Health Tree Foundation
Scunthorpe General Hospital,
Cliff Gardens, Scunthorpe,
DN15 7BH

Grimsby:

The Health Tree Foundation
Diana, Princess of Wales
Hospital, Scartho Road,
Grimsby, DN33 2BA

The Health Tree Foundation is the working name of the Northern Lincolnshire and Goole NHS

Foundation Charitable Funds. The principal address is: Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA

Registered charity number: 1054935

THE HEALTH TREE FOUNDATION

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Inspiring change in your NHS

Annual Report
2022/2023

Contents

Welcome to our Annual Report for 2022/23

It's been an incredible year for us all and what a journey it has been! The support we have received has been heartfelt!

The local communities have wanted to do their bit to support their local hospitals and community services and we have been overwhelmed and humbled by the generosity people have shown us.

Thanks to generous donations from the public and local businesses, we have been able to fulfil our appeal for our new Emergency Departments within Grimsby, Diana Princess of Wales Hospital and Scunthorpe General Hospital.

Our local community have pulled together to get behind the NHS from donating amazing gifts to supporting staff and patients, volunteering their time to help improve our hospitals and providing generous monetary donations.

We couldn't have achieved any of this without the backing of our local communities, corporate supporters and those who have kindly remembered us in their wills.

Thank you all for your continued support for our local hospitals. Your help will always be remembered.

Lucy Skipworth
Charity Manager
The Health Tree Foundation

Clare Woodard
Head of Smile Health
HEY Smile Foundation

A Message from our Chair

As your Charity's Independent Chair, I am delighted once again to provide a brief welcome to this Annual Report of The Health Tree Foundation. I emphasise that it is "Your" Charity, supporting patients and their families in Goole, Grimsby, and Scunthorpe Hospitals as well as those served by the Trust's Community Services.

In line with it being "Your" Charity, I and my fellow Trustees continue to be astonished at the selfless generosity of donors within our community, whether they be individuals or businesses. Without your continuing support, especially in these difficult financial times for everyone, the Health Tree Foundation would not be able to make your NHS sparkle with both small and large differences.

It is pleasing to see within this Annual Report, the varied ways in which funds are raised, generously donated and then spent. I do urge you to have a good read of the several articles, which explore the inventiveness and dedication of the Health Tree Foundation's many supporters. May I just highlight one example from the many? The Cleethorpes Seaview Street Cancer Charity Shop has been running for many years and provides a steady Charity income stream. By supporting the volunteers there and using the shop to donate items or to buy things, you are actively contributing to the Charity for which I thank you.

I must also draw attention to the Trust's many staff who go above and beyond to support the Charity, in addition to their regular work. Let me encourage you too, to spread the word throughout the Trust and thus increase the awareness of and participation in Health Tree Foundation's activities.

To everyone involved in making the Health Tree Foundation such a successful and effective investor in benefitting patients across the Trust, I send my sincere thanks on behalf of the Trustees and the Health Tree Team.

Neil Gammon

Independent Chair of Health Tree Foundation Trustees' Committee

A Message from our Patron

It has been a pleasure to serve as your Patron of The Health Tree Foundation for the past two years, times which have been difficult for many but during which the generosity of Health Tree donors and supporters has shone through.

I have seen at first hand the work which the Charity does across the three hospital sites and in the Community to deliver meaningful benefits to patients and their families – enhancements that would not be possible otherwise.

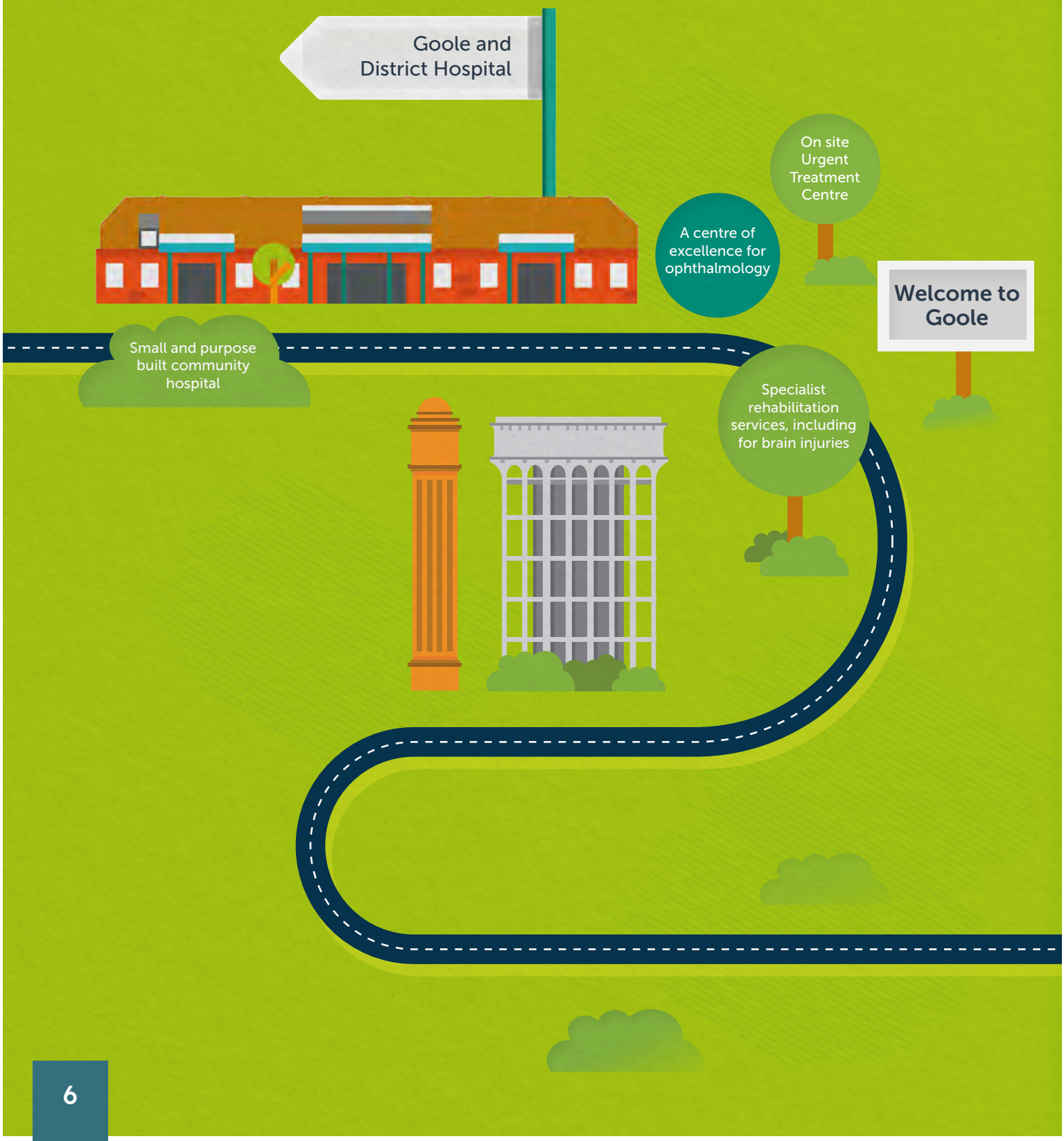
I know that Trustees and the Health Tree Team take their responsibilities very seriously and do their utmost to maximise the benefits of the hard-won donations. Such contributions would not be possible, were it not for the continuing personal endeavours of donors across our Northern Lincolnshire and Goole communities.

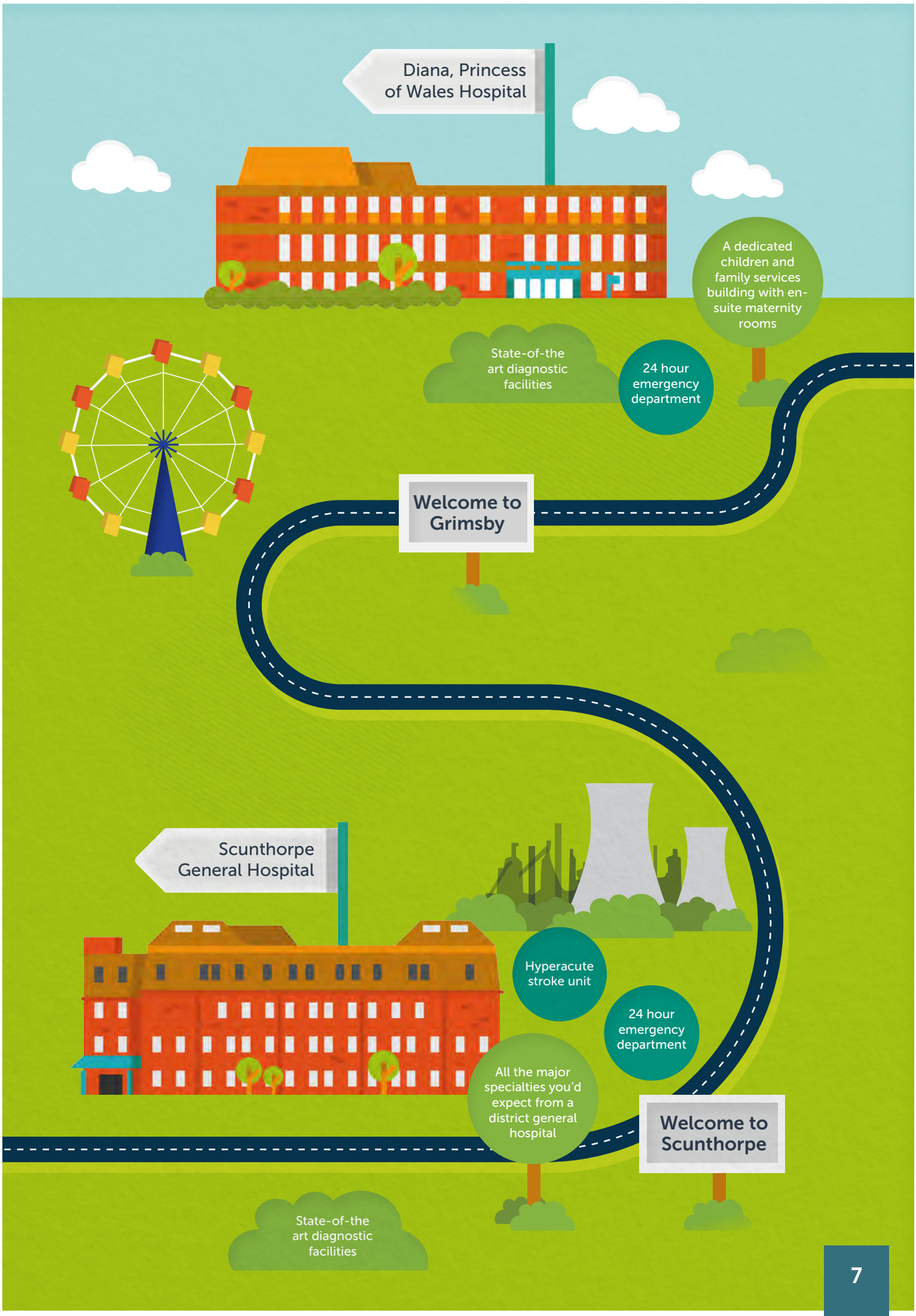
I thank you all for your kindness and generosity and ask that you keep up the good work and spread the message far and wide.

Sir Reginald Adrian Berkeley Sheffield

Bt. DL

The Health Tree Foundation




Diana, Princess of Wales Hospital
A dedicated children and family services building with en-suite maternity rooms
State-of-the art diagnostic facilities
24 hour emergency department
Welcome to Grimsby
Scunthorpe General Hospital
Hyperacute stroke unit
24 hour emergency department
All the major specialties you'd expect from a district general hospital
Welcome to Scunthorpe
State-of-the art diagnostic facilities

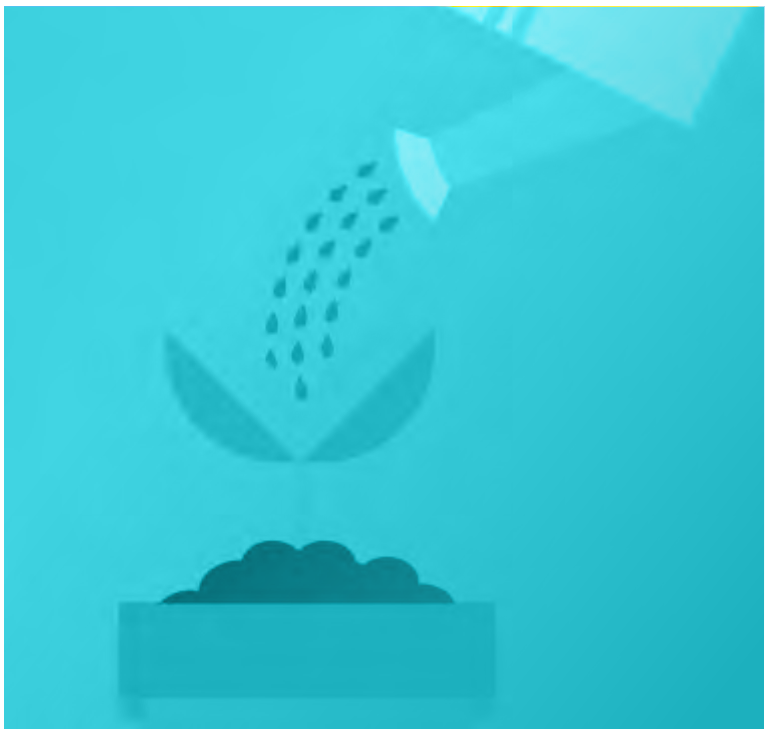
Meet Scrubs!

Scrubs the Bear is the large and cuddly mascot for NHS charity The Health Tree Foundation (HTF).

Don't be alarmed if you spot Scrubs at your local hospital! He will be there to entertain youngsters on the children's wards, warm the hearts of the Trust's adult patients, and encourage the communities to raise funds for each hospital.

Our Vision

To be recognised as a leading NHS Charity in the UK.

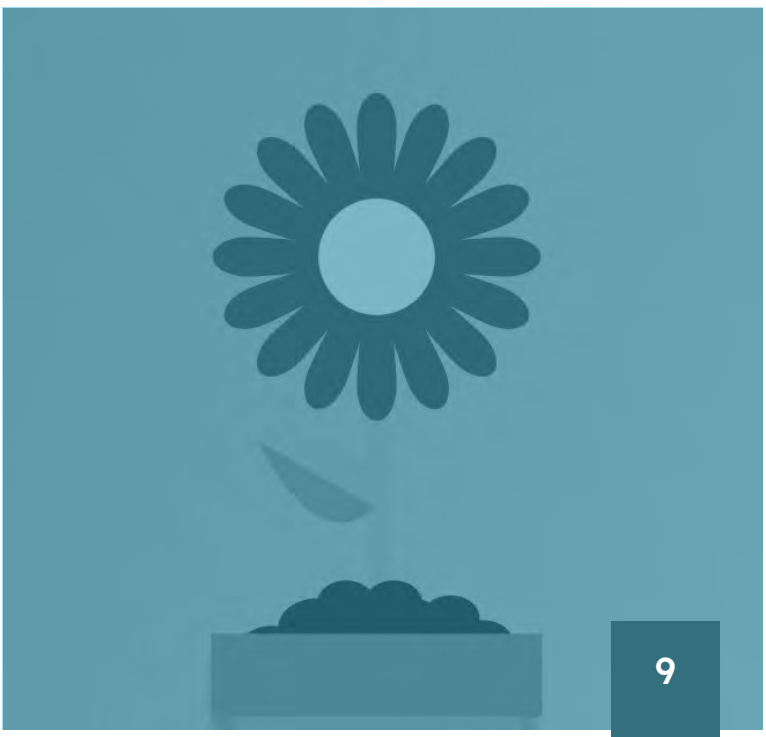


Our Mission

To inspire, engage and channel the charitable intent of your local community, helping to turn donations of time and money into making your NHS sparkle.

Our Promise

Above all we will ensure that funds, however big or small, are used to make a positive difference to our community's healthcare.



Highlights of the year 2022/2023

From on-line fundraising events to coastal running events and everything in between. Here are some of the highlights of the year.

Grimsby Town Football Club Cheque Presentation

April

Diana Princess of Wales Hospital, Grimsby

Grimsby Town Football Club raised an amazing £400 for The Pink Rose Suite at Grimsby Hospital by holding a Fun Day!

Debby Wilkinson – Memory Tree

March

Diana Princess of Wales Hospital, Grimsby

Staff members of The Cardiology Unit wished for a tree to be planted in memory of their colleague Debby Wilkinson who sadly passed away.

On Friday 11th March they held a lovely ceremony to remember Debby and enjoy the lovely Tree and Plaque in her memory.

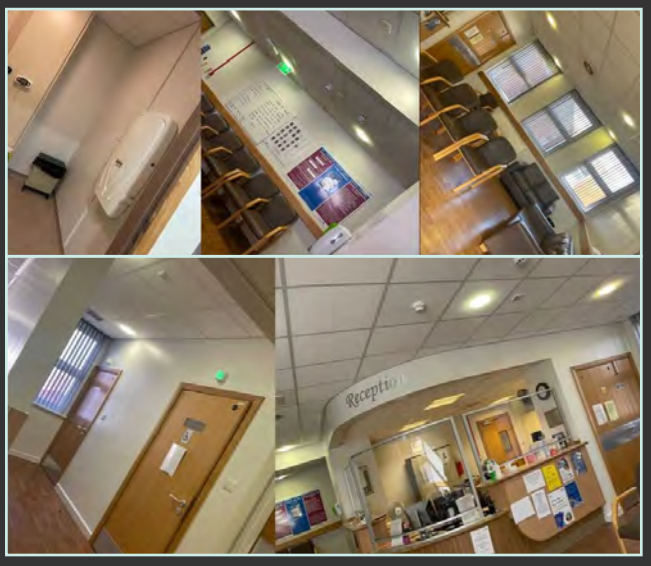
Pink Rose Suite

March

Diana Princess of Wales Hospital, Grimsby

A staff member on the Pink Rose Suite (breast cancer care) requested that the Reception area on the ward be re-decorated to make the area more comfortable and relaxing while the patients are using the waiting room!

Thanks to your wonderful donations, we can grant amazing wishes like this.



Easter Deliveries

April

Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby

Over the Easter period, we received so many kind and generous donations of gifts for the children who were having to spend the Easter holiday in our hospitals.

Thank you so much to everyone who kindly donated.

Seaview Street Cancer Shop

June

Diana Princess of Wales Hospital, Grimsby

A charity shop in Cleethorpes donated another £20,000, which will benefit cancer patients at Grimsby hospital. Seaview Street Cancer Charity Shop has been drumming up funds for Grimsby Hospital for a large number of years, and has been affiliated to The Health Tree Foundation for the last four.

The money has been raised through donations customers have given and sales made through the store. This wonderful donation will be put towards specialist equipment, which will help cancer patients who need treatment during a very difficult time.

Golf Day

June

Scunthorpe General Hospital

Thank you so much to Lewis Downie and his team for raising £1,000 for the Disney Ward at Scunthorpe Hospital.

This amazing donation was raised at a Golf Day at Forest Pines on the 23rd April in memory of Sam Fewster who sadly passed away 19 years ago aged just 12 years old. 25 players took part in the event with each of them donating and 18 local businesses sponsored a hole at £20 each. With other donations, they all raised a fantastic £1,000!

Highlights of the year 2022

MRI Appeal launch

Scunthorpe General Hospital

June

The Scunthorpe MRI department is hoping to raise £5,000 to support the purchase of a piece of equipment to help claustrophobic patients complete their scans.

The piece of equipment we are hoping to purchase, provides a welcoming environment for both adults and children. A video screen which plays imagery and sound to distract the patient and a countdown timer shows how long their scan will last. The canopy also projects imagery on the scanner walls to give the illusion of more space.

Wedding Favours

Diana Princess of Wales Hospital, Grimsby

August

We had the honour of providing wedding favours for a newly married couple recently. Rachel has been fundraising for The Neonatal Unit at Grimsby Hospital and asked if we could create these favours to help raise more money for this ward. We hope you had a perfect day.

Cross Trainer

Diana Princess of Wales Hospital, Grimsby

July

Health Tree Foundation supported the Children's Physiotherapists Team by funding a static exercise cycle which proved to be a great success for their young patients. The Charity was then asked to help fund a cross trainer to go with the cycle so that the team could create a mini gym area for the children who visit for their treatments. Here is one of the young people trying the cross trainer out for size!

Grimsby Cars Event

July

Diana Princess of Wales Hospital, Grimsby

Babies on the Neonatal Intensive Care Unit (NICU) at Grimsby Hospital will benefit from an £8,000 donation from Grimsby Cars Annual Fundraising Event. This is the sixth year that Mike Croft, Managing Director of Grimsby Cars, and others have raised money for NICU. So far, they have raised £40,000 for the unit.

This year's donation will go towards items and equipment on NICU, to help improve the experience our babies receive.

Party in the field

August

Scunthorpe General Hospital

Thank you so much to our amazing fundraisers Lee and Emma Clay who raised £1,835 for the NICU at Scunthorpe Hospital from this brilliant event.

They organised a Party on the Field at White House Farm Camping and Caravanning and raised an incredible amount of funds which will go towards the Neonatal Intensive Care Unit.

James Watson Memorial Cup

May

Diana Princess of Wales Hospital, Grimsby

On Saturday 21st May 2022, The James Watson Memorial Cup was held at Brumby Hall Social Club organised by family members and friends of James.

They raised an incredible £3,000 for ITU at Grimsby Hospital.

Highlights of the year 2022

Organ Donation Trees

August

Scunthorpe General Hospital and Diana Princess of Wales Hospital, Grimsby

Thanks to your generous donations, we have been able to create these beautiful 'Tree of Life' memorials at both Grimsby Hospital and Scunthorpe Hospital.

Together with the Northern Lincolnshire and Goole (NLaG) ITU teams, we are commemorating and honouring those who have donated their organs in order to give the gift of life to others.

As well as being a memorial to the selfless donors and their families, we also hope the memorials will be inspirational and open up conversations about organ donation and encourage people to share what they would want to happen in the event of their passing.

Disney Room

September

Scunthorpe General Hospital

This is the newly decorated treatment room on the Disney Ward at Scunthorpe Hospital.

Just how incredible does it look? A member of staff submitted a wish to us to help make the treatment room more colourful and child friendly. The room previously had plain walls with no wall art to help distract children who were having procedures.

The walls now feature cartoon characters every child who enters the room will be able to recognise, making them feel more calm and comfortable when receiving treatments.

Thanks to your support and donations, this wish has come true!

Adele Coastal Run

Diana Princess of Wales Hospital, Grimsby

September

Adele took on the ABP Humber Coastal Half Marathon for the Maternity Unit at Grimsby Hospital!

She raised an amazing £385!

Murals

October

Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital

In the treatment areas, we now have beautiful murals and 'Sky Inside' panels to help put you at ease. Thanks to the wonderful support of our local community, we have made these amazing changes.

Cleethorpes Golf Club

November

Diana Princess of Wales Hospital, Grimsby

Patients with dementia at Grimsby hospital will benefit from a new machine they can interact with to help recall and share events from their past, thanks to a donation from Cleethorpes Golf Club. The club has donated more than £8,000 and this will be used to purchase a Reminiscence Interactive Therapy Activities (RITA) machine.

Members, visitors and supporters of the club raised the funds over the course of a year, by arranging events such as a charity golf day and an evening with ex-Grimsby Town Football Club (GTFC) legends as well as raffles and bingo nights.

Interactive Flooring

Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital

October

This year we have opened 2 new Emergency Department at Diana, Princess of Wales Hospital and Scunthorpe General Hospital. Following a successful fundraising appeal of £75,000, the new departments now have interactive flooring in the paediatric waiting area; information screens, and gaming consoles to help keep younger patients and children accompanying relatives entertained.

New Charging Banks

Diana Princess of Wales Hospital, Grimsby and Scunthorpe General Hospital

October

You won't have to worry about your phone battery dying, as the new department has mobile charging banks, to help you keep in touch with loved ones.

Highlights of the year 2022

Patient Blankets

December

All sites

We were very busy in December preparing gifts for all inpatients who unfortunately had to spend Christmas within our Hospitals.

All patients received Health Tree branded Blankets as a Merry Christmas from our charity!

Thanks to your donations and continuing support we can make these wishes come true!

A welcome to Michelle Soar

November

Diana Princess of Wales Hospital, Grimsby

We were delighted to welcome Michelle Soar to the Health Tree Foundation Team in November 2022. Shell is our Charity Coordinator Fundraising & Community for Grimsby Hospital.

