NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Annual Report and Accounts 2018/19

Northern Lincolnshire and Goole NHS Foundation Trust

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Presented to Parliament pursuant to Schedule 7,
paragraph 25 (4) (a)
of the National Health Service Act 2006.

Contents

Chair's foreword

Welcome to our Annual Report and Accounts for 2018/19.

In general I would say the year has been one of consolidation as the Trust, and its Board, continue to rebuild the organisation after being put into special measures for both quality and finance in 2017.

CQC inspection

In May 2018 the Care Quality Commission (CQC) re-inspected the whole Trust and, in September, changed their overall rating from 'inadequate' to 'requires improvement'.

I was really pleased with this improved rating given the hard work and effort of staff across the Trust in responding to the previous inspection.

Caring at the Trust was rated 'good' across the Board, highlighting the incredible care our staff deliver on our wards and in departments as well as in our emergency department and also out in community settings across North Lincolnshire.

I would like to mention, in particular, our maternity services and A&E departments which the CQC recognised had made real progress.

You can read more about the CQC's findings within this report and on our website.

Finances

Finance continued to be a real challenge for the Trust. As you will see from our accounts we posted a large deficit, much larger than what we forecast at the start of the financial year and what we agreed with our regulator NHS Improvement (NHSI).

Some of the reasons for this are clear: our continuing reliance on agency doctors and nurses, which helps us to provide safe care but which come at a premium cost; and the state of our building estate and information technology infrastructure which continued to throw up unforeseen problems across the year, which meant we lost two of our operating theatres at Scunthorpe General Hospital.

However we need to make sure we fully understand this deficit so that we do everything we can to hit our financial targets in 2019/20.

Safe services

Across most measures of performance the Trust has continued to improve its services, building on the work we started in 2017/18. There is more detail in Chapter Six of this report, the Quality Account.

I'm particularly pleased we saw progress in the four safety priorities we set out at the start of the year: we have: reduced pressure ulcers; reduced the number of patients waiting more than 52 weeks from a high of 322 at the start of the year down to less than then by the end of 2018/19; and reduced our mortality rates – as measured by the Standardised Hospital Mortality Indicator (SHMI) – by six points to be just above the 'as expected' range (see Chapter Six)..

Our staff

Importantly the staff survey, which was published in March, showed we are making small – but important – gains in changing the culture of the Trust and improving the morale of our fantastic employees.

Achieving what we stand for – to give the best care we can – means we need to make sure each and every patient gets the best experience they can.

This means wherever they are in contact with the Trust, such as A&E, in outpatients, on a ward, in an operating theatre or in their own homes.

It also means whoever they are in contact with. Each and every member of staff – as well as our wonderful team of volunteers – plays an important part in running our Trust.

Whether they are a porter, a hospital support worker, a receptionist, a nurse, a cook, an electrician, a doctor, an administrator, a physiotherapist or any one of the other hundreds of professions we have, the Trust couldn't run without them – I would like to thank each and every one of them for their unstinting commitment and huge efforts to care for our patients every hour of every day.

I commend this Annual Report to you.

Signature:

Chair: Anne Shaw
Date: May 2019

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Chapter One: The Performance Report

Chief Executive's performance statement

This year was my first full year as Chief Executive of the Trust. Throughout the year I have spent time with staff in all three of our hospitals and in the community and I would like to thank each and every one of them for their hard work, commitment and effort to care for our patients and to provide the best service we can.

It is humbling being their Chief Executive. I would also like to thank all the volunteers who spend some of their free time helping us and helping our patients – what a fantastic job they all do.

At the start of the year I set a number of priorities which reflected the position of the Trust at the end of the 2017/18 financial year. I will look at each in turn.

Safety

First the CQC Inspection in May 2018 lifted the Trust's ranking for 'Safe' from Inadequate to Requires Improvement, so now (as of May 2019) no services are ranked as Inadequate which is a really good foundation for us to build on in forthcoming years. Second the most improved score in the latest Staff Survey was related to staff views of being confident in reporting incidents and believing lessons will be learnt from them. This is really positive and is very different compared to previous surveys.