Donations – Scunny Bikers, Jax, Kier, GTFC

December

All sites

Over the Christmas period we received so many kind and generous donations of gifts for our patients having to spend Christmas in our Hospitals.

Thank you so much to everyone who kindly donated.

Highlights of the year 2023

Fish pond area

January

Diana Princess of Wales Hospital, Grimsby

We are delighted that a wish has been granted for artificial grass and additional extras to be put around the fishpond at Grimsby Hospital.

As you can see this has given the area a huge enhancement which will benefit our patients daily as this is located at the centre of the hospital.

We hope you love it as much as we do.

Kris 24 hour gaming

February

Scunthorpe General Hospital

On Thursday 9th February 2023, staff member Kris Weavill (Diagnostic and Imaging Systems Manager), along with friends and colleagues, took part in a 24 hour streaming of playing computer games to raise funds for Health Tree: Surgeon Simulator 2 and Minecraft, where together with colleagues, he created a virtual hospital.

The marathon was to raise funds for the MRI appeal at Scunthorpe Hospital launched by The Health Tree Foundation. We are looking to purchase additional, enhanced equipment to make receiving an MRI more calming for patients. Thanks to Kris's fundraising, we are one step closer to being able to purchase this innovative piece of equipment as he raised a brilliant £1,176.

NHS CHARITIES TOGETHER

We have received Community Grants of £472,000 and a Development Grant of £30,000 from NHS Charities Together.

The Community Grants have been awarded to charities in the local community.

The Development Grant will be used to support Operations, Learning and Evaluation and Fund Raising allowing us to develop the Charity, improve our processes and create a new role of Digital Fundraising within our Charity.

Thank you NHS Charities Together!

The Circle of Wishes

The Circle of Wishes has been open to requests from staff and patients for items which would improve patient care within our hospitals. We received 359 different wishes throughout the 22/23 period and invested £1,155,000 in granting wishes.

Health Tree Foundation invested £1,155,000 on wishes in 22/23.

Gift in Wills

Over the past few years Health Tree Foundation had benefited greatly from legacy gifts left in people's wills.

In 2022/23 we received £141,000 in legacy income!

Choosing which charities to include in a will is a very personal choice. You might have a connection with one of the hospitals we support or perhaps Health Tree Foundation has helped you or a loved one in the past, or you may simply want to support your local NHS.

If you would like to find out more about how easy it is to support your local hospital charity through a gift in your will or to learn more about the difference we have been able to make through generous donations, please contact us at **hello@healthtreefoundation.org.uk.**

In December 2021, Health Tree Foundation received notification that we had been left a substantial legacy from the late Mrs Elizabeth Fairchild, who at the time of her death was living in the USA. The gift of £326,000, was left for the benefit of patients at Scunthorpe General Hospital. This legacy will be used to make the wards at Scunthorpe General Hospital Dementia Friendly, this includes redecoration of the bays to create a Dementia Friendly aesthetic along with purchasing RITA Machines and financing a Fixed Term post for a Dementia Care Support Worker.

HTF Lottery

The Health Tree Foundation fundraising lottery has been a great success. Tickets are £1 each. A weekly draw with a jackpot of £1,000 and 80 prizes of £10 takes place each Friday. Raise funds for your local hospital charity via weekly draws and have the chance to win up to £10,000!

A review of our finances, achievements & performance

Public Benefit

As a Charity, our main purpose is to benefit the public. Our ambition is to transform donations of time and money into making the NHS sparkle for patients throughout our local community. We couldn't do this without donations, legacies and investment, which continue to be our main sources of income. Our total assets, income and expenditure for this financial year is set out in the next few pages.

Assets

To support The Health Tree Foundation's activities, the Charity continues to maintain a healthy cash balance and investment portfolio. The stock market continues to be volatile and changes within it have impacted the valuation of our investments, however these are reviewed on a regular basis by The Health Tree Foundation Trustees Committee to explore the potential for taking mitigating actions.

The Public Perception Test

When considering its use of funds, a person should ask him or herself; Would someone who puts a pound in a collecting bucket be happy for it to be spent this way? Would you be proud to tell a donor about this expenditure, and the difference it is making, or would you find yourself defending a purchase which you know should really come from your core budget?

Total Assets

2022/2023
1,412

2021/2022
2,020

Net Assets
Increase/(Decrease)

2022/2023
(598)

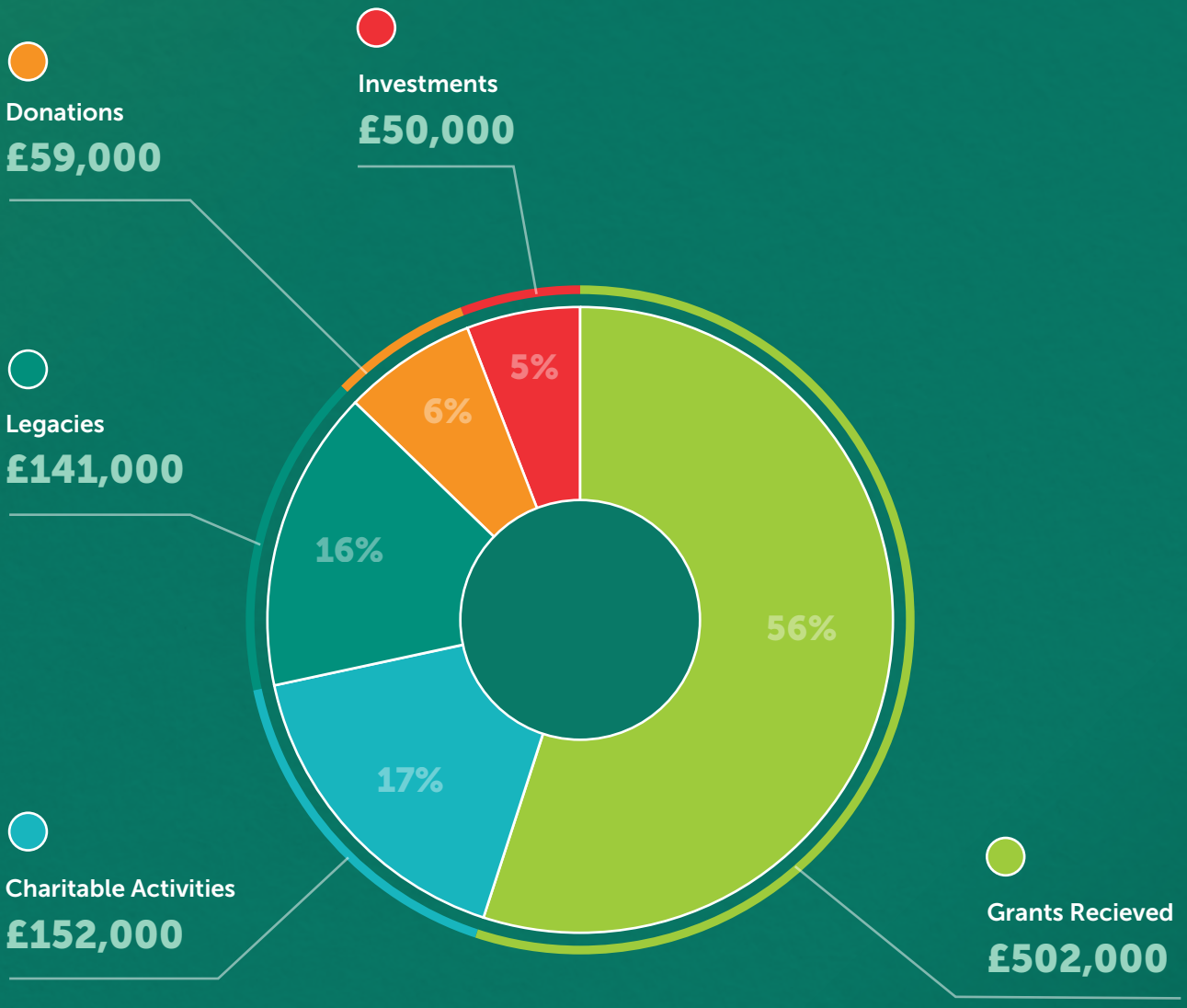
2021/2022
93

Valuation of Investments
Gain/(Loss)

2022/2023
(89)

2021/2022
138

Income
2022/2023



Total Income:
£904,000

Expenditure
2022/2023

New Equipment
£61,000

Support and Overheads
£58,000

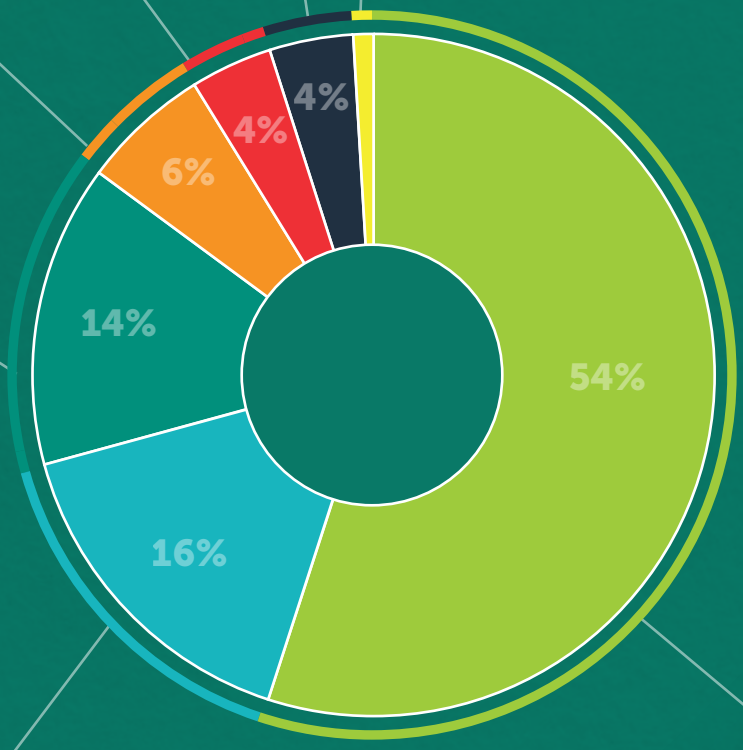
Printing, Stationary, Books & Journals
£1,000

Staff Education and Welfare
£80,000

Generating Funds
£200,000

Capital Additions
£245,000

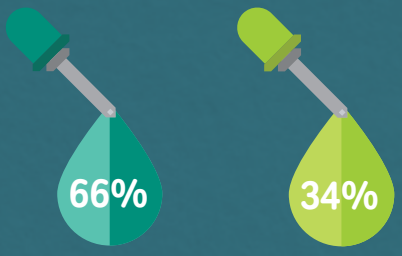
Patient welfare and amenities
£768,000



Total Expenditure:
£1,413,000

New Equipment

Buying new equipment represents a vital and valuable contribution to enhancing clinical and medical care across our region. Purchases range from small items costing a few pounds each, through to specialist diagnostic equipment costing several thousand pounds.



Medical equipment £40,000

Other Equipment, including IT equipment £21,000

Total: £61,000

Capital Additions

Capital additions reflect the money we spend on buying new assets, or improving existing ones, to further the quality of care that patients receive across our hospital sites.

Grimsby & Scunthorpe new A&E' Dept's:

• Feature Ceilings	£57,000
• Sensory Floors	£19,000
• Charge Boxes	£17,000
	£93,000
Breast Imaging/Breast Care	£61,000
Mobility Equipment	£39,000
MRI Ambient Experience	£27,000
ECG equipment	£25,000

Total: £245,000

Staff Education and Welfare

We're committed to delivering meaningful benefits to patients and their families. To do this, we need highly-skilled staff who can ensure we realise our ambitions. Training and developing our people is key to this, as is staff welfare.

Total: £80,000

Performance Management

The Health Tree Foundation does not have any direct employees. Fundraising and administration staff are seconded to the Charity from the Hull & East Yorkshire Smile Foundation, helping us keep costs down while providing the skills needed to make a real difference. These seconded employees manage our Charity, together with employees from the Northern Lincolnshire & Goole NHS Foundation Trust, ensuring we keep administration costs to a bare minimum.

Foundation Trust staff work closely with The Health Tree Foundation Trustees Committee (formerly known as Charitable Funds Committee) and the Equipment Group to identify priorities, assess the suitability of funding requests and make sure the money we spend makes a real difference to the communities we serve.

Reserves Policy & Investments

Reserves Policy Statement

The Trustees have updated the Charity's reserves policy following a review of the guidance set out by the Charity Commission, and the significant changes to Charities Statement of Recommended Practice (SORP) 2019.

The Trustees are under a legal duty to apply charitable funds in furtherance of charitable objectives within a reasonable time of receiving them. Under normal circumstances, a period of 12 months is considered reasonable; therefore the Charity would expect to hold reserves approximately equal to the running costs. This amounts to **£258,000** per year for fundraising staff costs, office costs and governance costs. The Trustees recommend that in addition to running costs, general expenditure costs for six months are maintained in reserves. Based on the 2022/2023 financial year, this would be **£578,000.** Therefore the minimum amount required to be held in reserves is **£836,000**.

The Trustees recognise that it may be necessary in the future to achieve the target level of reserves by retaining a portion of the income from investments. The Trustees consider it necessary to retain reserves over the longer term to:

- Minimise the risk should levels of donated income reduce significantly that the Charity cannot meet its obligations
- Hold sufficient reserves to ensure the Charity can cover its ongoing operational costs to process outstanding commitments.

The value of fixed asset investment goes down as well as up. Where values go down, funds need to be safeguarded from such losses through the level of reserves retained. The Trustees continue to review the balances held in all funds, in accordance with the provisions of the NHS Acts relating to charitable funds, to determine whether these are likely to be committed in the near future.

Investments

The corporate Trustee invests its charitable funds with CCLA Investment Management Ltd in their Charities Official Investment Funds (COIF). Dividends are paid directly into the Charity's bank account. As of 31 March 2023 89% (2021/2022; 88%) of non-liquid funds were invested in COIF.

As of 31 March 2023, the market value of investments were: COIF Ethical Investment Fund **£1,383K** (2021/2022; £1,772K)

The Health Tree Foundation Trustees Committee regularly reviews the level of investments and undertakes market testing to ensure the Charity has the correct balance between risk and returns, and maintains adequate liquidity.

During 2022/2023, the investments lost **£89,000** (2021/2022 gain of £138,000). The stock market continues to be volatile and the Health Tree Foundation Trustees Committee regularly reviews performance to explore the potential for mitigating action.

The Trust's ethical investment policy prevents investment in companies directly involved in the production of tobacco products, alcohol and arms.

The remaining balance of the liquid reserves are held in commercial bank accounts, which total **£170,000** (2021/2022; £246,000).

THE TRUSTEE GIVES THANKS

Northern Lincolnshire and Goole NHS Foundation Trust & Hull University Teaching Hospital NHS Trust is grateful to the many individuals, groups, associations, clubs and societies who have given generously of their time, money and bequests, to the Trust's Charitable Funds throughout the year.

On behalf of the staff and patients who have benefited from improved services and amenities they would like to express their thanks.

Approved on behalf of the Corporate Trustee

.....

Date:

Neil Gammon, Chair of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities

.....

Date:
Jonathan Lofthouse, Group Chief Executive for NLAG & HUTH

Reference and Administrative Details

The main Charity, Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related charities, registered Charity Number 1054935, was entered on the Central Register of Charities on the 26th April 1996. The Charitable Trust Funds, at 31st March 2023 is constituted of an 'Umbrella' Fund, which covers a total of 45 Funds (2021/2022:47)

The NHS Foundation Trust Board devolved responsibility for the on-going management of funds to the Health Tree Foundation Trustees' Committee (formerly Charitable Funds Committee) that administers the funds on behalf of the Corporate Trustee. The names of those people who serve as agents for the Corporate Trustee, as permitted under regulation 16 of the NHS Trusts (Membership and Procedures) Regulations 1990, is as follows as of 31st March 2023:

Mr N Gammon
Independent Chair of the Health Tree Foundation Trustees Committee, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Lyons
Chair, Northern Lincolnshire & Goole NHS Foundation Trust, Non-Executive Director

Dr P Reading
Chief Executive, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned June 2023)

Mr L Bond
Chief Financial Officer, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs C Brereton
Director of People, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned December 2022)

Mr J Johal
Director of Facilities Management, Northern Lincolnshire & Goole NHS Foundation Trust

Ms SP Liburd
Non-Executive Director (Appointed October 2022)

Mrs E Monkhouse
Chief Nurse, Northern Lincolnshire & Goole NHS Foundation Trust

Dr K Wood
Medical Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Hall
Associate Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs L Jackson
Vice Chair & Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Nearney
Director of People, Northern Lincolnshire & goole NHS Foundation Trust (Appointed January 2023)

Mrs F Osborne
Associate Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mr S Parkes
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mrs G Ponder
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust

Mr M Proctor
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned September 2022)

Mrs K Truscott
Non-Executive Director (Appointed August 2022)

Mr M Singh
Associate Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned September 2022)

Mr M Whitworth
Non-Executive Director, Northern Lincolnshire & Goole NHS Foundation Trust (Resigned September 2022)

Mr P Marchant
Chief Financial Accountant, Northern Lincolnshire & Goole NHS Foundation Trust

Principle Charitable Fund Advisor to the Board

For 2022/23, the Chief Executive of the Northern Lincolnshire and Goole NHS Foundation Trust was Dr P Reading who, under a scheme of delegated authority approved by the Corporate Trustee, has overall responsibility for the management of the Charitable Funds. Dr Peter Reading resigned in June 2023, Mr J Lofthouse was appointment Chief Exective in August 2023.

The arrangements for approval of charitable fund expenditure under the scheme of delegation of the Corporate Trustee are as follows:

Delegation Limits

£1 - £250
Authorisation from The Health Tree Foundation Charity Manager

£251 - £5,000
Further authorisation from Fund Guardian

£5,001 - £25,000
Further authorisation from Charitable Funds Clinical Champion

£25,001 - £50,000
Further authorisation from Charitable Funds Committee

£50,001 and above
To be noted by NHS Foundation Trust Board

Mr Paul Marchant acts as the Principal Officer overseeing the day-to-day financial management and accounting for the charitable funds during the year.

The Directors do not receive remuneration or expenses from the Charity.

Structure, Governance and Management

The Charity was incorporated on March 19th, 1996 by a declaration of trust deed, and all funds held on trust as at the date of registration were either part of the unrestricted funds, registered restricted funds or unregistered restricted funds.

The Corporate Trustee fulfils its legal duty by ensuring funds are spent in accordance with the objects of each fund. By designating funds, the Trustee respects the wishes of our generous donors to benefit patient care and advance the good health and welfare of patients, carers and staff. Where funds are received with specific restrictions set by the donor, the donation will be ringfenced for a specific area within the wider relevant fund – for example, Cardiology, Cancer Equipment, Ophthalmology, General Surgery, Urology, and for specific wards. The Board of Trustees manage the funds on behalf of the Corporate Trustee. The Board of Trustees consists of Executive and Non-Executive Directors. Non-Executive Directors are appointed by the Council of Governors and Executive Directors are subject to the Trust's recruitment policies.

Acting for the Corporate Trustee, The Health Tree Foundation Trustees' Committee is responsible for the overall management of the Charitable Funds. The Committee is required to:

- Provide support, guidance and encouragement for all its income-raising activities whilst managing and monitoring the receipt of all income.
- Control, manage and monitor the use of the fund's resources.
- Ensure best practice is followed in the conduct of all its affairs and fulfil all its legal responsibilities.
- Adhere to the Investment Policy, as approved by the Foundation Trust Board, and ensure performance is continually reviewed whilst being aware of ethical considerations.
- Keep the Trust Board fully informed on the activity, performance and risks of the charity.

The accounting records and the day-to-day administration of the funds are dealt with by the Finance Department's Charitable Funds section at Eastholme Building, Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA.

The fundraising, grant-making and other administration of funds are dealt with by The Health Tree Foundation, which has staff at Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA, and Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH.

Our Future Plans

The aims and objectives for the next twelve months are to continue to work to deliver on our three-year strategy. The strategy is framed around five key workstreams:

- Income generation to support a three-year Fundraising and Operations Delivery Plan.
- Internal relationships, awareness, and impact maximisation
- External communications, marketing, and community positioning
- Improved working with fund guardians
- Effective systems, processes, and governance

In addition to the workstreams, three key priority areas have been identified for 2022/23 as follows:

- Build a network of fundraisers and supporters
- Greater engagement with clinical teams and trust staff.
- Maximizing potential funds
- Our charitable expenditure will continue to be determined by the equipping needs of the hospital and may include the following areas of spend:
- Purchase of Medical equipment
- Enhancement of patient facilities
- Staff training, conferences, and educational resources
- Support of research projects

Based on the Accounts for the financial year the Trust Board, on behalf of the Corporate Trustee, believes that the Charity can meet all their current and future foreseeable commitments.

Risk Management

The Corporate Trustee is responsible for managing risk issues for the Charity, which is underpinned by the internal policies and procedures of the NHS Foundation Trust, including:

- Code of Conduct
- Standing Orders
- Fraud Policy
- Standing Financial Instructions and Scheme of Delegation

Statement of Trustees' Responsibilities

The Trustee is responsible for preparing the Trustees' Annual Report and the financial statements in accordance with applicable law and United Kingdom Accounting Standards (United Kingdom Generally Accepted Accounting Practice).

The law applicable to charities in England and Wales requires the Trustee to prepare financial statements for each financial year, which give a true and fair view of the state of affairs of the Charity and of the incoming resources and application of resources of the Charity for that period.

In preparing these financial statements, the Trustee is required to:

- Select suitable accounting policies and then apply them consistently.
- Observe the methods and principles in the Charities SORP
- Make judgments and estimates that are reasonable and prudent.
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the financial statements.
- Prepare the financial statements on the going concern basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for keeping proper accounting records that disclose with reasonable accuracy at any time the financial position of the Charity and enable them to ensure that the financial statements comply with the Charities Act 2011, the Charity (Accounts and Reports) Regulations 2008 and the provisions of the trust deed.

They are also responsible for safeguarding the assets of the Charity and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

The Trustee is responsible for the maintenance and integrity of the Charity and financial information included on the Charity's website. Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Northern Lincolnshire and Goole NHS Foundation Trust is grateful to the many individuals, groups, associations, clubs and societies who have given generously of their time, money and bequests, to the Trust's Charitable Funds throughout the year. On behalf of the staff and patients who have benefited from improved services and amenities they would like to express their thanks.

Approved on behalf of the Corporate Trustee

.....

Date:

Neil Gammon, Chair of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities

.....

Date:

Jonathan Lofthouse, Group Chief Executive for NLAG & HUTH

Independent Auditor's Report

Independent auditor's report to the Trustees of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities.

Opinion on financial statements

We have audited the financial statements of Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds and Other Related Charities (the 'charity') for the year ended 31 March 2023 which comprise Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flows, and notes to the financial statements, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland" (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the charity's affairs as at 31 March 2023 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the "Auditor's responsibilities for the audit of the financial statements" section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustees' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The trustees are responsible for the other information. The other information comprises the information included in the Annual Report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Independent Auditor's Report

Matters on which we are required to report by exception

In light of the knowledge and understanding of the charity and its environment obtained in the course of the audit, we have not identified material misstatements in the Annual Report.

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 require us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the Annual Report; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of Trustees

As explained more fully in the Statement of Trustees' Responsibilities set out on page 30, the Trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of noncompliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Based on our understanding of the charity and its industry, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, health and safety regulation, and anti-money laundering regulation.

Independent Auditor's Report

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- Inquiring of management and, where appropriate, those charged with governance, as to whether the charity is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- Inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- Communicating identified laws and regulations to the engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- Considering the risk of acts by the charity which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as the Charities Act 2011.

In addition, we evaluated the trustees' and management's incentives and opportunities for fraudulent manipulation of the financial statements, including the risk of management override of controls, and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, in particular in relation to revenue recognition (which we pinpointed to the cut off assertion, use of restricted funds, and significant one-off or unusual transactions).

Our audit procedures in relation to fraud included but were not limited to:

- Making enquiries of the trustees and management on whether they had knowledge of any actual, suspected or alleged fraud;
- Gaining an understanding of the internal controls established to mitigate risks related to fraud; Discussing amongst the engagement team the risks of fraud; and
- Addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of the audit report

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and regulations made or having effect thereunder. Our responsibility is to audit and express an opinion on the financial statements in accordance with applicable law and

International Standards on Auditing (UK). Those standards require us to comply with the Financial Reporting Council's Ethical Standard. Our audit work has been undertaken so that we might state to the charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the charity' trustees as a body for our audit work, for this report, or for the opinions we have formed.

Signed:

.....