In terms of specific quality measures:

- As of the time of writing our mortality score (measured by SHMI – Standardised Hospital Mortality Index) has improved from 119 (Oct. 2016 – Sept. 2017) to 112 (Jan 2018 - Dec. 2018), which is within the nationally defined 'expected range' (see Chapter Six). We will continue to focus on mortality in the 2019/20 financial year as it is one of the – if not the – most important indicators of safety in hospitals.
- The Trust's acute hospital proportion of patients with a new pressure ulcer has improved over the last 12 months although this is still below national average.
- We slightly improved the percentage of patients seen in A&E in under four hours (85% in 2018/19 compared to 84% the previous year), but because attendances soared by 7.65% (an additional 10,289 – 28 more every day) the Trust saw 10,000 more patents in under four hours over the year. In cancer, however, we made very little progress: the two week wait performance was sound (97.8%), but our 62 Day Referral to Treatment position worsened from 78.5% to 71.4%, as has the number of patients waiting longer than 62 or 104 days for treatment.
- The Trust started the year with the largest number of patients waiting 52 weeks or more (compared to size of trust) in the country, but from a peak of 322 in May 2018, this number was down to six by the end of March 2019, and down to zero in April 2019.

Vacancies

From April 2018 to February 2019, vacancies fell from 540.39 whole time equivalents (wte) to 370.17, despite an increase in the number of staff we have budgeted for of 91 wte. Over that period vacancies for doctors fell by 58, for registered nurses by 21 and for HCAs by 43. The number of doctors in the Trust is the best for four years, and is expected to improve further due to recruitment in the pipeline.

Finally staff turnover (12 month moving average) improved from 11.43% to 9.5%, which means more staff are choosing to stay with us rather than leave – this is really good news.

Staff engagement

Our Pride and Respect programme, which has been set up to improve the Trust's culture and to reduce bullying, is going from strength to strength: we now have 100 Champions; 900 staff completed the training during the year, which has now rolled out as part of our new staff induction programme; and 48 cases have been helped through the new Let's Talk in-house mediation service.

In April we launched our new Trust Values (Kindness, Courage and Respect), which were developed with the input of 800 staff members. Disappointingly, the 2018 NHS Staff Survey saw only very modest changes, with improvements in most of the 80 questions, although not in all, and we still lag behind most other trust when our scores are compared to theirs. There is more detail on this in Chapter Three and Chapter Six.

Clinical leadership

We appointed to roles across both medical and nursing roles including: five Divisional Clinical Directors and two Deputy Medical Directors; two Deputy Chief Nurses; and four Divisional Heads of Nursing and a Head of Midwifery.

The Clinical Lead tier was being restructured and strengthened in the early part of 2019/20, following formal consultation, and the Matron tier changes were also nearing completion with the amalgamation of the Operational and Quality Matron roles, including a designated Matron for Goole District Hospital. Finally a Ward Manager Leadership Programme commenced in summer 2018 to build leadership and management capability at a ward level.

Finance

The area of greatest disappointment is the Trust's finances, where the deficit has slumped very badly to around £60 million, in spite of delivery of £14.7m of the £15m target Cost Improvement Programme.

Over-optimistic assumptions about income, continued difficulties in controlling agency spend, additional estates and fuel price challenges and the need to make several investments to improve quality and safety, all contributed to this severe deterioration in the Trust's finances. More successful has been the Trust's pursuit of additional capital, with 2018/19 seeing an additional £39.5m being secured through the STP, emergency and winter capital and investment in electronic prescribing and medicines administration (the final £8.1m of this is subject to formal confirmation).

Plans for 2019/20

Looking ahead to 2019/20 many of the priorities remain. In terms of planed activity we have agreed with the CCGs to plan for an increase in A&E attendances of around 6.5% and we have said we will see 15% per cent more patients in ambulatory care, which means these patients are not admitted. We have also agreed we will have no patients waiting more than 52 weeks and our intention is, by the end of the financial year (March 2020), we will have no one waiting for longer than 40 weeks.

We are also planning to reduce our outpatient follow up waiting list by nearly 14,000. To make sure we can do all of this we know we need more beds, especially over winter, so we have plans in place to create a new ward of 25 beds at Scunthorpe. Our quality priorities for 2019/20 are set out in Chapter Six of this report. Like most Trusts a crucial issue is having enough staff to do everything we need to do and to lessen the pressure I know many of them face on a daily basis because some areas just don't have enough staff. We know we need to do more to reduce our vacancy rate and our reliance on agency staff.