Date:

Brian Clerkin

Senior Statutory Auditor
For and on behalf of ASM (B) Ltd
Chartered Accountants & Statutory Auditors
4th Floor Glendinning House
6 Murray Street
Belfast
BT1 6DN

Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2022/23 Financial Statements.

Statement of Financial Activities for year ended 31 March 2023

	NOTES	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	TOTAL 2022/23 £000	TOTAL 2021/22 £000
Income from:					
Donation	3.1	59	0	**59**	101
Legacies	3.1	141	0	**141**	359
Grants received	3.1	502	0	**502**	62
Charitable activities	3.2	152	0	**152**	197
Investments	3.3	50	0	**50**	51
Total Income		**904**	0	**904**	**770**
Expenditure on:					
Raising funds	4.1	200	0	**200**	182
Charitable activities	4.2	1,155	0	**1,155**	592
Governance	4.3	58	0	**58**	41
Total Expenditure		**1,413**	0	**1,413**	**815**
Net gains / (losses) on investments	6.1	(89)	0	**(89)**	138
Net movement in funds		**(598)**	0	**(598)**	**93**
Reconciliation of funds:					
Total funds brought forward		2,010	0	2,010	
Net movement in funds		(598)	0	(598)	
Total funds carried forward	**9.1**	**1,412**	**0**	**1,412**	

The notes on pages 37 to 46 form part of these financial statements.

All results from continuing operations.

All gains and losses recognised in the year are included in the Statement of Financial Activities.

There is no material difference between the net outgoing resources on ordinary activities and the net outgoing resources for the financial year stated above and their historical cost equivalents.

Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2022/23 Financial Statements.

Balance sheet for year ended 31 March 2023

	NOTES	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 MARCH 2023 TOTAL FUNDS £000	31 MARCH 2022 TOTAL FUNDS £000
Fixed assets:					
Investments	6.1	1,383	0	1,383	1,772
Total fixed assets	6.2	**1,383**	0	**1,383**	**1,772**
Current assets					
Debtors	7.1	48	0	48	30
Cash at bank and in hand	7.2	170	0	170	246
Total current assets	7	**218**	**0**	**218**	**276**
Creditors: Amounts falling due within one year	8	189	0	189	38
Current assets		**29**	0	**29**	**238**
Total net assets		**1,412**	0	**1,412**	2,010
Net assets		**1,412**	0	**1,412**	2,010
The Funds of the Charity:					
Unrestricted funds	9.2	1,412	0	**1,412**	2,010
Total charity funds	9.1 , 9.5	**1,412**	0	**1,412**	**2,010**

The notes on pages 37 to 46 form part of these financial statements.

The financial statements on pages 34 to 46 were approved by the Board of Trustees and signed on its behalf by.

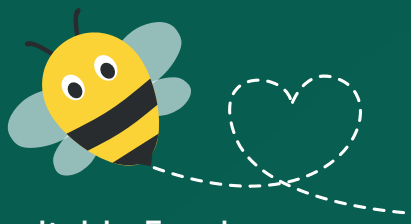
Signed:..... Date:

Mr Neil Gammon,

Chair of Northern Lincolnshire & Goole NHS Foundation

Trust Charitable Funds and Other Related Charities

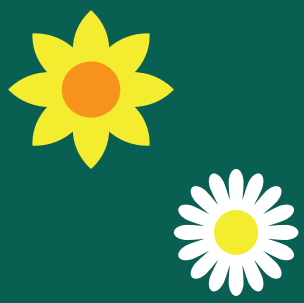
Financial Statements



Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2022/23 Financial Statements.

Statement of Cash Flows for year ended 31 March 2023

	NOTES	TOTAL 2022/23 £000	TOTAL 2021/22 £000
Cash flows from operating activities			
Operating (deficit) / surplus from continuing operations		(559)	(96)
Operating (deficit) / surplus		**(559)**	**(96)**
Non-cash income and expense:			
(Increase) / decrease in Trade and Other Receivables		(18)	(5)
(Decrease) / Increase in Trade and Other Payables		151	(40)
NET CASH (USED) / GENERATED FROM OPERATIONS		**(426)**	**(141)**
Cash flows from investing activities			
Sales of financial assets		300	0
Interest received		50	51
Net cash generated from investing activities		**350**	**51**
(Decrease) / increase in cash and cash equivalents		(76)	(90)
Cash and Cash equivalents at 1 April 2022		246	336
Cash and Cash equivalents at 31 March 2023		**170**	**246**



Financial Statements

Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities 2022/23 Financial Statements.

Notes to Financial Statements

General Information

The Northern Lincolnshire & Goole NHS Foundation Trust Charitable Funds and Other Related Charities is Charity registered with the Charity Commission for England and Wales. The working name of the Charity is the Health Tree Foundation. The Charity is incorporated in England.

Statement of compliance

The individual financial statements of Northern Linconshire and Goole NHS Foundation Trust Charitable Funds and other Related Charities have been prepared in compliance with United Kingdom Accounting Standards, including Financial Reporting Standard 102, "The Financial Reporting Standard applicable in the United Kingdom and the Republic of Ireland" ("FRS 102") and part vi of the Charities Act 2011 and the Charities (Accounts and Reports) regulations 2008.

1 Accounting Policies

1.1 Basis of Preparation

The financial statements have been prepared under the historic cost convention and going concern basis, with the exception of investments which are included at market value. The financial statements have been prepared in accordance with Accounting and Reporting by Charities: Statement of Recommended Practice (FRS102) and applicable UK Accounting Standards and the Charities Act 2011. The accounting policies have been applied consistently in dealing with items considered material in relation to the financial statements.

The principal accounting policies applied in the preparation of these financial statements are set out below. These policies have been consistently applied to all the years presented, unless otherwise stated. The company has adopted FRS 102 in these financial statements.

The Charity has taken advantage of the exemption, under FRS 102 paragraphs 11.39 to 11.48A and paragraphs 12.26 to 12.29, the requirement to disclose financial instruments, as the information is already provided in the consolidated financial statements of Northern Lincolnshire and Goole NHS Foundation Trust.

1.2 Funds Structure

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non-binding wishes or where the trustees, at their discretion, have created a fund for a specific purpose.

The Charity does not have any expendable endowments.

The major funds held in each of the above categories are disclosed in note 9.

1.3 Incoming Resources

All incoming resources are recognised once the Charity has entitlement to the resources. Provided it is probable that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

1.4 Incoming Resources from Legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is probable; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

A receipt is normally probable when;

- there has been grant of probate;
- the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and
- any conditions attached to the legacy are either within the control of the charity or have been met.

Legacies to which the Charity is entitled and for which notification has been received but uncertainty over measurement remains, are disclosed, if material, as contingent income.

1.5 Gifts in Kind

Assets given for distribution by the funds are included in the Statement of Financial Activities only when distributed.

In all cases the amount at which the gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised.

1.6 VAT and Tax

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

The Charity is a registered Charity, and as such is entitled to certain tax exemptions on income and profits from investments, and surpluses on any trading activities carried on in furtherance of the Charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

1.7 Allocation of Overhead and Support Costs

Overhead and support costs have been apportioned on an appropriate basis between all funds and are included within governance costs on the Statement of Financial Activities. The apportionment is in proportion to the quarterly aggregate balance on each of the funds or the fund incoming resources and is distributed on a quarterly basis.

1.8 Charitable Activities

Costs of charitable activities comprise all costs incurred in the pursuit of the charitable objects of the Charity. These costs comprise direct costs and an apportionment of overhead and support costs. Liabilities are recognised when an order is placed and is monitored against the fund as a commitment. Once an invoice, goods or services are received then an accrual or a payment is shown in the financial statements.

1.9 Governance Costs

Governance costs comprise all costs incurred in the governance of the Charity. These costs include costs related to statutory audit together with an apportionment of overhead and support costs.

1.10 Fixed Asset Investment

Investments are stated at market value as at the Balance Sheet date. The statement of financial activities includes the net gains and losses arising on revaluation and disposals throughout the year.

The Common Investment Fund Units are included in the Balance Sheet at the closing dealing price at 31st March 2023.

1.11 Financial Instruments

The Charity has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments are initially recognised at transaction value and subsequently measured at their settlement value. The investments held by the Charity are classified as financial assets measured at fair value through income and expenditure.

1.12 Realised Gains & Losses

All gains and losses are taken to the Statement of Financial Activities as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.13 Pooled Investments

An official pooling scheme the ***"Northern Lincolnshire and Goole NHS Foundation Trust (Expendable Funds) Common Investment Fund"*** is operated for investments relating to the following funds:

- Northern Lincolnshire and Goole (NLAG) Charitable Funds
- Scunthorpe General Hospital Charity
- Goole & District Hospital Charity
- Diana Princess of Wales Hospital Charity

The Scheme was registered with the Charity Commission on 26th August 1997.

2 Related Party Transactions

The NLAG is the sole beneficiaries of the Charity.

The Charity has provided funding to the NLAG of £928k (2021/22: £815k) for approved expenditure made on behalf of the Charity. This funding is included in the total grant making costs of £1,413k (2021/22: £815k).

The Charity has incurred administration fees of £58k (2021/22: £41k) payable to the NLAG.

Amounts due to NLAG Trust at 31st March 2023 £96k (2021/22: £19k).

2.1 Ultimate Parent

NLAG is the immediate and ultimate parent undertaking and controlling party. It's principal activity is the provision of Heathcare and it prepares fully consolidated statements which are available at the following wbesite: www.nhs.nlg NLAG is the Corporate Trustee of the Charity.

2.2 Role of volunteers

The Charity enlists the support of volunteers to achieve its objectives. The volunteers primarily assist in fundraising activities.

3 Analysis of Income Excluding Investment Income

3.1 Incoming resources from General Funds

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Donations from individuals & organisations	59	0	59	101
Legacies	141	0	141	359
Grants Received From NHS Charities Together	502	0	502	**62**
Total	**702**	0	**702**	**522**

* Community Grants of £472,000 and Development Grants of £30,000 have been received by NHS Charities Together

3.2 Incoming resources from Charitable Activities

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Fundraising	152	0	152	197
Total	**152**	**0**	**152**	197

3.3 Investment Income

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Investments in a Common Investment Fund	**50**	0	**50**	**51**
Total	**50**	0	**50**	**51**

All investments were held within the UK

Total Income	**904**	0	**904**	**770**

4. Expenditure

4.1 Expenditure on Raising Funds

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Charges for seconded staff	159	0	159	154
Other fund raising expenses	41	0	41	28
Total: Fund Raising Expenditure	**200**	0	**200**	**182**

4.2 Total Charitable Activities

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Patients Welfare and Amenities	768	0	**768**	170
Medical Equipment	40	0	**40**	6
Other Equipment including IT	21	0	**21**	8
Staff Other Equipment	0	0	**0**	1
Equipment Supplied by partner charities	0	0	**0**	9
Printing, Stationery, Books and Journals	1	0	**1**	1
Staff Welfare & Amenities	71	0	**71**	78
Staff Furniture & Fittings	1	0	**1**	1
*Training & Education including Educational Aids	7	0	**7**	14
*Travel and Subsistence	1	0	**1**	3
Capital Equipment Purchased	245	0	**245**	301
Total: Charitable Expenditure	**1,155**	0	**1,155**	**592**

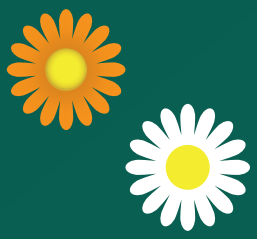
* Grants to individuals to attend training courses amounted to £ Nil (2021/22: £ Nil)

4.3 Governance Costs

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
External Audit - audit fees	6	0	6	6
Financial Services Charges and Overheads	52	0	52	35
Total	**58**	0	**58**	**41**

Financial Services Charges and Overheads includes salary costs of £40k (2021/22: £29k) related to staff resources and £5k (2021/22: Nil) reacted to system charges bought in from the Northern Lincolnshire and Goole NHS Foundation Trust. The external audit fee accounted for within the financial statements is based on prior year costs. The final agreed external audit fee for 2022-23 is £12,500.

4.4 Total resources expended



	2022/23 £000	2021/22 £000
Grants to Northern Lincolnshire and Goole NHS Foundation Trust	**928**	**815**
Total	**928**	**815**

4.4 Employee Costs & Numbers

The Charity does not have any employees (2021/22: Nil)

Charges in relation to NHS Foundation Trust staff regarding their time spent on Charitable Funds finance and administration are included within governance costs, see note 4.2.

During the year the fund raising team were seconded to Charitable Funds from the Smile Foundation.

The costs of this secondment are included within the costs of generating voluntary income. These costs are apportioned to individual funds in proportion to the income raised.

The trustee does not receive remuneration or expenses from the Charity, (2021/22: Nil)

5 Transfers

During the year there were no transfers from unrestricted funds into restricted funds (2021/22: None)

6 Investments

6.1 Movement in Fixed Asset Investment

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Market Value at 1 April	1,772	0	**1,772**	1,633
Add: Purchases at carrying value	0	0	**0**	0
Less: Disposals at carrying value	(300)	0	**(300)**	0
Add: Net gain / (loss)	(89)	0	**(89)**	138
Reclassification	0	0	**0**	1
Total: Market Value at 31 March	**1,383**	0	**1,383**	**1,772**

6.2 Fixed Asset Investments:

Investment

	Held in UK £000	2022/23 TOTAL FUNDS £000	2021/22 TOTAL FUNDS £000
Investment Fund and Fixed Interest Fund	1,383	**1,383**	1,772
Total: Market Value	**1,383**	**1,383**	**1,772**
Investments in a Common Investment Fund		**1,383**	1,772
Total: Market Value		**1,383**	1,772
All investments were held within the UK			

7 Analysis of Current Assets

7.1 Debtors Under 1 Year

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2023 TOTAL FUNDS £000	31 March 2022 TOTAL FUNDS £000
Trade Debtors	10		10	13
Prepayments	3	0	**3**	5
Other Debtors	35	0	**35**	12
Total: Debtors < 1 Year	**48**	0	**48**	**30**

7.2 Cash at bank and in hand

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2023 TOTAL FUNDS £000	31 March 2022 TOTAL FUNDS £000
Cash at bank and in hand	170	0	**170**	246
Total: Cash at bank and in hand	**170**	**0**	**170**	246
All short term investments and deposits are held in the UK with commercial banks and the Charities Official Investment Funds (COIF)				
Total of Current Assets	**218**	**0**	**218**	291

8 Creditors: Amounts falling due within one year

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2023 TOTAL FUNDS £000	31 March 2022 TOTAL FUNDS £000
Trade Creditors	68	0	**68**	4
Amounts owed to group undertakings	96	0	**96**	19
Accruals and deferred income	25	0	**25**	15
Total: Creditors: amounts falling due within one year	**189**	0	**189**	**38**

Amounts owed to group undertakings represents sums owed at the year end by the Charity to Northern Lincolnshire and Goole NHS Foundation Trust, who is a related party, for costs incurred by the NHS Foundation Trust on behalf of the charity, in the furtherance of the charity's objects.

Purchase Commitments

Orders raised at the Balance Sheet Date, for which goods have not been received amounted to £43k (2021/22; £142k).

9 Analysis of Charitable Funds

9.1 Charitable Fund Balances

	UNRESTRICTED FUNDS £000	RESTRICTED FUNDS £000	31 March 2023 TOTAL FUNDS £000	31 March 2022 TOTAL FUNDS £000
Total Charity Funds	**1,412**	**0**	**1,412**	2,010

9.2 Unrestricted Income Funds

	Fund Balance as at 01.04.22 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.23 £000
Unrestricted Funds	336	566	(684)	0	(12)	206
Unrestricted Designated Funds (See Note 9.6)	1,674	338	(729)	0	(77)	1,206
Total General & Designated Funds	**2,010**	**904**	**(1,413)**	**0**	**(89)**	**1,412**

9.3 Total charity funds

	Fund Balance as at 01.04.22 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.23 £000
Total General & Designated Funds	**2,010**	**904**	**(1,413)**	**0**	**(89)**	**1,412**

9.5 Analysis of designated fund movements

	Fund Balance as at 01.04.22 £000	Incoming Resources £000	Expended Resources £000	Funds Transferred £000	Gains and Losses Inv. £000	Fund Balance as at 31.3.23 £000
Big Thank You Appeal - Diana Princess of Wales Hospital	18	36	(46)	0	(1)	7
Big Thank You Appeal - Goole District Hospital	30	21	(32)	0	(1)	18
Big Thank You Appeal - Scunthorpe General Hospital	312	4	(75)	0	(14)	227
A&E	43	5	(50)	5	(2)	1
Big Red Heart	114	1	(27)	(5)	(5)	78
Cancer Care - General	495	29	(80)	0	(21)	423
Cancer Care - Pink Rose	141	17	(121)	0	(6)	31
Critical Care	43	9	(37)	0	(3)	12
Diabetes	53	0	(5)	0	(2)	46
End of Life Care	9	5	(7)	0	0	7
Goldern Leaves	53	9	(18)	0	(2)	42
In Your Community	75	15	(53)	0	(4)	33
Little Lives	29	55	(82)	0	(2)	0
Little Lives Bereavement	12	1	(2)	0	0	11
Medical	10	2	(10)	0	(1)	1
Research & Diagnostics	36	0	(3)	0	(1)	32
Rheumatology	54	1	(4)	0	(3)	48
Stroke	35	7	(20)	0	(2)	20
Surgery	112	121	(57)	0	(7)	169
Total General & Designated Funds	**1,674**	**338**	**(729)**	**0**	**(77)**	**1,206**

The Trustees set an opening or closing balance of £100,000 or above as the threshold for the separate reporting of material designated funds.

In the interests of accountability and transparency a complete breakdown of all such funds is available of request.

The objects of all these funds is for the welfare and benefit of staff and patients in the relevant wards and clinical areas.

10 Reconciliation of net income/(expenditure) to net cash flow from operating activities

	TOTAL 2022/23 £000	TOTAL 2021/22 £000
Net income/(expenditure) for the reporting period (as per the statement of financial activities)	(598)	93
(Gains)/Losses on investments	89	(138)
Dividends and interest from investments	(50)	(51)
(Increase)/decrease in debtors	(18)	(5)
Increase/(decrease) in creditors	151	(40)
Net cash used in operating activities	**(426)**	**(141)**

A big THANK YOU!

"Our patients, team members, doctors, they all love the revamp done, we have trips of people coming to see it.

The quality and timeframe of work was beyond our expectations, with no disturbance to our service.

New furniture and pictures are fantastic and color matching.

The foil with the picture to cover the window was absolutely brilliant idea and it looks beautiful now.

Urology Waiting Area revamp at Scunthorpe Hospital.

I've used them in Grimsby and they were brilliant.

I had an emergency visit to A&e one Saturday morning when I lost clear vision in one eye - and I didn't charge my phone the night before

Popped it in here and I knew my phone was safe and charging, I didn't have to keep near the lockers as it was locked away - no risk of it getting pinched!

And my phone had a half decent charge when I needed to ring the hubby to ask him to take me to Scunthorpe A&E.

So thank you for this wonderful addition!"

Free Mobile phone charging lockers, ChargeBox, within the A&E Waiting area.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Simon Priestley, Chief Pharmacist (NLAG)
Title of the Report	**Annual Medicines Optimisation Report 22/23**
Executive Summary (to include recommendations)	The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year. Key achievements: • The progress being made aligning formularies and shared care following the formation of the Humber Area Prescribing Committee • Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting • Expansion of the ward based Higher Level Pharmacy Support Worker role at Diana Princess of Wales Hospital and Scunthorpe General Hospital to help support movement of medications with patients to reduce waste, duplicated work, and omitted doses • Maintained improvements from 2021-2022 in Safe and Secure Storage of Medicines Key areas of concern: • National shortages across the pharmacy workforce, the impact this has on our ability to recruit and retain pharmacy staff and on pharmacy ability to undertake medicines reconciliation within 24 hours continues to be an area of concern. Key plans for next year • Improve medicines reconciliation within 24 hours of admission towards the 80% target • Revitalise Safe and Secure Quality Improvement to achieve further improvements across core standards • Build upon the Discharge Medicines Service Commissioning for Quality and Innovation framework progress to date • Implement new policy for controlled stationary to improve recording and accounting for prescriptions • Submit business case for additional investment in Band 3 Ward Based Pharmacy Support Worker role to improve availability of medicines by transferring medicines with the patient and strengthening dispensing for discharge service model • Review pharmacy services across the group to implement opportunities for collaboration to improve equity of service and deliver efficiencies

Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: QGG & QSC
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

Northern Lincolnshire and Goole NHS Foundation Trust

Medicines Optimisation

Annual Report

2022/23

Simon Priestley

Chief Pharmacist and Clinical Lead for Medicines Optimisation

July 2023

Executive Summary

The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year.

Key achievements:

- The progress being made aligning formularies and shared care following the formation of the Humber Area Prescribing Committee
- Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting
- Expansion of the ward based Higher Level Pharmacy Support Worker role at Diana Princess of Wales Hospital and Scunthorpe General Hospital to help support movement of medications with patients to reduce waste, duplicated work, and omitted doses
- Maintained improvements from 2021-2022 in Safe and Secure Storage of Medicines

Key areas of concern:

- National shortages across the pharmacy workforce, the impact this has on our ability to recruit and retain pharmacy staff and on pharmacy ability to undertake medicines reconciliation within 24 hours continues to be an area of concern.

Key plans for next year

- Improve medicines reconciliation within 24 hours of admission towards the 80% target
- Revitalise Safe and Secure Quality Improvement to achieve further improvements across core standards
- Build upon the Discharge Medicines Service Commissioning for Quality and Innovation framework progress to date
- Implement new policy for controlled stationary to improve recording and accounting for prescriptions
- Submit business case for additional investment in Band 3 Ward Based Pharmacy Support Worker role to improve availability of medicines by transferring medicines with the patient and strengthening dispensing for discharge service model
- Review pharmacy services across the group to implement opportunities for collaboration to improve equity of service and deliver efficiencies

Recommendation to the Board

This report is presented for the Board's assurance and approval.

Trust Medicines Optimisation Annual Report

1. Introduction

The purpose of this report is to:

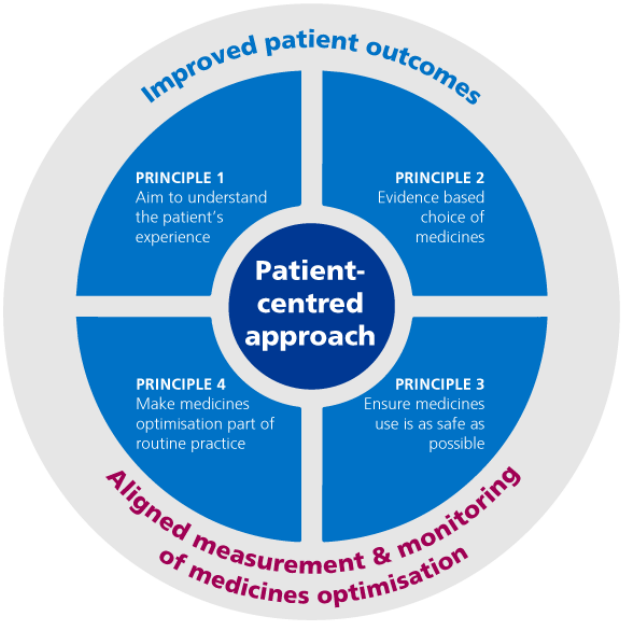
- Provide assurance to the Board that medicines are managed appropriately and effectively throughout the organisation.
- Summarise the activities and achievements relating to medicines optimisation undertaken over the last year
- Highlight the progress and areas for development with regards medicines optimisation

Several Key Performance Indicators are monitored through the year and reported to the Safer Medication Group, Quality Governance Group and Pharmacy Performance Review and Improvement Meetings. A copy of the dashboard is included as a table in appendix 1. Data for top 10 medicines savings, medication incidents per 1000 bed days and harm from medication incidents are obtained from the national Model Hospital system. These metrics haven't been updated in Model Hospital during 2022/23 and therefore were not available. The external EL(97)52 audits for the Pharmacy aseptic and the Radiopharmacy aseptic units were scheduled for January 2023 and March 2023 respectively. New action plans were subsequently developed and agreed with the external auditor. The gap in reporting on the KPI dashboard reflects the time taken to agree new action plans with the external auditor.

2. Medicines Optimisation Strategy

A medicines optimisation strategy drives the organisation's approach to medicines optimisation. It provides the framework through which medicines optimisation is managed under the overarching framework of the Trust Clinical strategy.

Medicine optimisation is the term used to describe four important principles that focus on patients and outcomes, rather than symptoms and processes:



3. Clinical Effectiveness

3.1. Medicines and Therapeutics Group

The role of the Medicines and Therapeutics Group is to approve and monitor all policies and guidance concerning medicines management within the Trust and agree the Trust position on Humber Area Prescribing Committee business, which includes controlling and managing the entry of new medicines to the joint formulary.

The Medicines and Therapeutics Group reports to the Quality and Governance Group within the Trust and to the Humber Area Prescribing Committee.

The Medicines and Therapeutics Group met eleven times out of twelve planned meetings over the year 2022-2023, with three of the eleven meetings not having sufficient attendees to be quorate. The Chief Pharmacist has recently written to the Divisional Medical Directors asking them to review and support attendance for their divisions. Once again good compliance with the formulary has been maintained, thereby ensuring patients are prescribed appropriate treatment.

3.2. Humber Area Prescribing Committee

We now have a single Humber Area Prescribing Committee website and work is progressing to align formularies and shared care agreements, addressing historical inequalities arising from different funding models across the Primary Care Networks prior to the formation of Integrated Care Systems.

3.3. Audit

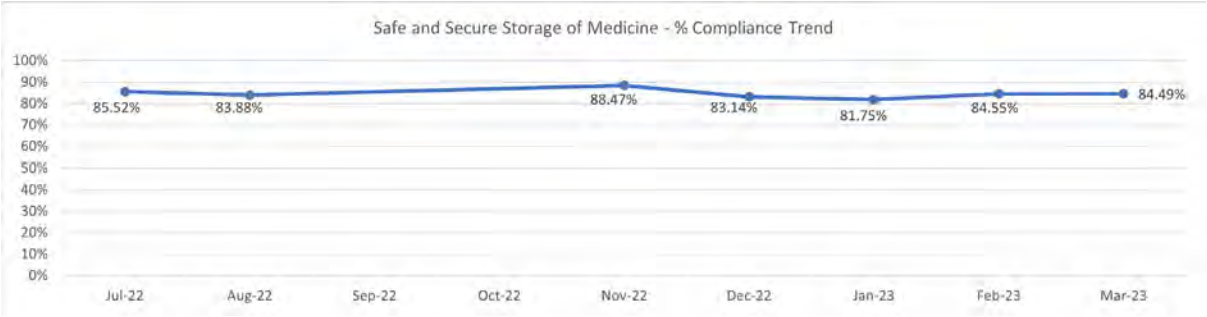
The Medicines Optimisation audit plan is overseen at the Safer Medication Group which reports to the Quality Governance Group. Over the last year a more focussed monthly Safe and Secure Handling of Medicines audit has been implemented to monitor key indicators following the positive improvements seen from the Quality Improvement work that had been undertaken. This supplements the annual audit which has been delayed this year. Overall previous improvements have been maintained however further work is required in the coming year to improve on these results.

3.3.1. Safe and Secure Handling of Medicines Audit

A full audit is conducted annually to demonstrate compliance with Care Quality Commission standards for medicines handling. All wards and departments where medicines are stored are audited. This is supplemented by monthly audits focussing on 9 priority standards:

- The area has a treatment room for the storage of medicines that can be locked.
- The treatment room door is locked when the room is not in use.
- Bulk, newly delivered ward stock is stored securely whilst awaiting transfer to medicines cupboards.
- Medicines for return to pharmacy are stored securely/appropriately prior to return to pharmacy.
- All medicines are stored in locked cupboards / medicines trolleys.
- All medicines are stored in original packaging.

- If present, the crash trolley/kit is readily accessible, in date and sealed with a tamper evident seal.
- The area has a treatment room for storage of IV fluids that can be locked.
- Medicines cabinets are in a lockable clean utility room or if not they are in an area with reliable restricted access.



Of the nine priority standards, further work is required to ensure that medicines are stored in original packaging as compliance with this standard remains in the range 60-70%.

3.3.2. Safe and Secure Storage of Controlled Stationary

In the last year we have expanded the Safe and Secure audit programme to include Controlled Stationary (prescriptions for controlled drugs, outpatient prescribing and prescriptions which can be taken to community pharmacies (FP10(HP))).

The Quarter 4 2022-2023 audit reported that 100% of areas were compliant with the standard of controlled stationary being stored securely.

As part of the effective management of prescription forms a record of prescriptions forms received and issued should be maintained in each area so their usage can be fully accounted for. This involves documenting the unique serial numbers on receipt and recording the date each form is issued and the prescriber they were issued to.

Overall compliance with this standard showed that approximately 60% of areas maintained an appropriate record, however in those areas there were several gaps in those records meaning not all prescription usage could be accounted for.

The risk of inappropriate use is partly mitigated by the fact the prescription forms are stored securely, i.e. in a locked cupboard with an Abloy lock or a key under the control of the nurse in charge of the ward/department.

A further mitigation is that the controlled drug forms and outpatient prescription forms can only be dispensed at the Trust outpatient pharmacy where they are cross referenced with a patient episode before being dispensed. If the outpatient pharmacy has any concerns about the prescription they will escalate to the hospital pharmacy team prior to dispensing.

FP10(HP) prescriptions can be dispensed by any community pharmacy therefore the focus for 2023-2024 will be on improving how FP10(HP) prescriptions are accounted for. The trust can access reports showing the items prescribed using these prescriptions via the Prescription Pricing Authority. Due to the way they are processed this information is 2 months in arrears however does enable us to request a copy of any prescriptions where we have concerns.

Work for 2023-2024 will focus on implementing a new policy for the storage of controlled stationary to ensure a clear audit trail for receipt and issue of controlled prescriptions.

3.3.3. Safe and Secure Storage of Controlled Drugs

Audits provided moderate to significant assurance relating to the Safe and Secure Storage of Controlled Drugs.

Across 19 standards, 18 standards demonstrated over 85% compliance overall and 5 standards demonstrated 100% compliance across the Trust. The key area of non-compliance involved documentation in the controlled drug register, particularly crossing out and overwriting errors rather than using brackets and an explanatory note added.

3.3.4. Medicines Reconciliation

The pharmacy service must ensure that medicine reconciliation is conducted in line with the National Institute for Health and Care Excellence Quality Statement 120 and audited in line with trust policy. The target is to undertake medicines reconciliation within 24 hours of admission for 80% of inpatients.

Due to workforce pressures the service has only achieved an average of 37% within 24 hours, however overall during the patients entire admission we provide medicines reconciliation for an average of 75% patients.

This remains an action for 2023-2024 to improve the proportion of patients who get pharmacy led medicines reconciliation within 24 hours of admission.

To mitigate the risks associated with delays in undertaking medicines reconciliation, the pharmacy team have explored ways to prioritise the patients who would benefit most. For example admissions wards are prioritised alongside intensive care, paediatric and neonatal wards when pharmacy staffing levels mean not all ward areas can receive a daily visit. Ward staff can also request pharmacy medicines reconciliation using a referral platform for patients who would benefit most i.e. on multiple medicines or complex clinical conditions.

Other options which have been explored include

- employing Advanced Clinical Practitioners to work in Emergency Departments to undertake medicines reconciliation, however there wasn't sufficient interest in these posts.
- working with locum agencies to secure additional locum pharmacists and pharmacy technicians. We have had some success and currently have 4 locums supporting the pharmacy service.

- developing a pharmacy bank to attract pharmacists and pharmacy technicians who want to have greater flexibility around their working life or are looking to change sector and want to gain some experience before committing to a permanent role.
- We have provisionally offered posts to pharmacists due to register with the General Pharmaceutical Council in January 2024.

The combination of Bank Pharmacists, locum pharmacists and new registrants in January 2024 should improve the pharmacy staffing position to the point we see an improvement in the medicines reconciliation performance.

4. Medicines Safety

4.1. Safer Medication Group

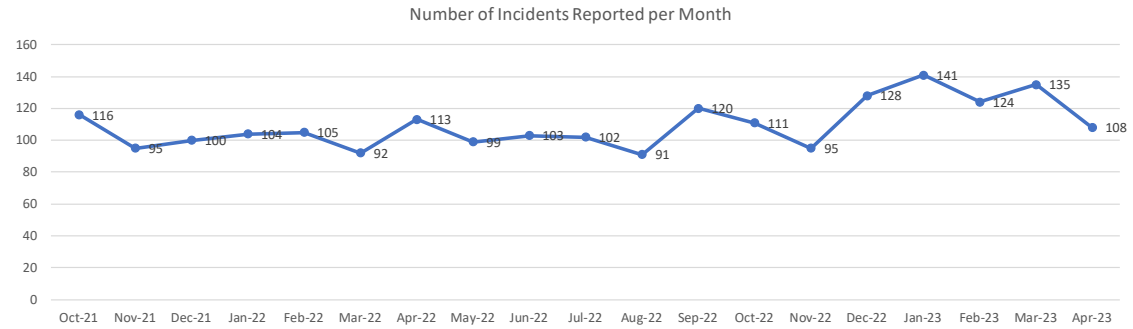
The role of the Safer Medication Group is to promote and support safer medication practice and provide assurance that the trust has in place the necessary controls to manage risk in relation to medication practice. It achieves this through its multi-disciplinary membership providing advice on the safe and effective use of medicines, sharing lessons from medication errors, seeking assurance from divisions on matters relating to medication safety and overseeing actions against recommendations outlined in National Patient Safety Alerts.

The Safer Medication Group reports into the Quality Governance Group.

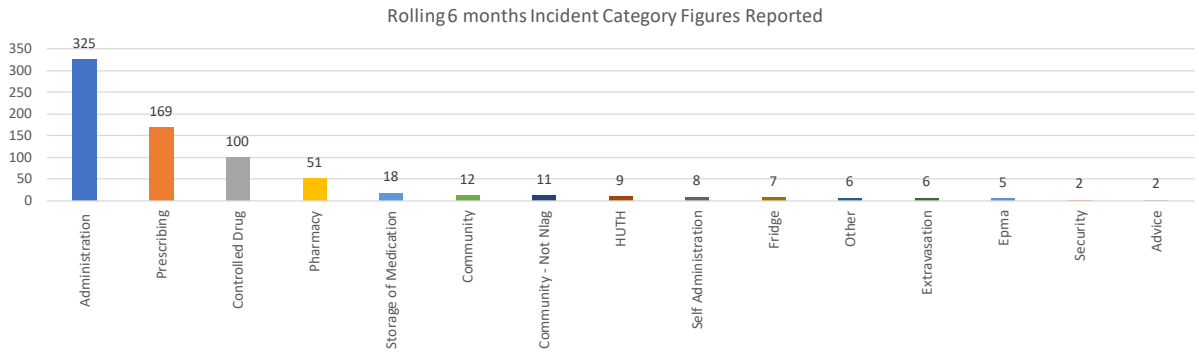
The Safer Medication Group met twelve times over the year 2022-2023, all meetings were quorate. The improvement in overall engagement and attendance seen last year has been maintained.

4.2. Medicines Incidents

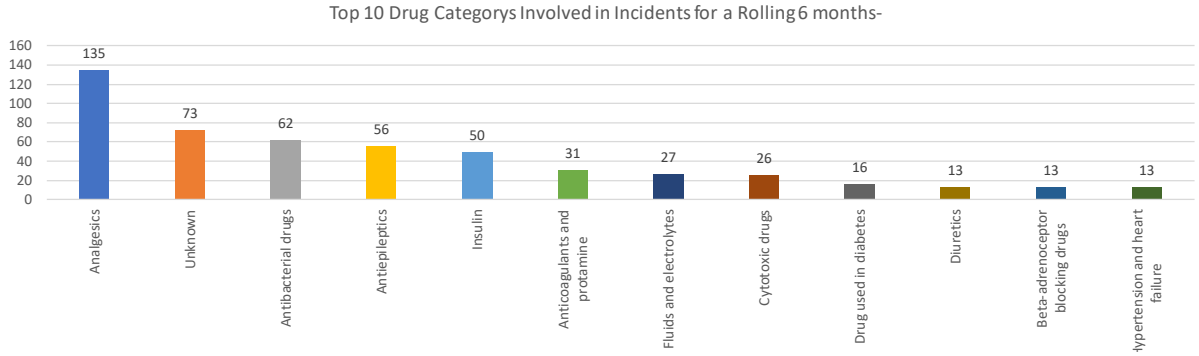
Medicine incident monthly reporting fluctuated in line with natural variation in 2022-2023, this is similar to 2021-2022.



The majority of incidents were categorised as either near miss or no harm. The highest reported category related to administration errors. Examples include omitted dose, delays in administration and administration of an incorrect drug or dose. Omitted doses are further categorised as omitted dose – drug available, omitted dose – drug not transferred with patient and omitted dose – drug not available.



The highest reported medication category related to analgesics.



4.3. Controlled Drugs

All healthcare organisations are required to promote safe and secure use of controlled drugs and ensure compliance with relevant legislative and regulatory requirements. A quarterly audit is conducted at all sites with action plans implemented where necessary.

In 2022-2023 a total of 208 incidents were reported relating to controlled drugs, a slight decrease from 2021-2022 total of 219. The majority were categorised as low risk (96% similar to 2021-2022 95%) with none categorised as extreme. Nearly half of all reported incidents continue to be errors with record keeping and minor deviations from policy not affecting patient safety. Reducing the proportion of unaccounted for losses was an action from last year's report. Some progress has been made with the proportion of incidents reporting lost controlled drugs reducing to 16% (from 20%) of reported incidents. There was also an increase in the proportion of all reported losses being accounted for following investigation, standing at 30% vs 25% last year.

All reported CD incidents are subject to review by the Specialist Pharmacy Technician - Governance as a triaging process for the Controlled Drug Accountable Officer and are shared with the Medicines Management Lead Nurse to support subsequent investigation. In cases where the investigation of a reported incident is considered insufficient by the Controlled Drug Accountable Officer, additional information will be sought from the manager investigating and additional support provided to triangulate and verify information received. Details of an individual's involvement with other controlled drug incidents are also considered as part of the investigation process. The investigation/review continues until the Controlled Drug Accountable Officer is satisfied that there is a complete picture of what went wrong, why it went wrong and what action is necessary to prevent further occurrence. The incident is then classed as "closed" by the Controlled Drug Accountable Officer. In cases where there is insufficient information, or it was

impractical to gather more details, the incident will be closed, but re-opened if further information comes to light through other incidents.

The Health Act 2006 created a new role of Accountable Officer for controlled drugs. The Controlled Drugs (Supervision of Management and Use) Regulations 2013 stipulates the requirement to appoint a Controlled Drug Accountable Officer and their roles and responsibilities. The appointment is notified to the Care Quality Commission who hold a register of Accountable Officers. The Trust Controlled Drugs Accountable Officer is the Chief Pharmacist.

The regulations permit the Accountable Officer to authorise people or groups of people to witness the destruction of controlled drugs in compliance with the regulations. The Trust medicines management nurses are appointed to witness such destructions as require witnessing in the regulations.

Accountable Officers for controlled drugs also have the responsibility to authorise individuals to enter and inspect premises in relation to the use and management of controlled drugs.

Quarterly occurrence reports of controlled drug incidents were submitted to NHS England Controlled Drug Accountable Officer in accordance with regulatory requirements.

Trust assurance is reported via the Safer Medication Group which reports to the Quality Governance Group.

4.4. Antimicrobial Stewardship

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' (National Institute for Health and Care Excellence guideline NG15, 2015). It is therefore an important part of Medicines Optimisation.

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, antimicrobial related adverse effects and the development of antimicrobial resistance, whilst maximising their clinical and cost effectiveness.
- The strategy outlines the antimicrobial activities and progress with the action plan made in 2022-2023 and activities related to antimicrobial stewardship

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary. Education and training are facilitated both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate durations of prescriptions for antimicrobials and optimise treatment for patients through an effective stewardship programme.

Local activities undertaken:

Guidelines

- Path Links paediatric antimicrobial guidelines reviewed. The plan is for them to be available on the Microguide app in 2023-1024
- Adult antimicrobial guidelines published on the Microguide app

Education and Training

- Induction training for junior doctors
- Induction training for pharmacy staff
- Point of care training
- Immunisation training
- Penicillin allergy training
- Teaching at post graduate institute

Other activities:

- The Trust Antimicrobial Consultant Pharmacist was the Chair of the Regional Antimicrobial group
- Raised the profile of antimicrobial stewardship
- Antimicrobial Stewardship ward rounds
- Local Urinary Tract Infection audit – results and actions fed back at relevant forums
- Continuing antimicrobial surveys – providing data on the prescribing of antimicrobials within the organisation
- Support for the Outpatient Parenteral Antibiotic Therapy service pilot – this has been successful and the Trust are now looking at expanding the service
- Networking with organisations within the region

National activities undertaken:

- Participation in TEACH study
- NHS benchmarking presentation
- World Antimicrobial Awareness Week
- Participation in national surveys

4.5.1. Audit and surveillance of antimicrobial use

Two antimicrobial stewardship related standards were included in the quality priorities namely the percentage of patients prescribed an antibiotic and the number of patients that have a review date documented.

The following targets were agreed for the 2022-2023:

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

Due to challenges with data collection for Q1 to Q3 – the data should not be relied upon to draw any conclusions. Data for Q4 showed the desired targets and thresholds were not achieved and specific actions will be implemented to improve this for the next financial year.

4.5.2. Trust strategy and ambitions action progress

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

Actions	Status
Continue to develop strategies to reduce overall consumption of broad-spectrum antibiotics in line with national targets where possible.	Green
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	Green
Continue to audit compliance against guidelines to ensure appropriate choice and dose prescribed. Feedback results to antimicrobial steering group, infection control committee and Medicines and Therapeutics Group quarterly	Green
Continue to use antimicrobial reduction and usage report to facilitate improvements in antimicrobial stewardship	Green
Reduce inappropriate duration of antimicrobials through effective stewardship programme.	Green
Reduce unnecessary prescriptions for antimicrobials through effective stewardship programme.	Green
Continued collaboration with regional antimicrobial pharmacists through regular network group meetings and email group to ensure shared good practice	Green
Regular review and implementation of national stewardship programmes and pathways for secondary care.	Green
Ensure electronic prescribing supports stewardship to track prescribing rates and guidance compliance	Green
Continue to review antimicrobial stock on clinical areas to ensure prompt administration of antibiotics for acute infections.	Green
Continue to monitor antimicrobial stock shortages and develop action plans to ensure optimal patient care when continuous supplies affected.	Green
Regular audit and feedback on 24-72 hour antibiotic review to reduce extended use of broad spectrum antibiotics.	Green
Regular review and implementation of national guidelines for specific infections e.g. treating uncomplicated urinary tract infections.	Green
Ensure data is submitted as required for the Antimicrobial related Commissioning for Quality and Innovation framework. Progress to be reviewed at the Antimicrobial Stewardship Group meetings.	Green
Facilitate education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses	Green
Continue to support Outpatient Parenteral Antibiotic Therapy	Green

5. Benchmarking Pharmacy Services

The Trust continues to participate in the annual NHS Benchmarking Networks Pharmacy and Medicines Optimisation. The aim is to compare pharmacy services and medicines optimisation metrics with providers across the country.

The 2023 report is the ninth iteration of the project which has taken place annually since 2015. It includes data from 78 submissions from provider organisations across the UK and contains data from 1st April 2022 to 31st March 2023.

Overall the report concludes that "a notable challenge facing pharmacy services is capacity, with factors such as high workforce vacancy limiting the available staff resource and potentially impacting the quality of care that can be provided".

Results of the 2023 data collection include:

- Total medicines cost per 100 beds — median £6m, Trust £4m
- Total pharmacy staff in post per 100 beds — median 21, Trust 15
- Total pharmacy vacancy rate — median 13%, Trust 18%
- Pharmacist time spent on clinical activities — median 80%, Trust 76%
- Pharmacy technician time spent on clinical activities — median 55%, Trust 61%

6. Workforce

Developing and maintaining a high-level workforce is a key priority. The pharmacy workforce continues to face difficulties recruiting to vacant posts. This isn't unique to the Trust. The 2023 NHS Benchmarking Networks Pharmacy and Medicines Optimisation report shows that the median pharmacy vacancy rate was 13%. We reported a rate of 17.9% with 19 organisations reporting a higher vacancy rate.

The pharmacy department is working very closely with the Trust's talent acquisition team. We have developed video's to promote both the pharmacy department and to showcase the work undertaken in our Aseptic Unit. These are used as part of our recruitment campaigns. This year we will have a stand at the Clinical Pharmacy Congress North (held in Manchester) where over 1,200 pharmacy professionals are expected to attend so we can actively showcase the Trust and promote the area.

We have been able to recruit to most of our pharmacy technician vacancies and have secured 3 locum pharmacists and 1 locum pharmacy technician to support the pharmacy service, though still have a reduced service (in line with our business continuity measures) to maintain core pharmacy service. This includes prioritising medicines reconciliation for patients admitted within the last 24 hours and medicine supply. Routine prescription reviews are undertaken at a reduced frequency; however the clinical pharmacy teams work with nursing and medical colleagues to identify and prioritise patients requiring pharmacy input. We have provisionally offered a number of pharmacist posts to trainee pharmacists who are due to register with the General Pharmaceutical Council in January 2024.

In the NHS Benchmarking Networks Pharmacy and Medicines Optimisation report the established pharmacy staff posts per 100 beds was in the bottom quartile across each staff group.

Pharmacists	median 8.1 vs Trust 5.3
Pharmacy Technicians	median 7.4 vs Trust 5.3
Pharmacy Support Worker	median 4.5 vs Trust 3.1

NHS England and Health Education England produce workforce dashboards, the most current data being for 2022. For pharmacy staffing the dashboard insights report an increase in vacancy rates for all pharmacy roles. In 2022 the vacancies figures for the pharmacy workforce across all sectors showed 20% for pharmacy technicians, 16% for pharmacists and 9% for dispensing assistants. There was a reduction in the number of pharmacists and pharmacy technicians working in community pharmacy and a significant increase in the number working in Primary Care Networks (GP practices) between numbers reported in 2021 and 2022.

The Pharmacy Aseptic Services team have also had challenges with Pharmacy Support Worker recruitment and retention. This shows in the Key Performance Indicator (appendix 1) with the Support Worker capacity by March 2023 being 45%, well within acceptable capacity limits due to vacancies, Pharmacy Technician capacity being 143% and Pharmacist capacity being 92%, both above the acceptable level as they backfill the support worker tasks to maintain a safe and effective service for our patients. To support the service we also buy in products from aseptic compounders where appropriate and have switched to using pre-made Total Parenteral Nutrition to reduce the need to make bespoke products in the unit.

7. Summary

The Annual Medicines Optimisation report provides an account of medicines management and optimisation activities undertaken over the last year. It is intended to update the Board on the Trust's medicines optimisation arrangements, outlining progress made in year, as well as the key areas of concern and plans going forward for the next year.

Key achievements:

- The progress being made aligning formularies and shared care following the formation of the Humber Area Prescribing Committee
- Achieved the Commissioning for Quality and Innovation framework linked to the implementation of the discharge medicines service to improve patient outcomes by collaboratively communicating with community pharmacies about medicines when patients transfer to a different care setting
- Expansion of the ward based Higher Level Pharmacy Support Worker role at Diana Princess of Wales Hospital and Scunthorpe General Hospital to help support movement of medications with patients to reduce waste, duplicated work, and omitted doses
- Maintained improvements from 2021-2022 in Safe and Secure Storage of Medicines

Key areas of concern:

- National shortages across the pharmacy workforce, the impact this has on our ability to recruit and retain pharmacy staff and on pharmacy ability to undertake medicines reconciliation within 24 hours continues to be an area of concern.

Key plans for next year

- Improve medicines reconciliation within 24 hours of admission towards the 80% target
- Revitalise Safe and Secure Quality Improvement to achieve further improvements across core standards
- Build upon the Discharge Medicines Service Commissioning for Quality and Innovation framework progress to date
- Implement new policy for controlled stationary to improve recording and accounting for prescriptions
- Submit business case for additional investment in Band 3 Ward Based Pharmacy Support Worker role to improve availability of medicines by transferring medicines with the patient and strengthening dispensing for discharge service model
- Review pharmacy services across the group to implement opportunities for collaboration to improve equity of service and deliver efficiencies

Recommendation to the Board

This report is presented for the Board's assurance and approval.