The good news is we are expecting another high fill rate for junior doctors, building on our great improvement last year, and we have 20 nurses from the Philippines in pipeline which should be joining us by the end of September. We also have plans to bring in 65 newly qualified nurses around the usual time at the end of this calendar year. We're planning to bring in more new roles – we are introducing Physician Associates on a two year rotational preceptorship programme, for example, and plan to introduce six Band 3 Physician Assistants – and we will be building on our fantastically successful Apprenticeships work.

Bringing in new staff is only half the story though. We also need to make sure we do everything we can to make sure staff stay and feel this is a good place to work. To do this we will continue to look at ways to communicate and engage with staff and what we can do to respond to the feedback they gave us through the latest staff survey.

Looking back at the year overall there is a definite picture of improvement throughout 2018/19 although the finances continued, and continue, to be really difficult for the Trust. Our challenge for 2019/20 is to maintain and build on our improvements and manage our financial position. I believe we can do that because the Trust Board and our regulators are working together to put in place achievable plans to build sustainable services for local people. I also believe we can do that because we have built strong and successful relationships with our partners in the CCGs, local authorities, neighbouring Trusts and local politicians. I would like to thank them all for their help, support and, on occasions, challenge: without this the work we are doing would not be as focused or as successful.

Finally I believe we can do this because we have such brilliant, ambitious and committed staff, once again a massive 'thank you' to them all.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Overview

The purpose of this overview section is to set out: the purpose and activities of the Trust; the issues and risks which could affect the Trust in delivering its objectives; an explanation of the adoption of the going concern basis; and a summary of performance for 2018/19 against the national standards.

About the Trust

The Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) is an acute foundation trust serving a population of more than 445,700 people across North Lincolnshire, North East Lincolnshire, the East Riding of Yorkshire and West and East Lindsey.

The Trust was formed on April 1 2001 following the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust, and has been a foundation trust since May 1 2007.

This means the Trust has more freedom to act than a traditional NHS trust, although it is still closely regulated and must comply with the same strict quality measures as non-foundation trusts.

In April 2011 it became a combined and community services trust for North Lincolnshire.

As a result of this the name of the Trust, while acknowledging the geographical spread of the organisation, was changed during 2013 to reflect the fact the Trust does not just operate hospitals in the region.

NLaG provides acute and community health services.

It offers services in three main hospitals – Scunthorpe General Hospital, Grimsby's Diana Princess of Wales Hospital and Goole and District Hospital – as well as in a range of community settings such as health centres, clinics, Louth hospital and in people's own homes.

Scunthorpe General Hospital (SGH)

The hospital was first built in the 1920's and occupies a 'land-locked' site surrounded by residential properties.

The site has grown over time with expanded buildings attached to original structures.

It provides the full range of district general hospital services, including an emergency care centre, medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services.

The hospital has around 310 inpatient beds, plus 27 day case beds and 18 beds for children.

Medical specialties on site include emergency ambulatory care and frail elderly assessment services, diabetes and endocrinology, cardiology (with facilities for cardiac catheterisation and pacing), respiratory medicine, elderly care, dermatology, haematology and gastroenterology, stroke services including hyperacute, palliative medicine, rheumatology and neurology.

Oncology, outpatient cardiothoracic surgery, plastic surgery and renal medicine are provided by visiting consultants from Hull.

There is a clinical decision unit supported by ambulatory care and a short stay ward for acute medical emergency patients.

Surgical specialities on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, breast services, urology, ophthalmology, ENT and maxillo-facial and orthodontics and pain services. The hospital was equipped with seven theatres, including two theatres dedicated to trauma and orthopaedic use (both with ultra-clean air facilities). One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends. However, during 2018/19 two theatres were closed due to problems with the water supply in the block where they are located.

Women and children services provide the entire maternity pathway using a more traditional service model comprising antenatal/postnatal clinics, a dedicated central delivery suite and a dedicated obstetric ward. In addition gynaecology is provided through a range of outpatient clinics and an inpatient ward facility.

Acute/emergency paediatrics is provided by specialist nurses in A&E in conjunction with doctors. The children's ward works closely with A&E assessing and receiving medical and surgical patients ensuring the pathway is seamless. An inpatient paediatrics service is provided caring for children aged 0-16 years, supported by a community service.