KPI Dashboard 2022-2023

Key Performance Indicators	Standard	Thresholds			Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Pharmacy KPIs																
Reliability of dispensing service (first check) DPOW	99.4% of items dispensed prior to final check in Pharmacy are dispensed accurately	99.4%	98.6-99.3%	98.5%	99.92%	99.92%	99.93%	99.86%	99.90%	99.93%	99.92%	99.89%	99.94%	99.96%	99.88%	99.94%
Reliability of dispensing service (first check) SGH	99.4% of items dispensed prior to final check in Pharmacy are dispensed accurately	99.4%	98.6-99.3%	98.5%	99.97%	99.89%	99.96%	99.90%	99.93%	99.75%	99.98%	99.86%	99.95%	99.83%	99.86%	99.92%
Outpatient non haem/onc prescription turnaround time DPOW	95% of prescriptions presented to Pharmacy are dispensed within 30 minutes	95.0%	85.1-94.9%	85.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Outpatient haem/onc prescriptions turnaround time DPOW	95% of prescriptions presented to Pharmacy are dispensed within 60 minutes	95.0%	85.1-94.9%	85.0%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%	96.74%
Outpatient non haem/onc prescription turnaround time SGH	95% of prescriptions presented to Pharmacy are dispensed within 30 minutes	95.0%	85.1-94.9%	85.0%	100.00%	99.84%	100.00%	100.00%	100.00%	99.07%	99.41%	100.00%	100.00%	100.00%	99.35%	100.00%
Outpatient haem/onc prescriptions turnaround time SGH	95% of prescriptions presented to Pharmacy are dispensed within 60 minutes	95.0%	85.1-94.9%	85.0%	99.60%	99.60%	100.00%	100.00%	100.00%	95.51%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
Wasted medicines	99.5% of medicines purchased are supplied to wards/departments or patients	99.5%	99.1-99.4%	99.0%	99.26%	99.98%	99.87%	99.99%	100.00%	99.96%	99.83%	99.99%	100.00%	100.00%	99.75%	99.99%
Monthly Average Daily Stockholding Model Hospital	Benchmark 15 days	15	16-20	21	12.93	14.55	14.52	15.14	17.39	14.48	17.54	14.99	16.64	16.19%	16.24%	No Data
Aseptic Capacity - Support Worker - Preparation only	Benchmark over 80% considered unsafe - Datix to be raised	0-69%	70-79%	>80%	49%	47%	57%	61%	48%	44%	41%	43%	46%	48%	45%	45%
Aseptic Capacity - Technician + management tasks	Benchmark over 100% considered unsafe - Datix to be raised	0-79%	80-99%	>100%	129%	143%	160%	167%	146%	145%	136%	139%	153%	154%	144%	143%
Aseptic Capacity- pharmacist + management tasks	Benchmark over 100% considered unsafe - Datix to be raised	0-79%	80-99%	>100%	80%	80%	95%	105%	93%	90%	88%	88%	97%	97%	93%	92%
Medicines Optimisation KPIs																
Top 10 Medicines Savings Model Hospital					Data obtained from the Model Hospital system which hasn't been updated during 2022/23											
Reported Medication Incidents per 1000 bed days	Benchmark 3.9 per 1000 bed days	4.00	3.90	3.80												
Harm from Medication Incidents	Less than the NHS Average (around 12% NPSIR Apr19-Mar 20)	Below Average	Average	Above Average												
Omitted/delayed medicines	Less than 15% of medications prescribed contained a missed dose	0.1-10.9%	11-15%	15.1-100%	1.9%	2.0%	2.1%	2.0%	2.0%	1.8%	2.4%	1.9%	1.8%	2.0%	1.9%	1.4%
Medicines Management Training (eLearning)	Trustwide mandatory training compliance monitored at Safer Medication Group				90%	90%	90%	No data available	93%	89%	89%	86%	87%	No data available	87%	87%
Safe Use of Insulin training (eLearning)	Trustwide mandatory training compliance monitored at Safer Medication Group				89%	90%	91%	No data available	94%	92%	92%	90%	91%	95%	92%	92%
Medical Gas training (elearning)	Trustwide mandatory training compliane monitored at Safer Medication Group and Medical Gas Committee				85%	85%	86%	No data available	84%	81%	81%	82%	81%	60% *	82%	83%
Statutory Inspections																
Inspection & date undertaken	**Standard**	**Outcome**	**Next inspection due**	**No. non-compliances**	**No. of non-compliances still open**											
EL(97)52 RQA audit DPOW Aseptic Preparation Suite ***30th June 2021***	Quality Assurance of Aseptic Preparation Services: Standards, 5th Edition	LOW RISK	12th January 2023	9	2	2	2	2	2	2	2	2	0	External Audit January 2023, action plan to be agreed with auditors		
EL(97)52 RQA audit DPOW Radiopharmacy ***1st July 2021***	Quality Assurance of Aseptic Preparation Services: Standards, 5th Edition	LOW RISK	14th March 2023	11	7	7	7	7	5	5	4	4	4	No update	No update	External Audit Planned

Data for top 10 medicines savings, medication incidents per 1000 bed days and harm from medication incidents are obtained from the national Model Hospital system. These metrics haven’t been updated in Model Hospital during 2022-2023 and therefore were not available.

The external EL(97)52 audits for the Pharmacy aseptic and the Radiopharmacy aseptic units were scheduled for January 2023 and March 2023 respectively. New action plans were subsequently developed and agreed with the external auditor. The gap in reporting on the KPI dashboard reflects the time taken to agree the action plans with the external auditor.

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Fiona Moore, Head of Quality Assurance
Title of the Report	**Annual Patient Reported Outcome Measures (PROMs) Report**
Purpose of the Report and Executive Summary (to include recommendations)	The Quality and Safety Committee approved the annual Patient Reported Outcome Measures (PROMs) report on behalf of the Trust Board at their meeting on 24 October 2023. Key points to note: • The Trust has improved significantly for case mix adjusted average health gains for total hip replacements as the previous year's results were outside the 95% control limits for all 3 measures and now all 3 are well within the control limit and are comparable to the England average. • The Trust's adjusted average health gain for total knee replacements has deteriorated slightly compared to previous year's findings and one of the three measures EQ Visual Analogue Scale (EQ VAS) is now outside the 95% control limit but is still within the 99.8% control limits. It is anticipated that when the Trust returns to operating on a more typical patient cohort the knee replacement EQ VAS measure will improve. • Participation rates have declined for the second year in a row but remain 8% higher than the England average. A plan is in place to improve participation rates.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: QSC
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

ANNUAL PROMs REPORT

Chief Medical Officer Directorate

Patient Reported Outcome Measures (PROMs)

Hip and Knee Replacements: Finalised data
(April 2021 – March 2022)

Contents

Introduction

The National Patient Reported Outcome Measures (PROMs) assesses the quality of care delivered to NHS patients from the patient's own perspective. The PROMs programme covers 2 procedure groups: hip replacement and knee replacement surgery. Patients are invited to complete a questionnaire prior (pre-operative) to their surgery and then again 6 months after (post-operative) surgery, to determine how much (in their own view) they have improved or worsened. From these pre and post-operative scores, health gains are calculated.

Both procedures (hip replacement and knee replacement) have scores for the EQ-5D™ Index and EQ VAS. Hip replacement and knee replacement each have their own condition-specific measure, which combine into a single score. The patient is asked to answer a number of health questions of particular relevance to their procedure.

- EQ 5D™ Index – collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- EQ Visual Analogue Scale (EQ VAS) – is a simple and easily understood 'thermometer' style measure based on a patient's self-scored general health on the day that they completed their questionnaire, which provides an indication of their health that is not necessarily associated with the condition for which they underwent surgery and which may have been influenced by factors other than healthcare.
- Oxford Hip Score (OHS) / Oxford Knee Score (OKS) – contains 12 questions on activities of daily living that assess function and residual pain in patients undergoing total hip/knee replacement surgery.

Previously, publications from NHS digital occurred biannually – in August, provisional data and then finalised data for the same data period would be published the following February. Due to delays in the completion of the development and assurance work in operational processes, provisional data, which was supposed to be published in August 2022, was published in June 2023. This was followed by the publication of the finalised PROMs data in July 2023, which normally would have been published in February 2023.

Historical Background

Provisional data from the period between April 2018 and March 2019 showed there was a statistical difference to England rates for total knee replacements, the Trust had fallen outside the 95% control limits for all three measures: the EQ-5D, EQ VAS and the Oxford Knee, which acted as an alert to a potential outlier status. A thorough review of the 18/19 data was carried out and an extensive action plan was put in place.

Data for the following finalised data period of April 2019 – March 2020 showed the Trust within the 95% control limits for all three measures (EQ-5D, EQ VAS and Oxford Hip/Knee Score) for both hip and knee replacements.

For the April 2020-March 2021 data period The Trust was within the 95% control limits for all three measures for total knee replacements but for total hip replacements all three measures (EQ-5D, EQ VAS and Oxford Hip Score) were outside the 95% control limits but were still within the 99.8% control limits. A deep dive was carried out which showed no concern for individual consultants but highlighted that lower risk patients had been transferred to the independent sector which was likely to influence the average PROMs scores.

The investigation also highlighted that the process differed across sites for handing out the pre-operative questionnaires to patients. DPoW pre-assessment nurses hand out the questionnaires to the patients at their pre-assessment appointments, whereas patients are given the questionnaires on the day of surgery at GDH. This process difference may have contributed to the participation rates results, as a handful of

patients may have had their pre-assessment at GDH and deemed too high risk for surgery there and so their surgery took place at DPoW hospital. These patients won't have been given a pre-operative questionnaire.

Current Position

Casemix-adjusted average Health Gain

Whilst the England average has deteriorated from the previous year in 2 of the 3 measures. (EQ-5D and Oxford Hip Score), for the March 2021-April 2022 period the Trust values have improved and is now within the 95% control limits for all three measures (EQ-5D, EQ VAS and Oxford Hip Score) for total hip replacements and above the England average for adjusted average health gain on the EQ 5D measure (NLAG: 0.458, England 0.456).

The Trust's adjusted average health gain for total knee replacements has deteriorated slightly compared to previous year's findings and one of the three measures (EQ VAS) is now outside the 95% control limit but is still within the 99.8% control limits. The England average has improved in all 3 measures. It is anticipated that when the Trust returns to operating on a more typical patient cohort the knee replacement EQ VAS measure will improve.

For a full breakdown of the casemix -adjusted average health gains for NLaG, please see appendices A and B.

Participation Rates

The table below shows the pre-operative participation rate, post-operative issue rate and response rate for NLaG over the last 3 years, with the results for England included as a reference. For a full breakdown of response rates, with a comparison to April 2020– March 2021 rates and a breakdown of modelled records, please see appendix C.

In summary the Trust's overall participation rate has decreased from 86.1% (in 2020/21) to 77.6% (in 2021/22), although this is still above the England average of 69.2%.

The Trust's overall issue rate has increased from 91.5% (in 2020/21) to 95.7% (in 2021/22) which is also higher than the England average of 90.3%. There has also been an increase in the response rate which was 53.8% (in 2020/21) and is now 59.1% (in 2021/22), although this is slightly lower than the England average of 61.2%.

Pre-operative participation and post-operative issue and return						
All procedures	**Northern Lincolnshire & Goole NHS Foundation Trust**			**England**		
	Participation rate	**Issue rate**	**Response rate**	**Participation rate**	**Issue rate**	**Response rate**
April 19 – March 20 (finalised)	95.5% (764 / 800)	97.3% (743/764)	69.6% (517/743)	88.4%	89.1%	68.5%
April 20- March 21 (Finalised)	86.1% ↓ (378/439)	91.5% ↓ (346/378)	53.8% ↓ (186/346)	66.5% ↓	86.0 ↓	59.5% ↓
April 21- March 22 (Finalised)	77.6%↓ (514/662)	95.7%↑ (492/514)	59.1%↑ (291/492)	69.2%↑	90.3%↑	61.2%↑

- **Participation rate:** an approximation of the rate of participation in PROMs by the organisations patients, being the number of pre-operative questionnaires returned as a percentage of eligible hospital inpatient procedures carried out by the organisation.
- **Post-operative issue rate:** percentage of returned pre-operative questionnaires for which a post-operative questionnaire has been sent to the patient.
- **Post-operative response rate:** percentage of issued post-operative questionnaires which have been returned.

Issue rates and response rates are not in The Trust's control as Quality Health issue the post-operative questionnaires. The response rate depends on how many patients return their questionnaire. Quality Health initially send the patient a full pack which consists of a covering letter, a questionnaire and a returns envelope. All non-responders then receive a reminder letter 3 weeks later and then 3 weeks after that all non-responders receive another full pack encouraging them to complete the PROMS questionnaire.

Discussion

The results have been discussed with the Clinical Lead who was satisfied with the results for hip replacement patients. The knee replacement EQ VAS measure, for which the Trust has fallen outside the 95% control limit, but is still within the 99.8% control limit, is considered to be a generalised wellbeing score, rather than a specific knee operation outcomes score. The scores which are more relevant to the specific condition are still within the expected range.

The patient cohort from the data collection period (April 2021 – March 2022) included a large group of patients who had waited a long time for their procedure and also numerous patients transferred from outside the Trust (e.g. Hull) who tended to also be patients who had waited a long time for the procedure or were high risk patients. Due to these factors these patients are likely to be less satisfied in general and are likely to be more negative about the procedure. It is anticipated that when the Trust returns to operating on a more typical patient cohort the knee replacement EQ VAS measure will improve. No clinically related actions are recommended currently.

Conclusion

The Trust has improved significantly for casemix adjusted average health gains for total hip replacements as the previous year's results were outside the 95% control limits for all 3 measures and now all 3 are well within the control limit and are comparable to the England average. Although there has been a decline for total knee replacements, 2 measures are still within the 95% control limit. The EQ VAS value for knee replacements is now outside the 95% control limit but is still within the 99.8% control limit.

Participation rates have declined for the second year in a row but remain 8% higher than the England average.

Next steps

To improve participation rates, the process for handing out the questionnaires should be the same across the Trust so patients who are pre-assessed at one site and then have surgery at another won't be missed. A trial is taking place at DPOW for the ward clerk to hand out the pre-operative questionnaires on the day of the patient's surgery which will mirror the current process at GDH. A full action plan is contained in Appendix D.

Appendix A: Casemix-adjusted average Health Gain

The data report link received from NHS Digital provides a spreadsheet of each provider's/Trusts results and contains a funnel plot tab giving the ability to compare the score of participating organisations to the national picture.

How to interpret funnel plots

An organisation outside of the dashed inner funnel plot lines is statistically different to the national average using 95% confidence intervals.

An organisation outside of the dotted outer funnel plot lines is statistically different to the national average at 99.8% level. This means that, as there are only 1 in 500 chances that the organisation is an outlier by chance, there is very likely to be a 'special cause' for this variation.

For all of the procedures and measures in this report:

- If an organisation is a positive outlier (at the top end of the charts in this report) then it is achieving health gains which are significantly better than average and can be used as an example of good practice.

- If it is a negative outlier (at the bottom end of the chart) then it is achieving health gains which are significantly worse than average and the reasons for this need to be understood. If it is between the inner and outer funnel plot lines, it is classed as an alert; more seriously, if it is outside the outer funnel plot line it is classed as an alarm.

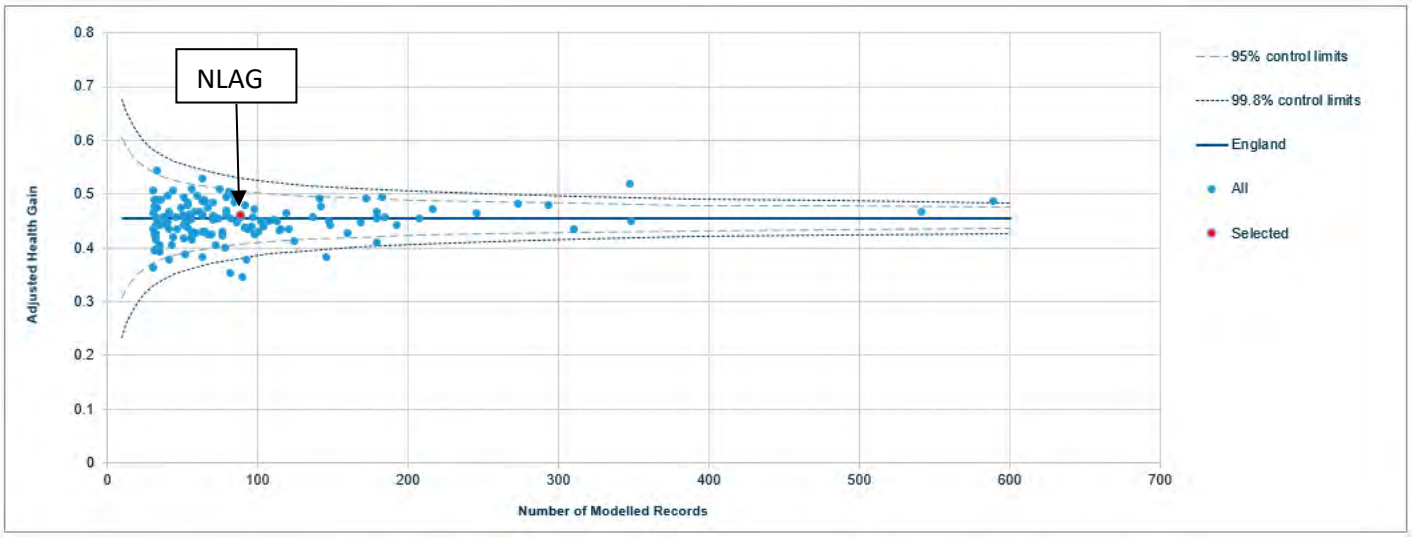
The PROMs funnel plots show the level of adjusted health gain by NLaG patients against the volume of modelled records for a 12 month period (April 21 – March 22) for hip and knee replacements.

Note: *The **EQ-5D™ Index** score ranges from -0.594 (worst possible health) to 1.0 (full health). This is the patient's **self-reported** health.*

Note: *The **EQ Visual Analogue Scale (EQ VAS)** is the patient's **own global rating** of their overall health gain on a 0 – 100 scale (0=worst health state imaginable, 100=best health state imaginable).*

Note: *The **Oxford Hip Score (OHS)/ Oxford Knee Score (OKS)** score ranges from 0 (worst) to 48 (best).*
Note: *Modelled records are the number of questionnaire-pairs for which it has been possible to apply the casemix-adjustment model.*

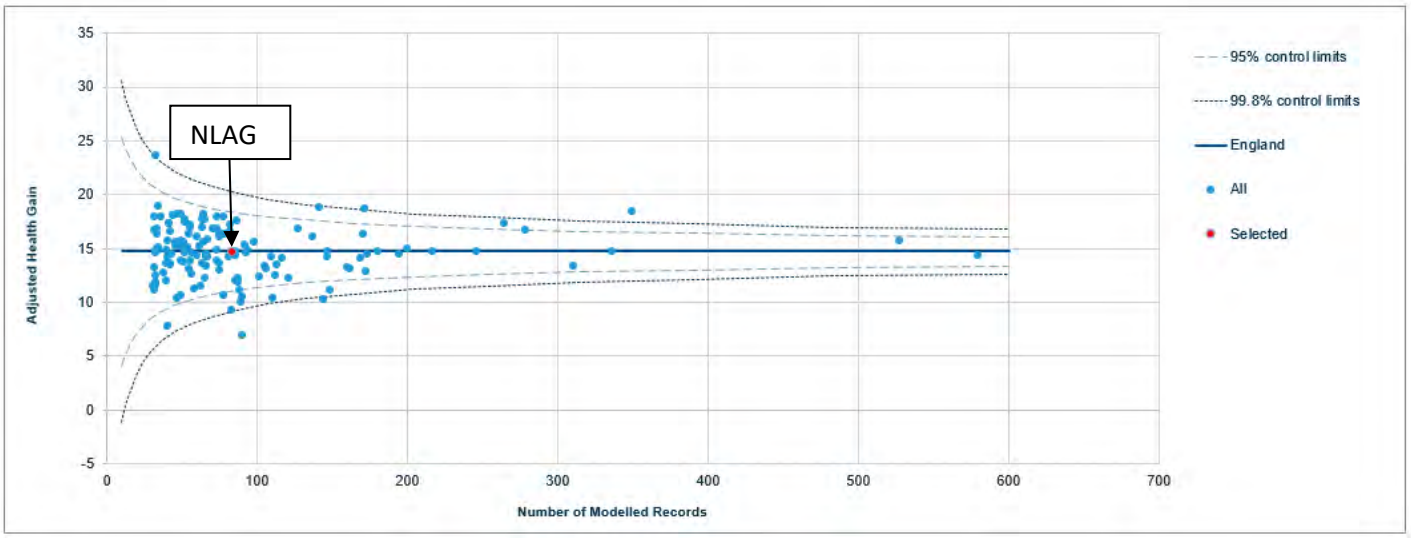
Hip Replacement: EQ-5D Index



Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
89	0.458	0.456	0.408	0.505	0.380	0.533

- The adjusted average health gain on the EQ-5D Index for total hip replacement respondents following their operation was 0.458 (0.456 in England).
- The adjusted average health gain on the EQ-5D Index for hip replacement primary respondents following their operation was 0.465 (0.462 in England).
- The adjusted average health gain for hip replacement (revision) respondents could not be calculated as there were fewer than 30 modelled records.

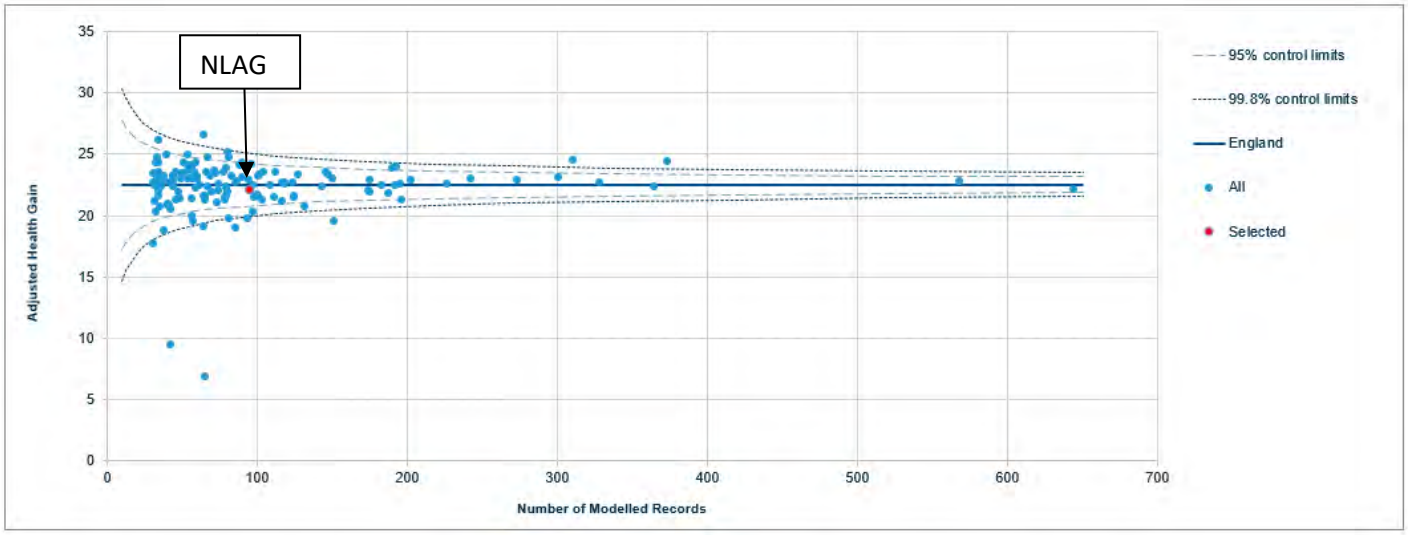
Hip Replacement: EQ-Vas



Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
84	14.586	14.717	11.132	18.301	9.065	20.368

- The adjusted average health gain on the EQ-VAS Index for total hip replacement respondents following their operation was 14.586 (14.717 in England).
- The adjusted average health gain on the EQ-VAS Index for hip replacement primary respondents following their operation was 14.939 (14.985 in England).
- The adjusted average health gain for hip replacement (revision) respondents could not be calculated as there were fewer than 30 modelled

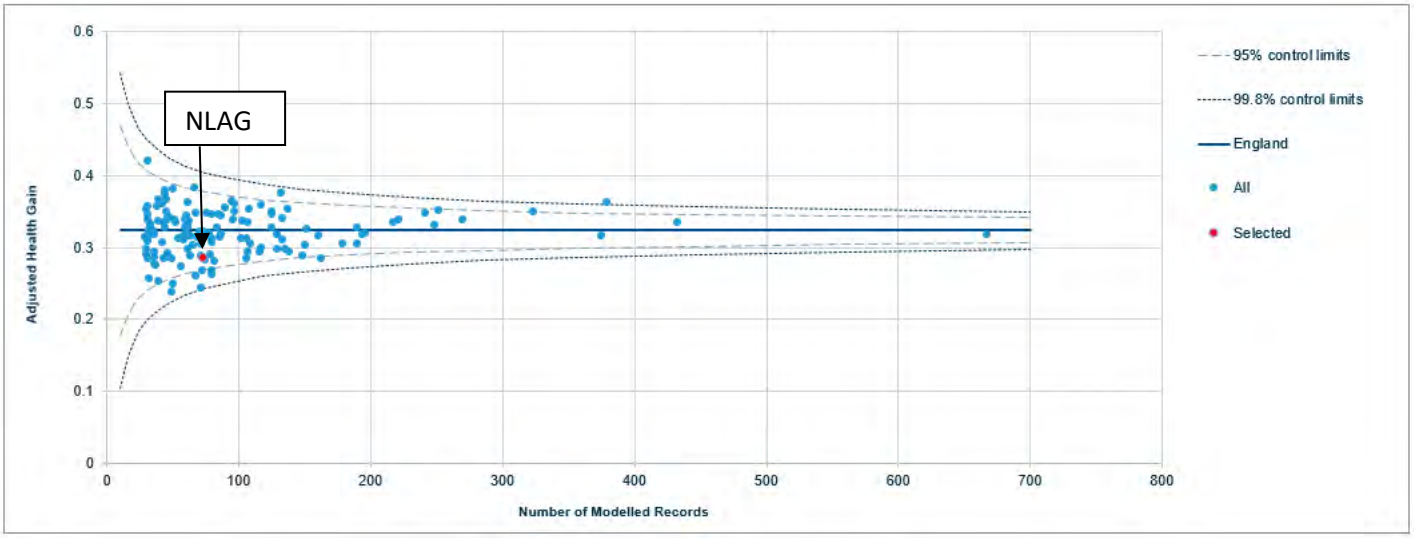
Hip Replacement: Oxford Hip Score



Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
95	22.023	22.515	20.851	24.180	19.890	25.140

- The adjusted average health gain on the Oxford Hip Score for total hip replacement respondents following their operation was 22.023 (22.515 in England).
- The adjusted average health gain on the Oxford Hip Score for hip replacement primary respondents following their operation was 22.482 (22.847 in England).
- The adjusted average health gain for hip replacement (revision) respondents could not be calculated as there were fewer than 30 modelled

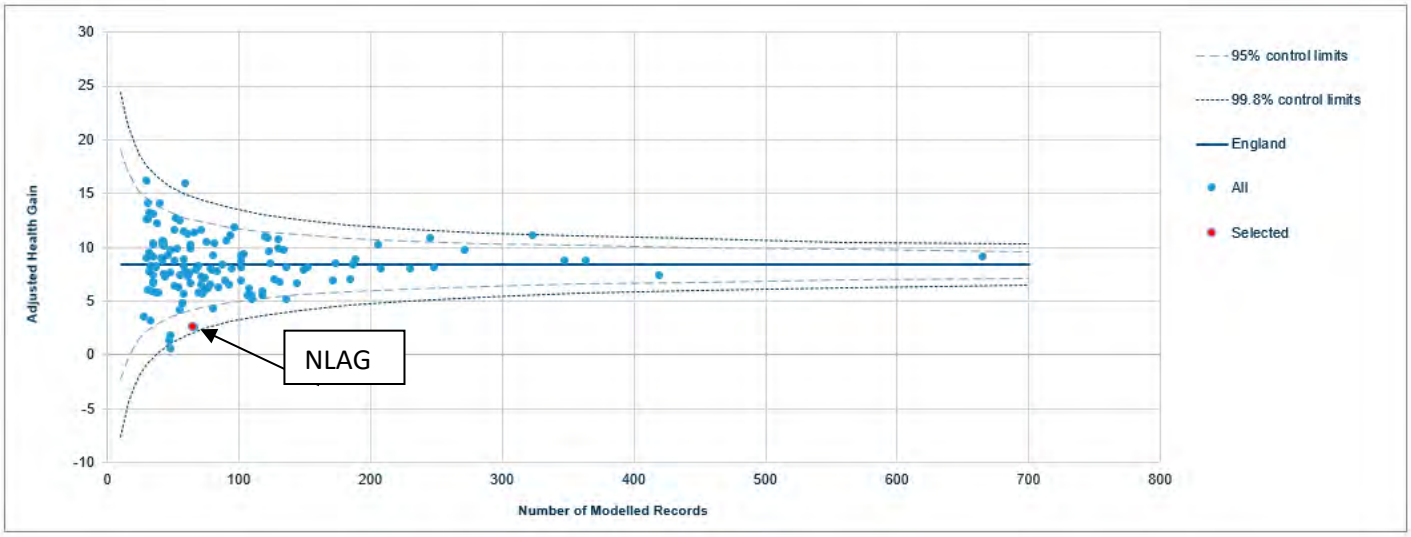
Knee Replacement: EQ-5D Index



Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
74	0.284	0.324	0.271	0.376	0.240	0.407

- The adjusted average health gain on the EQ-5D Index for total knee replacement respondents following their operation was 0.284 (0.324 in England).
- The adjusted average health gain on the EQ-5D Index for knee replacement primary respondents following their operation was 0.288 (0.324 in England).
- The adjusted average health gain for knee replacement (revision) respondents could not be calculated as there were fewer than 30 modelled

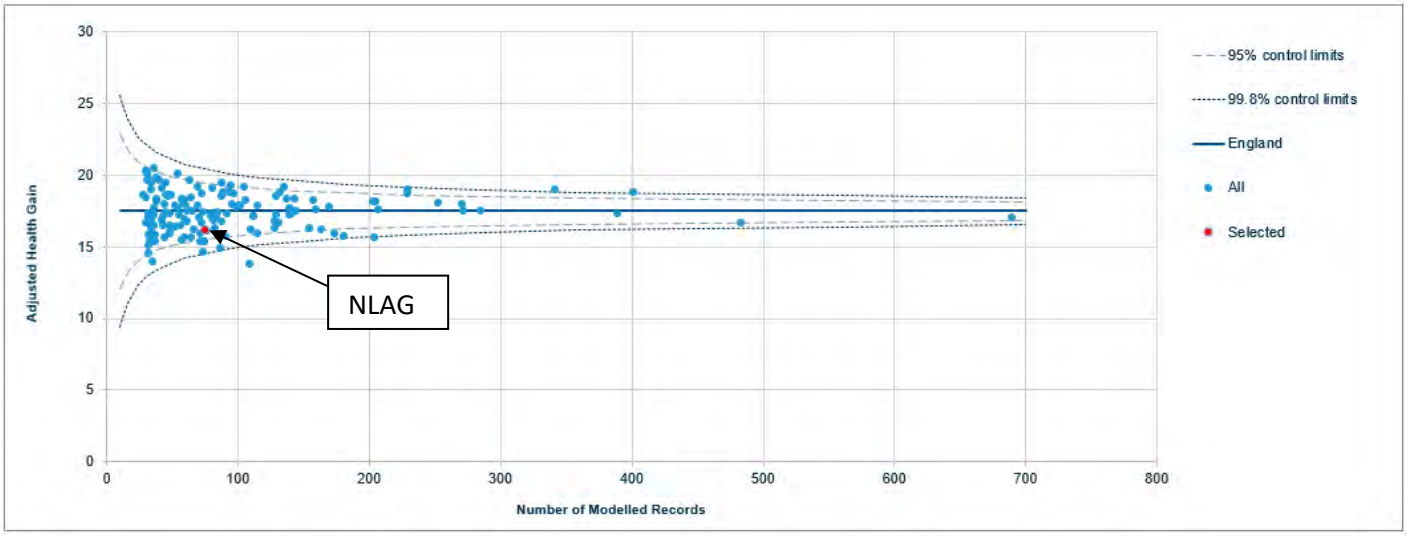
Knee Replacement: EQ-VAS



Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
66	2.550	8.360	4.279	12.441	1.926	14.794

- The adjusted average health gain on the EQ-VAS Index for total knee replacement respondents following their operation was 2.550 (8.360 in England).
- The adjusted average health gain on the EQ-VAS Index for knee replacement primary respondents following their operation was 2.676 (8.407 in England).
- The adjusted average health gain for knee replacement (revision) respondents could not be calculated as there were fewer than 30 modelled

Knee Replacement: Oxford Knee Score



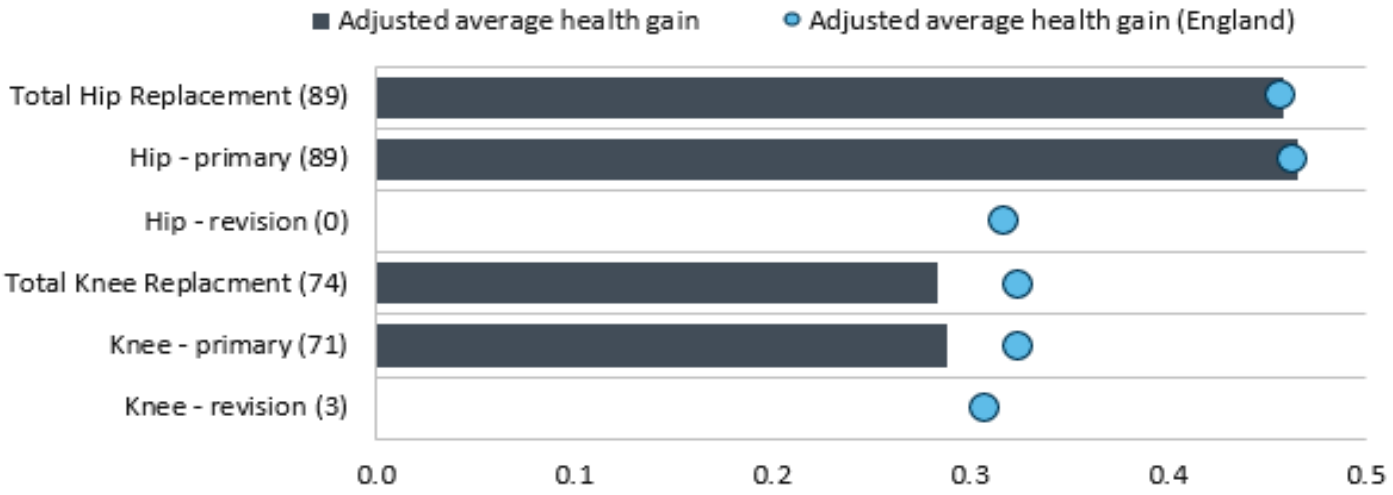
Modelled records	Adjusted average Health Gain	England average	Lower 95% control limit	Upper 95% control limit	Lower 99.8% control limit	Upper 99.8% control limit
76	16.092	17.482	15.578	19.386	14.479	20.484

- The adjusted average health gain on the Oxford Knee Score for total knee replacement respondents following their operation was 16.092 (17.482 in England).
- The adjusted average health gain on the Oxford Knee Score Index for knee replacement primary respondents following their operation was 16.362 (17.625 in England).
- The adjusted average health gain for knee replacement (revision) respondents could not be calculated as there were fewer than 30 modelled

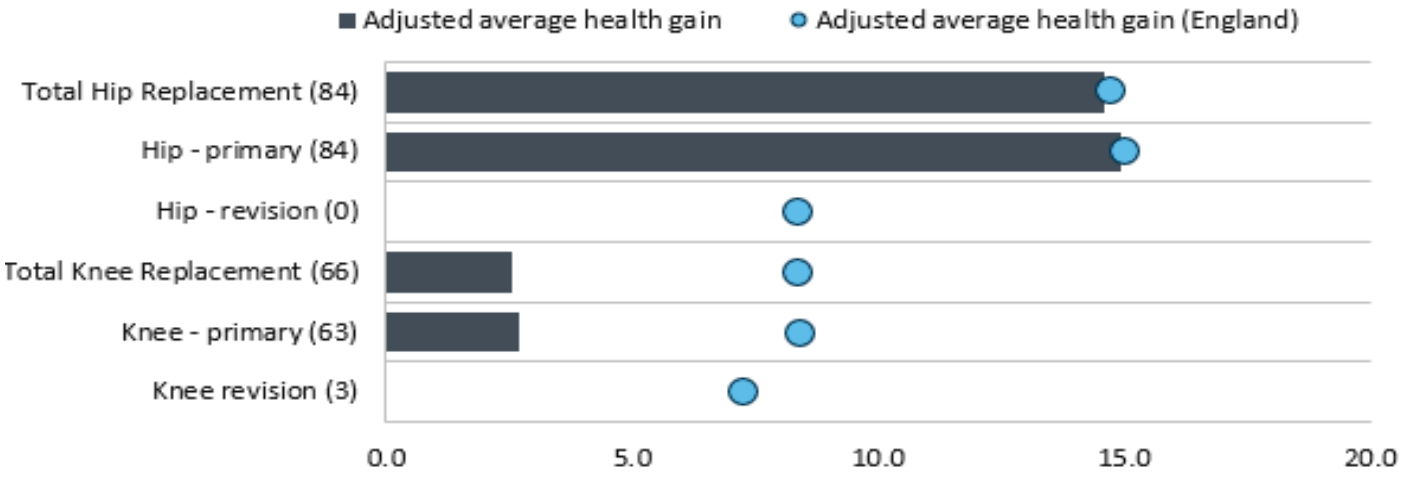
Appendix B: Adjusted average health gain (NLaG vs England)

The adjusted average health gain for hip replacement (revision) and knee replacement (revision) respondents could not be calculated as there were fewer than 30 modelled records. Casemix-adjusted figures are not calculated when there are fewer than 30 modelled records, as the underlying statistical models break down when counts are low and aggregate calculations based on small numbers may return unrepresentative results.

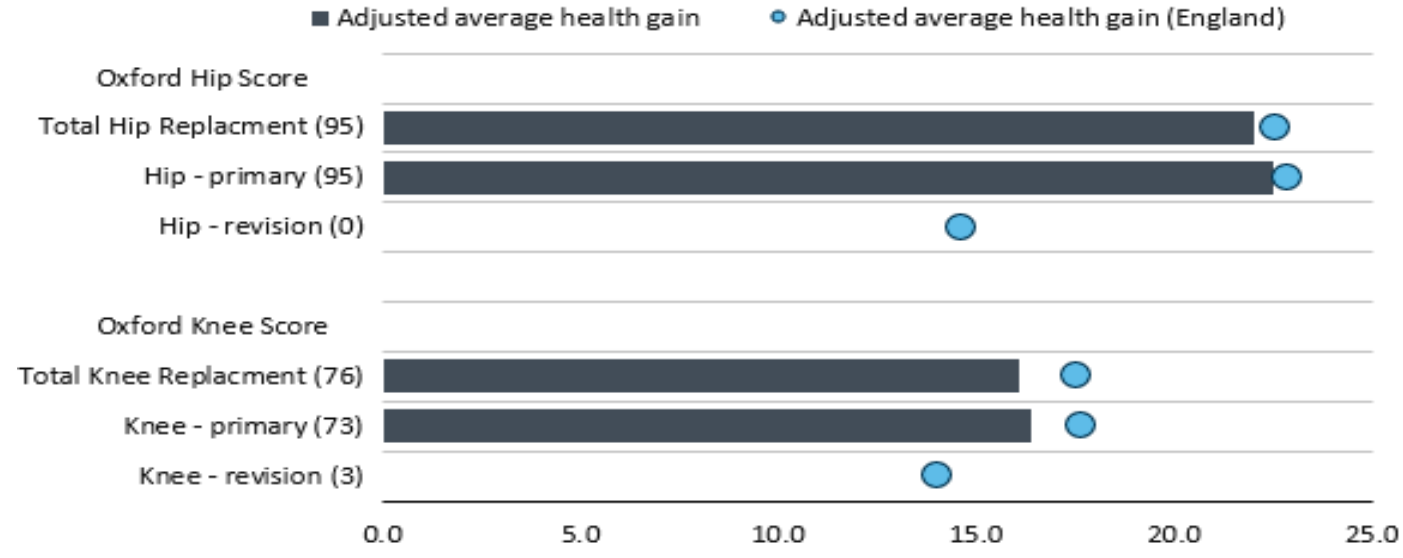
EQ-5D Index (a combination of five criteria concerning general health)



EQ VAS (current state of the patient's general health marked on a visual analogue scale)



Condition Specific Measures (a series of questions specific to the patient's condition)



Appendix C: Participation rate and response rate

There were 662 eligible hip and knee replacement hospital episodes/procedures within our Trust during the given time period of April 2021 – March 2022.

- **Pre-operative Participation Rate:** In total, 514 pre-operative questionnaires were returned. The Trust is accountable for giving out pre-operative questionnaires to the patients and returning them to Quality Health. At DPoW, patients are invited to complete a pre-op questionnaire during their pre-op assessment and at GDH this happens on the day of surgery. The completed pre-op forms are posted to PROMs each month (this is the **participation rate**). The Trust's participation rate was 77.6% in comparison to the England average of 66.5%.
- **Post-operative Response Rate:** Quality Health is responsible for distributing the post-operative questionnaires to the patients 6 months after their procedure based on the pre-operative questionnaires that they receive from the Trust (this is the **issue rate**). Of the 492 post-operative questionnaires sent out by Quality Health, 291 completed questionnaires have been returned. This brought the response rate of post-operative questionnaires to 59.1% which is just below the national (England) average of 61.2%.

The tables below show a comparison of the pre-operative participation and linkage rate from 20/21 (finalised data) and 21/22 (finalised data).

April 20 – March 21 (finalised data)

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	439	378	86.1%	218	57.7%
Hip Replacement	220	192	87.3%	104	54.2%
of which[1]					
Primary	204	98	48.0%	98	100.0%
Revision	16	6	37.5%	6	100.0%
Knee Replacement	219	186	84.9%	114	61.3%
of which[1]					
Primary	201	108	53.7%	108	100.0%
Revision	18	6	33.3%	6	100.0%

Linkage rate is the rate of which pre-operate questionnaires are linked to HES records.

April 21 – March 22 (finalised data)

Table 1: Pre-operative participation and linkage

	Eligible hospital procedures	Pre-operative questionnaires completed2	Participation Rate	Pre-operative questionnaires linked	Linkage Rate
All Procedures	662	514	77.6%	303	58.9%
Hip Replacement	280	248	88.6%	149	60.1%
of which1					
Primary	268	*	*	*	*
Revision	12	*	*	*	*
Knee Replacement	382	266	69.6%	154	57.9%
of which1					
Primary	356	*	*	*	*
Revision	26	*	*	*	*

The tables below show a comparison of the post-operative issue and response rate from 20/21 (finalised data) and 21/22 (finalised data).

April 20 – March 21 (finalised data)

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned[2]	Response Rate
All Procedures	378	346	91.5%	186	53.8%
Hip Replacement	192	172	89.6%	96	55.8%
of which *					
Primary	98	98	100.0%	80	81.6%
Revision	6	6	100.0%	4	66.7%
Knee Replacement	186	174	93.5%	90	51.7%
of which *					
Primary	108	105	97.2%	76	72.4%
Revision	6	6	100.0%	6	100.0%

April 21 – March 22 (finalised data)

Table 2: Post-operative issue and return

	Pre-operative questionnaires completed	Post-operative questionnaires sent out	Issue Rate	Post-operative questionnaires returned	Response Rate
All Procedures	514	492	95.7%	291	59.1%
Hip Replacement	248	245	98.8%	153	62.4%
*of which**					
Primary	*	*	*	103	*
Revision	*	*	*	0	*
Knee Replacement	266	247	92.9%	138	55.9%
*of which**					
Primary	*	*	*	*	*
Revision	*	*	*	*	*

Modelled Records

Modelled records are the number of questionnaire-pairs for which it has been possible to apply the casemix-adjusted model. The latest finalised data shows that there are currently fewer modelled records in comparison to previous years for total knee replacements but a slight increase for total hip replacements from the previous year. Both procedures are still significantly lower than pre-COVID levels.

Modelled records	Total Hip Replacement			Total Knee Replacement		
	EQ-5D Index	EQ VAS	Oxford Hip Score	EQ-5D Index	EQ VAS	Oxford Knee Score
April 19 – March 20 (finalised)	183	172	201	250	243	271
April 20 – March 21 (finalised)	79	71	87	79	73	83
April 21 – March 22 (finalised)	89	84	95	74	66	76

Appendix D - Action Plan

Ref	Recommendation (what are the key learning points / what changes need to be made)	Action	Action by Date	Person Responsible (Name and job title)	Evidence of Completion (sources of verification)	Action Status (Ongoing/ Complete/ Overdue)
Participation rates	To improve participation rates by replicating the hand out process of pre-operative questionnaires at both sites.	A trail at DPOW to take place for the ward clerk to hand out the pre-operative questionnaires on the day of the patient's surgery to mirror the process at GDH.	30.11.2023	Laura Cook - NLAG Lead Pre Assessment Nurse	Email from Lead pre-Assessment Nurse	Ongoing
Re-audit Details: (*Re-evaluation should only be conducted when there are indications that changes to practice have been made. They should not occur simply because a specified time period has passed. Rapid cycle audits/QIPs can be undertaken to demonstrate if improvements have been made and sustained)*						

Forum for sharing	Date
Quality and Safety Committee	24/10/2023
Trauma and Orthopaedics Audit Meeting	13/11/2023
Signed off at S&CC Governance Meeting	TBC

Name of the Meeting	**Trust Board of Directors**
Date of the Meeting	5 December 2023
Director Lead	Dr Kate Wood, Group Chief Medical Officer
Contact Officer/Author	Richard Dickinson, Associate Director of Quality Governance Kelly Burcham, Head of Risk Jess Smaller, Risk and Learning Manager
Title of the Report	**Serious Incident Annual Report for 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	This report provides an analysis of Serious Incidents (SIs) reported by Northern Lincolnshire and Goole NHS Foundation Trust via the Strategic Executive Information System (STEIS) during the period 01 April 2022 to 31 March 2023. This report aims to provide assurance of a robust system for identification and investigation of serious incidents in line with the Serious Incident Framework (NHS England 2015 Revised 2018) and associated Trust policy; in particular that investigations determine why the incident occurred, identifies the key learning and recommendations to prevent or significantly reduce further similar incidents occurring. This report has been presented at Quality and Safety Committee in October 2023, where the report was commended to Trust Board.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: QSC commended
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

2022-23
ANNUAL REPORT

SERIOUS INCIDENT INVESTIGATIONS

Report Period: 01 April 2022 – 31 March 2023

Contents

1.0 EXECUTIVE SUMMARY

This report provides an analysis of Serious Incidents (SIs) reported by Northern Lincolnshire and Goole NHS Foundation Trust via the Strategic Executive Information System (STEIS) during the period 01 April 2022 to 31 March 2023.

This report aims to provide assurance of a robust system of incident investigation into why patient safety incidents occurred, what lessons were identified, and recommendations made to prevent further similar incidents re-occurring.

Key points to note are:

- ✓ A total number of 27,503 Incidents were reported onto the NLAG's reporting platform Ulysses.
- ✓ There were 112 SIs declared compared to 123 in 2021-22 and 95 in 2020-21.
- ✓ 73 (65%) of declared SIs were Pressure Ulcers.
- ✓ SIs represented 0.40% of all incidents reported within NLAG
- ✓ 15 SIs were reported and subsequently de-logged. This continues to decrease from previous reporting periods: 18 de-logs during 2021–22 and 73 during 2020-21.
- ✓ 84% of SIs submitted to the ICB were assured upon first review.
- ✓ Medicine division had the highest number of SIs declared in 2022-23 with 46% of the total number. Medicine also had the highest activity and patient flow.
- ✓ 1 Never Event was declared (description of a Never Event has been highlighted later in this report) which occurred within the Surgery & Critical Care division.

Internal Audit Reports – Serious Incident Management

Reviews undertaken to provide assurance to management and the Board that the Trust has effective systems and processes in place for Serious Incident Management.

Report Published Date	Overall Opinion
January 2016	Significant Assurance
June 2020	Significant Assurance
April 2022	Significant Assurance

All associated actions in relation to minor improvement recommendations have been implemented.

2.0 SERIOUS INCIDENT ACTIVITY

SIs are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. SIs can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

The criteria for a SI is detailed within the Serious Incident Framework (NHS England 2015 Revised 2018) as well as within the Trusts Policy for Dealing with Serious Incidents (2022).

A total of 112 incidents were reported onto STEIS as declared SIs and thereby reported to the relevant ICB. A further 15 incidents were reported and subsequently de-logged.

De-logging is a process by which the Trust requests an incident is removed from STEIS and downgraded from a SI as further information has been identified meaning that it does not meet the criteria for a declaration or no harm to the patient was identified. Agreement to de-log is sought from internal processes such as Chief Nurse Directorate (Falls & Pressure Ulcers) and the SI Panel before being agreed by the relevant ICB, who in turn obtain permission to de-log from NHS England.

The incidents de-logged have been identifed below:

De-Logged Incident Type:	Number of De-Logged Incidents:
Fall- Fracture Neck of Femur	9
Fall – severe head injury death	2
Fall – Subdural Haematoma	1
Fall – unexpected death	1
Unexpected Death – deteriorating patient	1
Femoral fracture	1
Total:	**15**

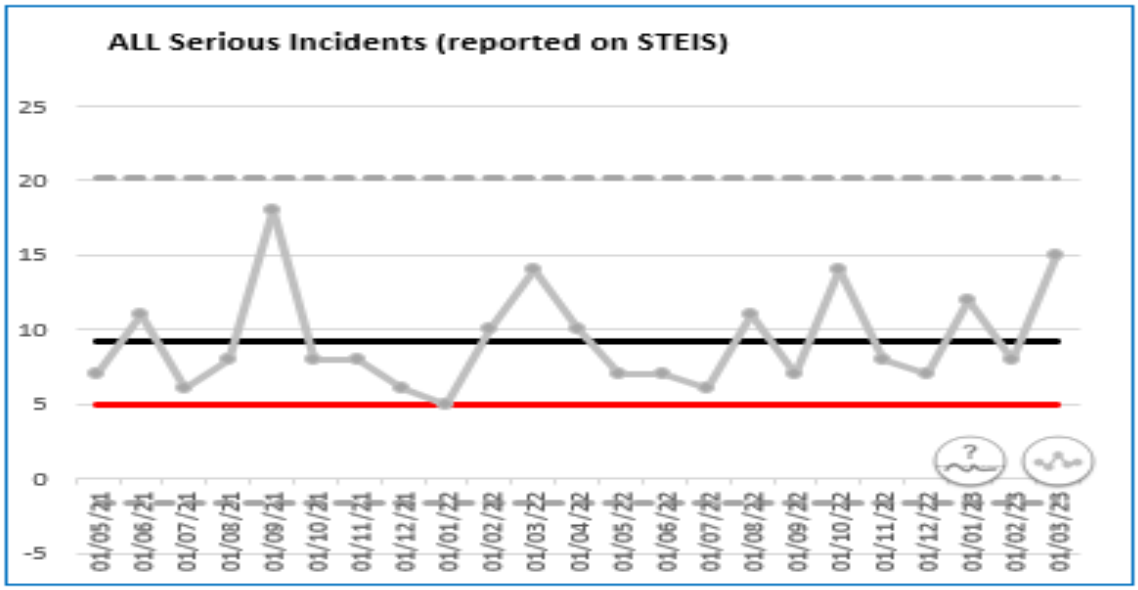
In April 2023 a decision was reached with the ICB that due to the level of assurance provided by the falls huddles and the delog process to move from reporting all falls with severe harm as serious incidents to reporting only those that meet the SI criteria following the huddle. Consquently, there has been a significant reduction in the number of delog requests during 2023-24.

2.1 Serious Incident Breakdown Analysis: By Various Measures

The following charts below present SI data by various measures with a comparison to the previous financial year:

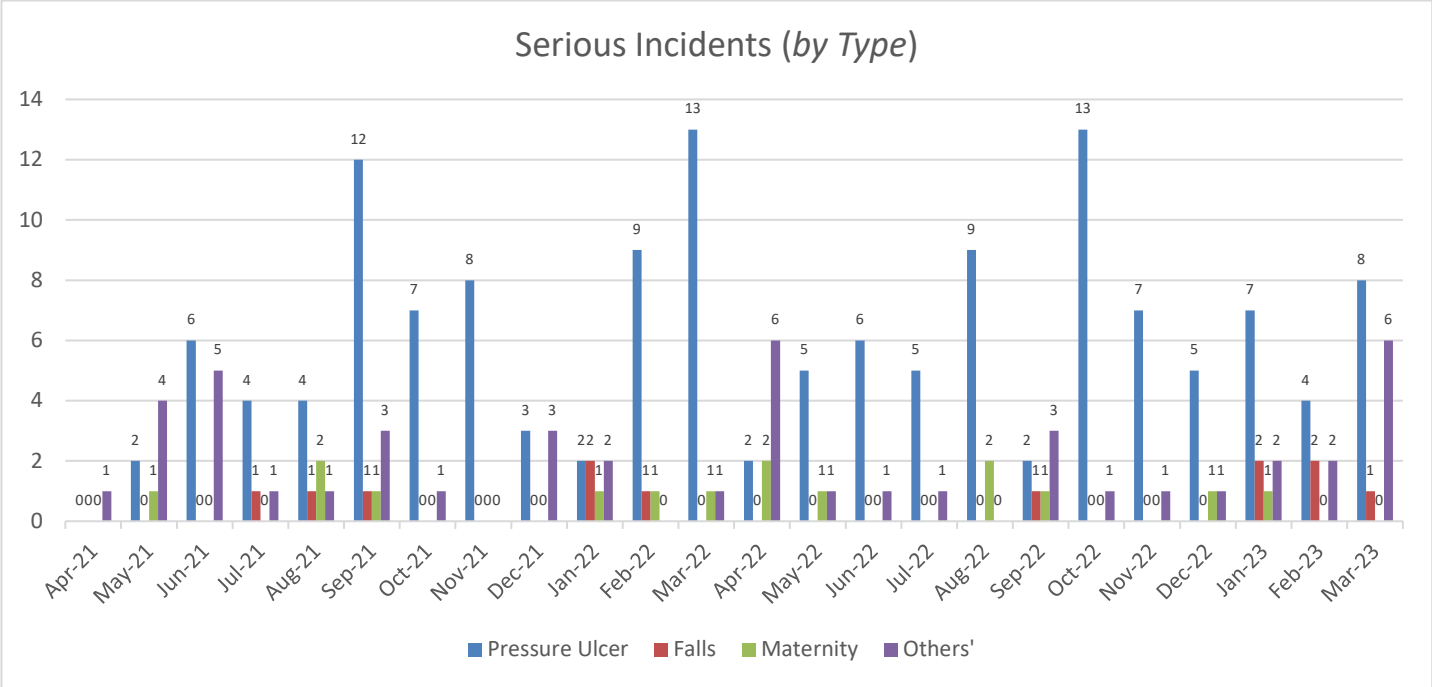
Total SI's reported to STEIS:	2020-21: *(Previous Report)*	2021-22: *(Previous Report)*	2022-23: *(Current Report)*
	95	105	112

Serious Incidents (Including Never Events) by Month reported on STEIS:

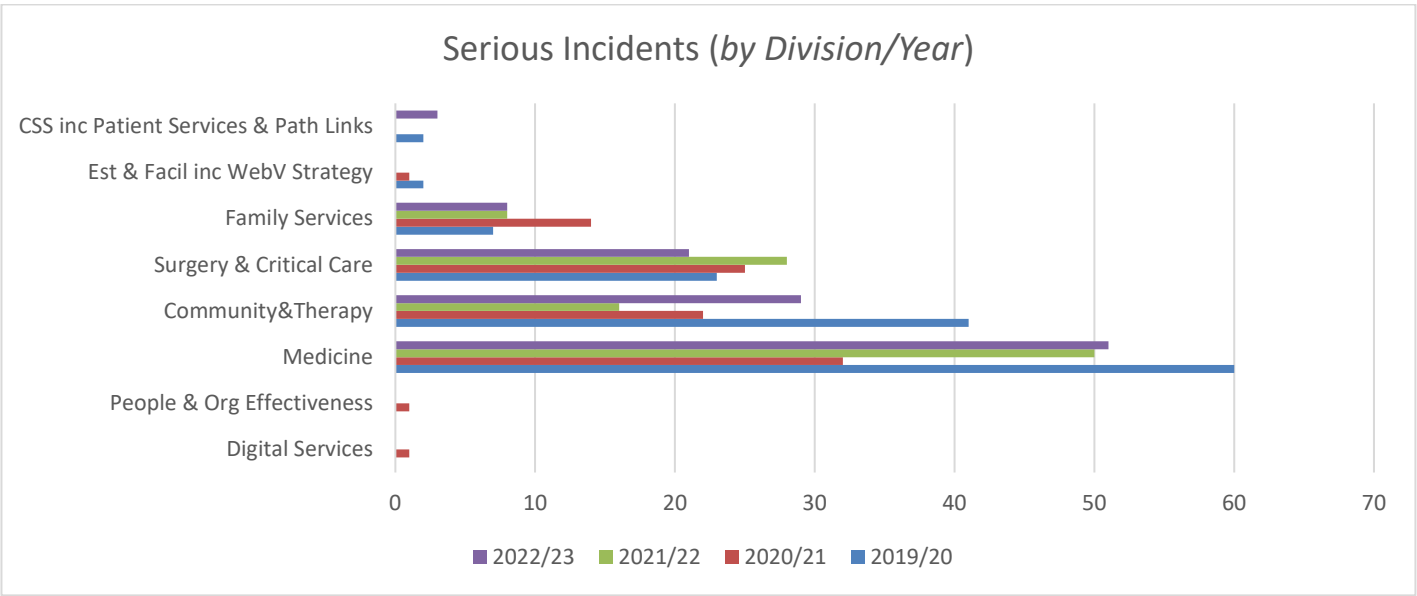


The SPC chart provided shows a normal variation pattern over time. The increase in SIs reported for both September 2021 and March 2022 is due to a rise in pressure ulcer SIs reported for each of those months. 12 pressure ulcer SI's were declared in September 2021 and 13 declared in March 2022.

Serious Incidents (Including Never Events) by Type:



Serious Incidents by Divisional Group & Financial Year comparison:



Serious Incidents by Specialty Group:

Surgery (24) ***12 x closed/action plan monitoring 12 x open (at the time of writing this report)***

- *Audiology (10)*

  - All linked to the same concern. Investigating together to produce one report.
- *General Surgery (8)*
  - 3 Pressure Ulcers
  - 2 Fall – fractured neck of femur
  - 1 Delayed referal for Lymphamadema
  - 1 Never Event – retained foreign object post-procedure
  - 1 Medication Error
- *Radiology (3)*
  - 2 Delayed Lung Cancer Diagnosis
  - 1 Results Module – not alerting

Medicine (51) ***48 x closed/action plan monitoring 3 x open***

- *General Medicine (19)*
  - 16 Pressure Ulcers
  - 1 Fall - fractured neck of femur
  - 1 Delayed appropriate escalation and initiating CPR
  - 1 Mismanagement of patient care following SIP
- *Gastro (12)*
  - 12 Pressure Ulcers
- *Stroke (8)*
  - 7 Pressure Ulcers
  - 1 Fall – fractured neck of femur
- *Elderly Medicine (4)*
  - 4 Pressure Ulcers
- *Emergency Care (3)*
  - 1 Delayed Treatment – unexpected death
  - 1 Fall – head injury
  - 1 Delayed care of deteriorating patient
- *Respiratory (2)*
  - 1 Fall – fractured neck of femur
  - 1 Delayed Treatment
- *Haematology (1); Cardiology (1); Acute Care (1)*
  - 3 Pressure Ulcers

Community & Therapy Services (29) ***ALL closed/action plan monitoring***

  - 27 Pressure Ulcers
  - 1 Delayed PEG Insertion
  - 1 SPA triage process not followed

Family Services (8) ***7 x closed/action plan monitoring 1 x open***

  - *Maternity & Obstetrics* (8)
    - 2 Neonatal death (1xpre-term)
    - 2 Fractured Skull following instrumental delivery
    - 2 IUD (delayed induction of labour; delayed escalation of C-section)
    - 1 Injury to baby during delivery
    - 1 Unexpected death following delivery.

2.2 Serious Incident Investigation Reports submitted to the Commissioners

Whilst there are still no national response timeframes currently in place (removed in response to the Covid-19 pandemic and related pressures) the Trust has endeavoured to ensure that, wherever

possible, every effort would be made to complete SIs within the 60 working day timeframe (as stipulated within the NHS England Serious Incident Framework (2015)) to avoid causing any additional stress or upset to patients and/or their families as well as ensuring key learning and improvements are identified in a timely manner.

Out of the 37 SIs declared within this reporting period (excluding Pressure Ulcers and HSIB investigations) 0 SI investigations were or will be completed within the 60 working day timeframe. At the time of writing this report a total of 6* investigations are still awaiting completion and submission.
* 10 audiology STEIS reported incidents counted as 1 serious incident investigation

The current target set out by the Trust is to achieve 80% compliance in submitting SI reports to the ICB within the timeframe. The main reason for extended time to complete investigations is divisional capacity followed closely by complexity of the case.

The table below is a comparison of the time period 2018-19 to 2022-23 to demonstrate the impact of individual capacity of Lead Investigators on the timeliness of completing investigations (comparison to time period that is both pre COVID and the highest number of SIs reported in a financial year).

	2018-2019	2022-2023
No. of completed investigations	132 inc. PU RCA SIs	22
Months taken to complete investigation in months (range)	3-11.5 months	4-15 months
Months taken to complete investigation in months (average)	4 months	9 months
No. (%) investigated within 3 months	80%	0 (0%)
Leads investigating more than 1 SI (%)	61%	12%
Leads investigating more than 1 SI (range)	2-8 SIs	2 SIs

To reduce the impact this has had on identification of learning, the review of the incident and subsequent discussion at SI Panel has considered any immediate actions required as well any existing or planned improvement work such as the results acknowledgement workstream. Examples of where this has occurred are as follows:

- Following identification of issues in testing hearing following screening by the Newborn Hearing Screening Programme, a service suspension was made until external experts could facilitate an in-reach service to undertake tests for the Trust, along with an external service review sought from the British Academy of Audiology (BAA), a look back exercise to identify any delayed or misdiagnosed child and callibration of all equipment used for the tests. Further actions are being taken to address the issues identified from the BAA service review.

- Immediate learning cascaded within ED following an unexpected death relating to delayed treatment and the need for early referral to the appropriate speciality, board rounds at specified times for MDT to maintain complete oversight of the deteriorating patient, and timely follow up of results/reports.

- The initial review of a patient death in relation to their care and treatment following a self-induced overdose identified potential missed opportunities for escalation. Standard operating procedure relating to TOXBASE guidance, and its usage shared with medical

staff by the ECC Clinical Lead. The calculation of NEWS scores in relation to confused patients referred to the Deteriorating Patient Group for review and appropriate action.

Existing process in relation to initial review of incidents also identify immediate learning and safety actions e.g.:

- All obstetrics and gynaecology incidents are reviewed weekly and identified cases escalated for a formal MDT rapid review to identify immediate learning and to inform a decision for those that require a discussion at SI Panel. SI Panel are informed of the immediate learning and associated actions.

- All fall SIs have had a falls huddle undertaken prior to escalation of requiring SI investigation where immediate learning is identified, and any new or emerging themes are used to inform the Trust's Falls Improvement Plan.

Timescales for completion of investigations are expected to improve moving forwards, as the SI framework is being replaced by the Patient Safety Incident Response Framework (PSIRF) which is expected to be implemented during Q3 of 2023/24. This change will revitalise the investigation process, while improving engagement with the people exposed to patient safety incidents. The focus moving forward will be to use system-focused investigation techniques, concise investigation timeframes, closer to the time of the incident being reported, which enable more rapid system improvements and release time to improve the quality of care. The Trust implementation group is taking forward this significant change, in line with the wider NHS.

2.3 Serious Incident Investigation Reports Assured at First Review

Of the 31 SI Comprehensive Investigation Reports that were submitted in the reporting period of 2022-23 and had undergone a review by the ICB, 84% (26/31) were assured on first review (note: Pressure Ulcer/HSIB investigations are excluded from this analysis as these are not part of the ICB assurance process).

The following table provides a summary for the last 5 years of the number of SIs for comprehensive investigations reported in the financial year, the average time to taken to investigate and the percentage assured on first review by the relevant CCG. Excludes Pressure Ulcers due to new process introduced in 2019 and HSIB led SIs which follow different processes and are externally investigated.

Financial Year	Comprehensive Investigations (exc. PUs/HSIB) reported in FY	Average time taken to investigate in weeks (SI Framework 2015 – 12 week deadline)*	Submitted investigation % assured on first review by the CCG
18-19	76↓	16↑	65%↑
19-20	40↓	27↑	62%↓
20-21	43↑	29↑	74%↑
21-22	32↓	31↑	89%↑
22-23	37↑	36↑	84%↓

**In the latter part of 2020 the national timeframes were suspended due to the pandemic and resulting operational pressures.*

Whilst the number of comprehensive investigations undertaken have reduced significantly in the last 5 years, the time to investigate has been increasing. This is in part due to the recognition that the 12-week deadline is not always sufficient to undertake a robust investigation and to ensure adequate review and sign off occurs. The increased focus on the quality and robustness of investigations has meant that on average the investigation time has doubled. Overall, the reduced number of SIs requiring a comprehensive investigation and the increased time to complete investigation has seen an increase in the number assured on first review by the relevant CCG. There was also a change in process in 2018 relating to the assurance assigned by the commissioners which meant less non-assured reports due to minor queries for the Trust to respond to. However, the time taken to investigate due to the capacity of the assigned Lead Investigator, despite the majority only having one investigation, will need close monitoring with the transition to PSIRF and investigation deadlines for PSII ideally being 3 months and agreed with patients/families.

2.4 Serious Incident Action Plans

Of the 7 Serious Incident Investigations whereby an action plan was agreed and submitted to the ICB, 3 of those were submitted within the agreed timeframe (where the action plan due date was prior to this report). This is not including Pressure Ulcers due to the trustwide improvement plan.

Since its inception in September 2018, the Serious Incident (SI) Panel has monitored the overdue actions with monthly updates provided by divisions. All actions that are delayed are reported and an extension request is made, which includes the mitigation being taken until fully completed, and the rationale for extension request. The extension requests include actions like follow-up audits demonstrating compliance following a change, policy document changes and technical developments. Extensive work has been undertaken by the Divisions to improve their position as shown below:

SI Panel (mth/yr)	Medicine	Surgery	Community	Family Services	CSS	Total
Sep 2018	24	13	14	39	5	95
Dec 2019	38	21	22	18	9	108
Dec 2020	3	2	0	7	0	12
Dec 2021	7	4	0	0	0	11
Dec 2022	4	0	0	6	0	10

The position at calendar year end in 2020 and 2021 shows significant improvements in the number of overdue actions despited operational pressures during COVID. It also demonstrates the effectiveness of the SI Panel in establishing monitoring and supportive measures for improvement.

3.0 SERIOUS INCIDENT THEMES

The following graph displays the main SI theme categories identified from incidents that were reported on STEIS in 2022-23:

Theme	No
Pressure Ulcer	73
Missed Diagnosis (Audiology – hearing loss)	10
Delayed: Assessment, Diagnosis, Treatment, Review	8

Theme	No
Falls (5 x fractured Neck of Femur)	6
Birth Instrument Injury (Maternity & Obstetrics) (2 x fractured skull)	3
HSIB (Maternity & Obstetrics)	2
Neonatal Death	2
Medication Error	1
Delayed PEG Insertion	1
Results Alert Module not Alerting	1
Mismanagement of patient care following SIP	1
Delayed escalation	1
Never Event (Retained foreign object)	1
Intrauterine Death (Maternity & Obstetrics)	1
Triage process not followed	1

SI Themes	Main Sub theme SIs	Safety Actions and Improvements
Pressure Ulcers	• Lead Nurse for Patient Safety undertakes analysis of pressure ulcer SI for themes and trends	• Trust Wide Pressure Ulcer Improvement plan in place
Missed Diagnosis	• Audiology (hearing loss) • Patients initially identified through a Trust request for external review of the Audiology Service.	• ABR diagnostic testing as part of the Newborn Hearing Screening Service suspended due to quality issues. (Has now recommenced with External staff or recruited staff with competency demonstrated). • The British Academy of Audiology (BAA) report recommendations and action plan have been developed. Trust investigation currently underway working with external specialist audiologists with further improvements to be identified.
Delayed: Assessment, Diagnosis, Treatment, Review	• Results not acted upon; documentation issues; lack of escalation; lack of / incomplete handovers; lack of communication and failure to follow guidance / policy and process (where in place).	• Ensure an effective handover process is implemented to promote patient safety and continuity of care using the SBAR framework. • Embed the requirement to annotate the appointment request, including specific time frames, when requesting that administration staff arrange follow up appointments – Hub Alert to ensure clinical staff have specified a time frame on follow up requests. • Undertake a workforce review within the ECC Department (greater emphasis on the out of hours and night shift rosters) as the current rota does not support the safe provision of care to patients attending the department during these time periods. Business Case to be produced for an extra

SI Themes	Main Sub theme SIs	Safety Actions and Improvements
		Middle Grade Doctor to be available 24 hours which will expand the out of hours rota. • Speciality Referrals to be extended to General Surgery & Urology for ED patients on WebV (electronic system). • Reporting Radiologists and Radiographers should add to their reports, when a plain x-ray, that they recommend the patient has cross sectional imaging if the patient continues to be symptomatic as small pockets of gas are difficult to identify on plain film X-rays. • Any acute abdomen CT scans to be viewed on a lung window (this is a different view on PACS of the image) so that small pockets of gas can be more easily identified.
Falls	• Lead Nurse for Patient Safety undertakes analysis of Falls SI for themes and trends	• Trust Wide Falls Improvement plan in place • Falls training provided to areas/individuals as identified through investigative processes, incident review or Nursing Metrics.
Maternity	• There have been 3 Serious Incidents relating to a baby suffering from a birth injury with 2 babies suffering a fractured skull in this reporting period. • Previously this has been highlighted a potential theme requiring external input and peer review.	• Conduct conversations with Maternity Voices Partnership and women to discuss whether or not to issue information about potential skull fractures following instrumental deliveries, to pregnant women within the patient information leaflet. If felt necessary, update the leaflet. • Update consent form for instrumental delivery (WQN 978) to include the rare complication of fetal skull fracture with forceps delivery and that of subgaleal haematoma (60 in 10:000) with instrumental (forceps/ventouse).

4.0 NEVER EVENTS

Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.

During 2022-23 1 x Never Event was reported across the Trust, this is a decrease from the previous reporting period of 2021-22 where 5 were reported:

STEIS 2022 24268 Never Event - Retained foreign object post procedure

Location: General Surgery - Theatres November 2022

Incident: Patient underwent laparoscopic cholecystectomy which was converted to open surgery due to bleeding. It was not safe to dissect the gallbladder and therefore only stones were removed and a cholecystostomy (an opening in the gallbladder to facilitate a placement of a drainage tube) was performed. The patient underwent surgery (16 months post-operative (open cholecystectomy and removal of foreign body). A BERT® bag (for laparoscopic tissue retrieval) containing stones was found to be the foreign body and removed.

Actions: Prior to this case being escalated to NLaG in November 2022, the Trust had already commissioned an ergonomist study (a study of people's efficiency in the working environment) to research into the accountable items process on all relevant hospital sites. This was in response to 'never events' that had occurred when an accountable item was retained in a patient during a surgical procedure. The ergonomics usability research was undertaken in February and March 2022.

Several changes have been made which significantly reduce the likelihood of this happening again due to these system improvements, see Appendix D.

5.0 DUTY OF CANDOUR

The Trust remained fully compliant in providing initial apologies following the reporting of SIs during 2022-23, however there were two breaches where a letter of apology was sent over the required 10 working days, both by 2 days. These were both part of the Pressure Ulcer process and were in the same division and the same specialty. Additional measures have been put in place to safeguard against further breaches in the the pressure ulcer process
While the Trust recognises that there are times when delaying or not sending a letter of apology is reasonable (for example, where the patient has died and had no living relative or advocate), there is a robust process for providing assurance that there has been scrutiny over whether the proposed exemption is reasonable and this rationale is added to Ulysses, providing an audit trail. Approval for exemptions or justifications for not sending a Duty of Candour (apology) letter is reviewed and approved by the Associate Director for Quality Governance.

Monitoring of all Duty of Candour is provided through reports on Ulysses and reported at each Divisional Governance meeting for assurance. Duty of Candour compliance is also monitored at the SI Panel.

6.0 INVESTIGATION THEMES

24 completed SI reports for 2022-23 have been reviewed and the following themes identified in relation to the problems identified and the action types. The following analysis does not include those SI investigations that have not yet been completed and submitted to the ICB.

The Chief Nurse Directorate undertakes thematic reviews of patient falls and pressure ulcer incidents including SIs which feeds into the Trust Wide Improvement Plans. As an example, the improvement plan for Pressure Ulcer preventions includes the common causes and known risks, including:

- RN oversight of pressure area care
- Plans of care and assessments are accurate and followed

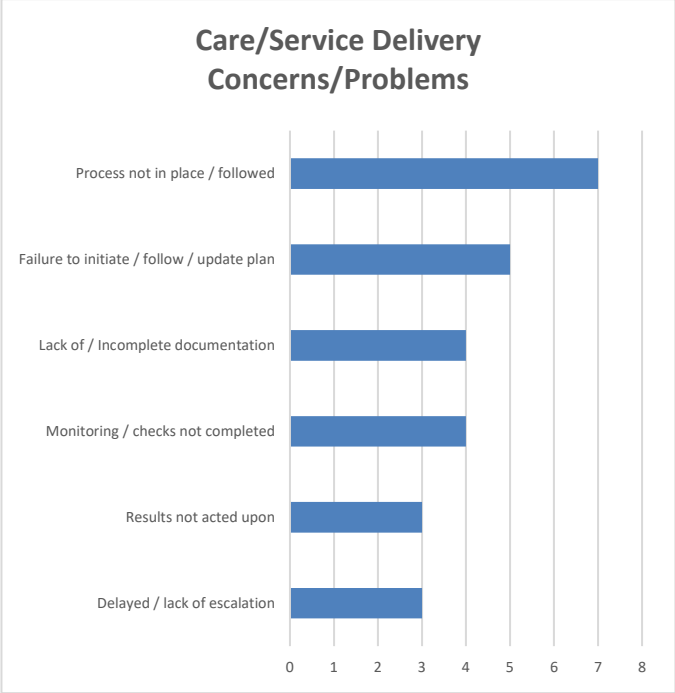
- Staffing impact upon care delivery
- Equipment access
- Risk assessments
- Tissue Viability team working
- Education
- Audit and assurance

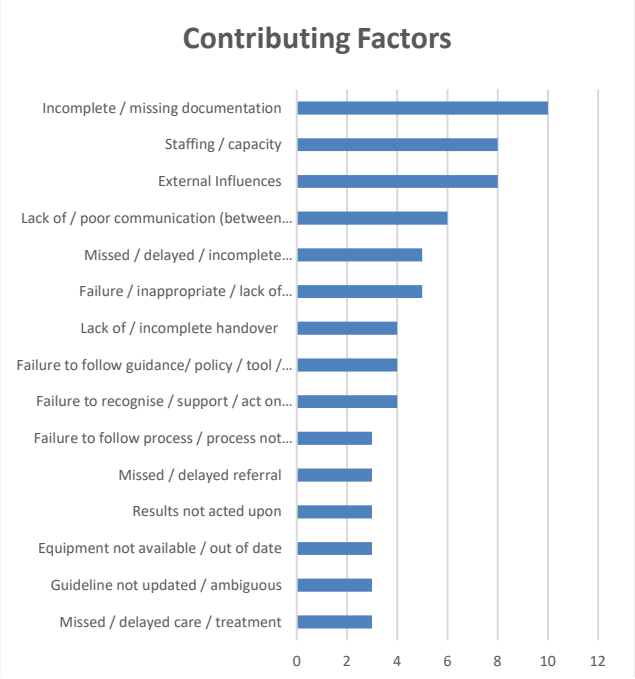
This topic is linked with the national CQUIN for pressure area risk assessment in 2023/24 and is also monitored through the nursing assurance reporting processes.

6.1 Care/Service Delivery Concerns

Care/Service Delivery Concerns/Problems are the key issues within an investigation which are analysed in great detail in order to identify contributory factors (the practices and factors that contribute to the issue(s)). It should be noted that these are the initial concerns, and the investigation may find that in some cases these were unfounded. There are often multiple concerns/problems analysed for each investigation which can be seen in the following graph.

The top themes identified were:



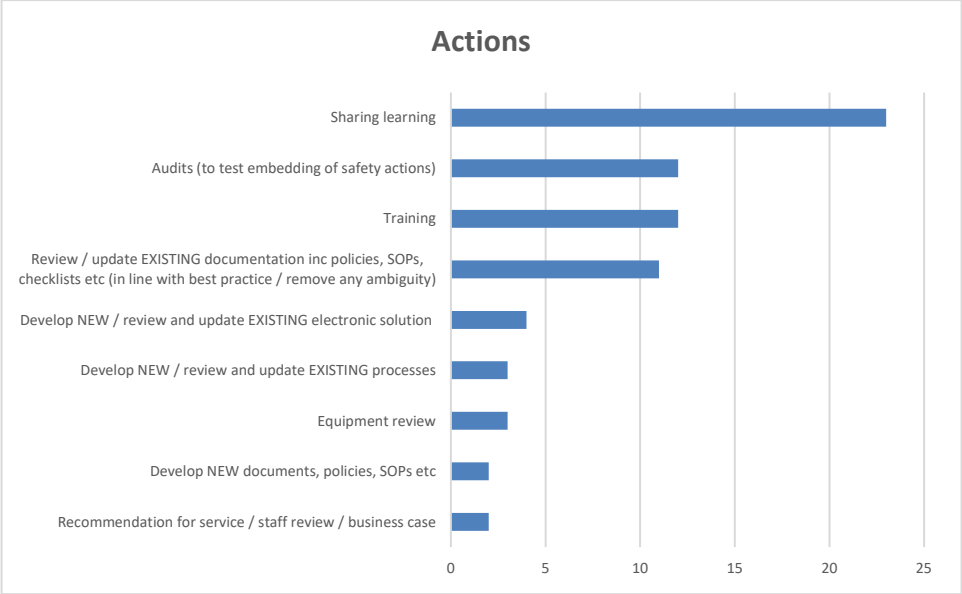


6.2 Actions

Actions are measurable agreements to make a change or undertake a task which has been developed to meet the recommendations from the investigation. These should be developed in collaboration with the team where the incident occurred, and the template report requires clear indication of the evidence required to show that the action has been completed. Recommendations and actions should address the root cause and the care or service delivery concerns.

Actions are monitored for delivery by the SI Panel.

Actions were grouped into action types, however for the purposes of this analysis, one page learning lessons and duty of candour follow up were not included as these are universally applicable standards to all SI Investigation reports. The top action types identified were:



The purpose of an investigation is to understand why the incident happened, identify the learning and turn that learning into safey actions (as per the above) that result in system safety improvements. Some of these system safety improvements are demonstrated in Appendix D.

7.0 LEARNING

Triangulated themes and sharing of learning

The quarterly CLIP report (presented and shared at the Quality and Safety Committee) brings together the key areas for learning across the Trust incorporating PALS, Claims, Inquests, Complaints, Clinical Audits, Mortality Reviews along with those from Serious Incident investigations and Patient Safety Incidents.

Through triangulation of the themes identified the following themes are highlighted for improvement:

- Documentation
- Treatment / Management of Care
- Communication
- Discharge
- Medication
- End of Life Care.

Themes from the CLIP report are used to inform the Trust's Quality Priorities and associated improvement work.

Sharing of learning from serious incident investigations

A 'suite of learning' is in place that identifies all the ways in which the Trust shares learning from SIs. This has been created in line with the wide range of ways in which individuals learn and encourages the Trust's learning to be shared in a variety of different ways to best reach the widest audience.

The table below lists the suite of learning in place and examples where these methods have been used to share learning from incident investigations.

METHOD OF SHARING:	DESCRIPTION:
Learning Lessons Newsletters	Trust wide learning lessons newsletter utilised to share learning from Serious Incidents (SI) **Example:** *The importance of sharing information at handover; checking investigations including waiting for formal investigation results not just checking images, before discharging patients' home; escalating abnormal CTG results and the accurate completion of Discharge Summaries for each and every patient in order to help healthcare professionals understand the patient's journey.*
Learning Lessons 1 page	One-page summaries completed following a Serious Incident investigation and shared Trust wide to ensure outcomes from SIs are accessible to all. This includes learning lessons that are potentially transferrable lessons which can be discussed in safety huddles. Learning in this format is used to share lessons externally to other providers such as General Practice. **Example:** *Completed for all investigations except pressure ulcers.* *Learning from an unexpected death in relation to delayed treatment for a potential perforated duodenal ulcer; a delay in appropriate escalation and initiation of Cardiopulmonary Resuscitation (CPR) and Prolonged Neonatal Resuscitation.*
Lessons of the week/local learning newsletters	Learning from SIs and incidents are shared via the lessons of the week template. **Example:** *Maternity Learning Lessons poster* *Maternity Safety Champion Bulletin* *PMRT Newsletter* *Fetal Monitoring lessons*
Risk to Patient Safety Alerts	Any high-level risks to patient safety are shared through a locally produced alert that is shared via the TW communication email. Other methods are used in conjunction to help ensure the message is shared as wide as possible to all staff in the Trust
Theme on a Page	Themes on a page are produced periodically to share learning from a key theme arising out of incidents including serious incidents **Example:** *Themes from pressure ulcers shared via this route*
Simulation / Live Drills / Podcast Videos	Simulation and live drills used to help share key lessons identified from serious incidents

Learning Lessons Folders	Learning information is made available in learning lessons folders to improve access to information for staff that have limited access to the intranet or that have missed face to face feedback **Example:** *1 page learning lessons from SI investigations* *Learning Lessons Newsletters*
Education / Training and Inductions	Specific areas for learning are included in existing education and training programmes **Example:** *Paediatric medication training*
Learning Events	Presentation on key learning via Microsoft Teams to enable cross site as well as wider community learning on key topics
Task and Finish Groups	Learning is shared with specific task and finish groups to ensure that these are considered as part of the improvement work being undertaken. **Example:** *Process mapping group ongoing set up to look at improvements required in relation to the process for Oesophagogastro Duodenoscopy (OGD) and histology reporting*
Face to Face	Face to face discussion on learning in team / specialty meetings and at safety huddles on learning that is specific to them. This is an ideal way to engage staff who will ultimately have the greatest impact on changing practice as well as be able to offer solutions. **Example:** *Patient Safety Huddles* *Handovers* *Speciality/Team meetings*
Posters / Quality/Staff Boards / Screensavers	**Example:** *Poster for correctly calculating NEWS scores* *Displays to aid the identification, management and escalation of Deteriorating Patients including the use of NEWS2 (i.e. Patient's conscious level ACVPU on WebV / when to escalate to the Outreach team) on the Emergency Department Boards* *Learning lessons posters developed to share learning from maternity incidents including medication errors; medical reviews for ventilated babies with concerns over PCO2 levels and the current guidelines around delayed cord clamping*

Learning from SIs is also cascaded via the Divisional Governance meetings, Business speciality meetings, and to specific groups overseeing improvements Trust Wide such as the Deteriorating Patient, Nutrition and Hydration, and End of Life.

A Learning Lessons Hub page is available which includes learning from SIs and incidents along with access to learning lessons newsletters, HSIB investigations, learning from claims, medical devices, safer medications, and pharmacy.

Divisional Key Learning Points from 2022-23 Investigations
Divisions share key learning from Serious Incident incidents as detailed above. Once an investigation is completed and learning identified this is then turned into safey actions that result in

system safety improvements. Examples of some of these system safety improvements are demonstrated in Appendix D.

8.0 INVESTIGATOR TRAINING

The Trust continued to provide one day Lead Investigator training for staff up until November 2022 as delivered internally by the Head of Risk. This traning was ceased due to the recent launch of the National Patient Safety Incident Response Framework (PSIRF) in September 2022 which replaces the Serious Incident Framework (SIF 2015) in Autumn 2023.

Learning response leads, those leading engagement and involvement, and those in PSIRF oversight roles require specific knowledge and experience as outlined in the PSIRF standards document. As part of the preparation for PSIRF, a training plan was developed in which identified staff for PSIRF roles were provided with details to access the training offered by the HSSIB (accredited trainers) that would ensure the minimum requirements for training and CPD under the framework would be met.

The training offered by NLaG in house has provided a good foundation for the move to PSIRF. The NHSE just culture guide had been a part of the Trust training for investigators since the guide was launched in 2018 to help ensure a just, fair and balanced approach is applied throughout the review process. The training had also been updated in early 2022 to include the PEACE model for investigative interviewing endorsed by HSSIB. Both the Lead Investigator / RCA Toolkit and in house training were designed to help leads undertake an investigation which is focused on the systems and situational context of the activity undertaken at the time of the incident/event rather than focus on the actions of individuals. This is very much in keeping with the PSIRF approach to learning from patient safety events.

APPENDIX A - 2022-23 OBJECTIVES

Objective	Assurance/Comments
Further development work on the Governance Report to add divisional analysis (by divisions)	As the Power BI reports were not re-established and no analyst post in place (until May 2023) this has not been achieved, however in the interim specialty reports have been produced to support Divisions to understand their themes at specialty level.
Complete annual SI report for 2022-23	This objective has been met with the 2022-23 annual report completed.
Triangulation of themes including SIs for the CLIP report in support of the Learning Strategy and to inform the Quality Priorities for the Trust	This objective has been met, the triangulation of themes continues to be included within the CLIP report. Quarterly reports submitted to QSC for review and to QGG for information. Was used by Head of Quality Assurance to help inform the Quality Priorities.
Provide support to the Patient Safety Partner aligned to patient safety investigations once appointed	1 Patient Safety Partner appointed and another is being interviewed. To take forward to 23-24 objectives.
Working towards to the Patient Safety Incident Response Framework (PSIRF) and completion of the NHSE training	Work has commenced and continues toward the Patient Safety Incident Response Framework (PSIRF)* along with the completion of the NHSE training. Implementation Group in place. Ongoing training being undertaken by the PSIRF roles which is monitored at this group. As work continues this objective should be carried forward into the 2023-24 reporting period.
Identify core list of Lead Investigators from divisions	Initial delays with the Divisions identifying key members of staff to undertake role due to resource implication concerns. Identification of Lead Investigators (Learning Response Leads) has commenced and is monitored by the PSIRF Implementation Group.
Consider Lead Investigator training requirements in relation to the PSIRF as part of the orientation phase	Complete.
Update of the Lead Investigator/RCA toolkit to meet the needs of PSIRF	Complete. A newly devised Learning Response Lead Pack is in progress to reflect the training requirements of PSIRF.
Produce a Power BI Dashboard from Ulysses data to identify incident themes as a priority.	Not complete as the Power BI reports no longer available / current freeze on the development of all Power BI reports (implementation of the new data warehouse). Manual systems being used in the interim. This objective has not been met with assurance and should be carried forward into the 2023-24 reporting period.

APPENDIX B - 2023-24 OBJECTIVES

1. Working towards to the Patient Safety Incident Response Framework (PSIRF)* and completion of the NHSE training (carried forward from 2022-23 objectives)
2. Produce a Power BI Dashboard from Ulysses data to identify incident themes as a priority (carried forward from 2022-23 objectives) in support of risk profiling for PSIRF and local level reviews
3. Provide support to the Patient Safety Partner aligned to patient safety investigations once appointed (carried forward from 2022-23 objectives)
4. Transition to PSIRF– Transition date agreed for the Trust to be operating under the new framework. Management of a 2-system approach whilst closing off SI and Concise investigations – to be closely monitored by SI Panel (Learning Response Panel when established).
5. Undertake learning responses in line with the Trust's PSIRP.
6. Monitoring PSIRF training compliance including CDP requirements.
7. Divisions to provide details of further Learning Response Leads and Engagement Leads as required under PSIRF.
8. Ongoing development of the relevant learning response documentation and toolkits/packs.
9. Development of the governance arrangements around PSIRF and collating insights from learning responses.
10. Review of current reporting arrangements for reporting to committees and groups in relation to PSIRF whilst maintaining current arrangements around the SI Framework (SIF).

APPENDIX C – GOVERNANCE ARRANGEMENTS

Governance Arrangements for Serious Incidents :
The process of grading incidents and decision making on STEIS reporting

The Trust is committed to improve patient safety by identifying, reporting and investigating SIs ensuring that actions are taken to reduce similar incidents reoccurring and that learning is shared across the organisation.

A SI Panel is held on a weekly basis to assess potential serious and severe harm incidents that may meet the reporting criteria. Decisions are collectively made with regard to the escalation to a SI investigation and any other issues that arise as a result of the decision, for example appointing an appropriate Lead Investigator. Duty of Candour is monitored closely to ensure an initial apology is made to the patient/family and that they are invited to meet to discuss any concerns they would like to be included in the investigation.

All SIs are reported to commissioners. A root cause analysis investigation (RCA) is undertaken for each SI (except Pressure Ulcers) and a report and action plan produced. The report is reviewed first in the division, to ensure there is agreement on the recommendations and actions. Each report is then reviewed at the SI panel which consists of the the Deputy Medical Director, Deputy Chief Nurse, Associate Director for Quality Governance, Divisional Quad representatives (Divisional Medical Directors, Heads of Nursing), Divisional Governance Leads, Head of Risk, Risk & Learning Manager, Chief Medical Information Officer, Head of Safeguarding, Radiologist, and the Pharmacy/Safer Medications Lead, to ensure it addresses the root cause(s) of the incident and identifies appropriate actions. Further quality assurance is provided by the Head of Risk and the Associate Director for Quality Governance before Director sign off is obtained. The report is submitted to the commissioners for their review and then sent to the patient/family with a further apology and invitation to meet to discuss the findings.

Reporting Arrangements:

Within divisions SI reports are presented at the monthly Governance meetings and completion of actions arising from these are monitored. The divisional Governance Report also provides details on ongoing investigations and actions for monitoring and escalation purposes.

Regular dialogue with commissioners takes place via dedicated monthly collaborative meetings with representatives from Quality Governance and the Chief Nurse Directorate in attendance. Ad hoc attendance by divisional representatives occurs when further assurances are required about the Trust response to specific investigations or identified themes.

A monthly Maternity and Key Serious Incident highlight report is presented to the Quality & Safety Meeting. The report highlights any progress on open Maternity and Key Serious Incidents, including detail of extension requests, open Maternity Serious Incident action plans, how many actions have been closed and remain open. Also included are any Maternity Serious Incident action extensions /amendments and identified learning from Maternity and Key Serious Incidents. A high level overview including learning and themes relating to maternity and neonatal SIs included in the Maternity Oversight Report to the Trust Board.

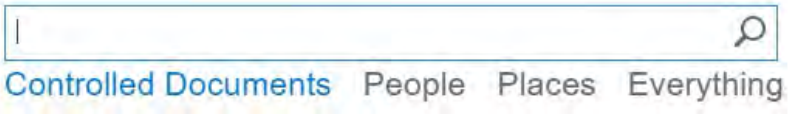
The SI Panel produce a SI Highlight report monthly at the Quality Governance Group which includes any Serious Incident reported within the reporting period, all overdue SI actions by Division and any learning identified.

APPENDIX D – SYSTEM SAFETY IMPROVEMENTS in 2022-23

Learning into safety actions following serious incident investigations

Insights from Investigations		System Improvements / Reducing the Risk
Retained Foreign Object **Surgery & Critical Care** Accountable items not being visibly recorded and no robust process for 'counting in' in Theatre all equipment used during procedures. An Ergonomic Research Project into the 'Accountable Items Process' commissioned in response to retained object Never Events that had occurred in theatres.		Trust wide changes with the introduction of standardised whiteboards which include the use of any supplementary equipment.  Initial supplementary items count location to take place in the Theatre not in the preparation room. This eliminates the risk of mistakes being made when the circulating practitioner writes the count on a piece of paper and then on the whiteboard. The practice is to write directly on the whiteboard when the items are opened and provided to the scrub practitioner. Implemented in all operating theatres since September 2022. √ Audit undertaken to ensure embedding of the Policy for Checking Swabs, Instruments, Needles and Sharps during and after Surgery (DCP233) and appropriate use of whiteboard(s), achieving 100% compliance.
Medication Dose Mis-Type **Medicine** Patient discharged with a higher than intended thyroid medication dose. They were subsequently continued to be prescribed / administered by their GP practice. Investigation found this was due to an additional '0' being added to the thyroid dose mistakenly on the discharge summary.		The introduction of ePMA interfacing with the WebV system has eliminated the need for discharging clinicians to type 'free text' medication including doses into discharge summaries. All medications inputted on ePMA are now automatically added to the patients discharge summary at the point of discharge, eliminating the risk of mis-typing details (not yet in place for Paediatric patients but is part of the roll-out plan). A direct electronic link to Community Pharmacy to update on high-risk changes or issues has been implemented with Pharmacy referring patients who meet the appropriate criteria. GP system changes made including an alert added to SystemOne in relation to prescription doses >200mcg for Levothyroxine and strengthened processes for prescribing in the practice. Learning shared widely in primary care by the ICB.

		√ The number of incidents received into the Trust for medication / doses missing / wrong continues to be on a downward trend.
Medication / Drug selection **Surgery & Critical Care** During an operation a patient was wrongly administered Ropivacaine (a local anaesthetic drug) instead of Paracetamol whilst under general anaesthetic. Medication was stored in **alphabetical** order with boxes containing larger items e.g. bags fluid/medication, remaining in boxes in the central storage cupboard. The local anaesthetic drug (Ropivacaine) was not stored in line with the Royal Pharmaceutical Society 2018 guidelines: '*All local anaesthetic infusions are stored separately from intravenous infusion solutions and other safe segregation practices are used'.*		Areas for improvement have been identified to reduce the risk of wrong drug selection. Local anaesthetic drugs are now kept on a **labelled** shelf and kept separately from all other drugs.   A separate drugs cupboard has been installed to separate local anaesthetic drugs from other intravenous drugs. A Standard Operating Procedure (SOP) for theatres is currently in development to include the Safe Storage of Medicines as per the Medicines Code Part 2. Monthly Pharmacy Audit now includes standards that will ensure Local Anaesthetics are segregated and stored in a designated cupboard in theatre. √Audit results provide assurance that both main theatres and the DPoW maternity theatre are fully compliant. The maternity theatre at SGH has interim measures in place until the new cabinet arrives. √ Environmental improvements in place for safer storage to support staff working in busy and distracting conditions to select the right medication.
Controlled Documents **Trust wide** Wrong versions of controlled documents being used when accessed via the Hub. A theme identified from		Reducing the risk of staff inadvertently using out of date documents when using the search function on the Hub. Change made in March 2023 to the search function on the Hub from automatically searching 'Everything' to making 'Controlled Documents' the default position.

incident reviews and SI investigations. Using out of date versions can result in incorrect processes being followed and patients are not receiving care in line with best practice.		 √Staff access to correct version of controlled documents significantly improved with no further concerns noted.
Delayed Induction of Labour / Confusion in Maternity Triage **Family Services** The local Induction of Labour Guideline offers routine induction when overdue (postdates) at 41+3 weeks or 41+5 weeks (depending on the consultant), which may have an adverse impact on the placenta and in turn impact on baby both before and/or during labour. A trial maternity triage line with dedicated 'triage system' operated between the hours of 08:00 and 01:00. Ward-based members of the midwifery team take calls in between these hours however are also looking after other antenatal, postnatal and labouring mothers. Both an electronic documentation and paper-based system for logging calls in place.		The Trust's local induction of labour guideline (DCG077) has been updated to reflect the recommended practice, in line with national guidance (NICE, 2021), which will see patients being offered induction of labour at 41+0 weeks in order to minimise the known risk factors associated with postdates (or appropriate timeframe according to condition). The investigation found that having two approaches to maternity triage can lead to confusion, lack of continuity compromising patient safety, incomplete documentation and inappropriate information given. Guidance has now been updated so that only a *qualified midwife* can answer triage calls and these calls are logged onto WebV (computerised system) to alleviate any discrepancy in advice. √ In order to improve continuity, standardisation and patient safety the dedicated triage service has been extended to 24 hours per day, 7 days per week from 16 October 2023.
Triage Tool Usage for Premature Baby **Community & Therapy Services** The Odyssey electronic triage system (which provides an outcome based on information given		During the investigation it was found that the Standard Operating Procedure (SOP) for Single Point of Access (SPA) does not specify that the electronic triage tool should be utilised and if unavailable, what should be used as an alternative. The Standard Operating Procedure (SOP) for Single Point of Access (SPA) has now been updated to reflect that the

and submitted) was not utilised due to lack of access. The Manchester triage system was utilised instead (this enables nurses to assign a clinical priority to patients, based on presenting signs and symptoms, without making any assumption about the underlying diagnosis and is suitable for use with adults and children). Had the Odyssey tool been used this would have then also guided the nurse to provide advice regarding a worsening condition and possible red flags. Whilst there is a paper copy of the tool for use within the department, in this case it was not utilised.		Odyssey triage tool is the designated tool for use along with the process to follow if the electronic system fails including the use of paper triage tools. √ Since the incident occurred the Odyssey system remained unavailable for use for a period of 12 weeks, due to a national cyber-attack that caused a major outage to NHS emergency services across the UK. Staff have reverted to the use of a paper triage tool and NO further incidents of patient harm have been reported.