In addition a neonatal intensive care unit is based close to central delivery suite allowing easy access for mum to baby. There are also four transitional care beds managed by the neonatal team.

All the diagnostic and service departments are based on site including endoscopy, radiology with plain film, ultrasound, CT and MRI. The hospital also hosts the Path Links laboratory for pathology and immunology.

Community and therapy services provide a wide range of support for inpatients, outpatients and throughout the community for adults, children and young people covering nursing, physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental. A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg.

The development of three Care Networks, which is being led by North Lincolnshire Clinical Commissioning Group, will result in further integration of primary, community and social care provision.

Diana, Princess of Wales (DPoW) Hospital

The hospital was built on a single site in 1983 and has undergone considerable expansion since then. It provides a full range of district general hospital services, including an emergency care centre, medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services.

The hospital is the largest in the Trust with 342 inpatient beds, 54 beds for day case work and 16 beds for children.

Medical specialties include diabetes and endocrinology, cardiology (including angiography, cardiac devices and permanent pacing facilities provided from a purpose built cardiology day case unit), respiratory medicine, elderly care, dermatology, haematology and gastroenterology, stroke services and rheumatology. Neurology, oncology, outpatient cardiothoracic surgery and plastic surgery and renal medicine are provided by visiting consultants from Hull.

The medical floor of the hospital has a medical assessment unit supported by ambulatory care and a short stay ward for acute medical emergency patients.

Surgical specialties on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, breast services, urology, ophthalmology, ENT and maxillo-facial and orthodontics and pain services.

The surgical floor of the hospital has a surgical assessment unit and short stay ward dedicated to the assessment and care of acute surgical emergency patients. The theatre suite provides eight fully equipped theatres each with its own anaesthetic room, with two theatres dedicated to orthopaedic use (both with ultra-clean air facilities). One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

Women and children services provide maternity services and paediatric services in a custom-built building comprising of maternity wards, gynaecology wards, dedicated obstetric theatres, children's wards and the child development centre.

Care throughout the maternity pathway is provided through a pregnancy assessment centre for antenatal and postnatal care. Complementary to this is the community midwifery service we provide.

Emergency/acute paediatric services are provided through the dedicated paediatric assessment and observation unit co-located in ECC. This is supported by a neo-natal intensive care unit and the children's ward, caring for medical and surgical patients. Four designated beds are provided for babies requiring transitional care within the maternity unit.

We also have a range of outpatient clinics, providing general paediatric clinics to specialist paediatric clinics. The pathway is continued through the delivery of community paediatrics, ensuring children are provided appropriate care at an appropriate setting.

All the diagnostic and service departments are based on site including endoscopy, radiology with plain film, ultrasound, CT and MRI. The hospital also hosts the Path Links laboratory for pathology and immunology.

Community and therapy services provide a wide range of support for inpatients, outpatients and throughout the community covering physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental.

A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg.

Goole and District Hospital

This is a purpose-built community-plus hospital which opened in 1988 integrating service from in and around the town of Goole.

Medical services include general medicine, elderly, cardiology, rheumatology, gastroenterology, dermatology a light treatment service, diabetes and endocrinology, haematology and immunology, oncology and a minor injuries unit.

The hospital has 44 inpatient beds with another 13 for day case work.

Surgical services provided include general surgery, orthopaedics, ophthalmology, ENT and audiology, gynaecology, urology and pain services.

There is also a surgical day case unit complete with a theatre incorporating endoscopy services.

Two further main theatres are equipped for major orthopaedic work and other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre and an outpatient department.

Internationally renowned specialist laser treatment is provided at Goole in collaboration with the Yorkshire Laser Centre.

Women and children services provide outpatient consultant-led gynaecology clinics, colposcopy services, hysteroscopy services and a purely midwife led 'Home from Home' unit for low risk deliveries.

A reduced level of consultant-led paediatric outpatient activity happens in Goole to try and provide care closer to home.

Therapy services are provided for both inpatients and outpatients with physiotherapy, occupational therapy, nutrition and dietetics and psychology services. There are two x-ray rooms together with mobile units, and an ultrasound room. The diagnostics department also provides a regular mobile MRI/CT service.

The hospital also provides a neurological rehabilitation centre.

The Trust is continuing to develop the hospital-based services focusing on expansion of elective care services and dedicated inpatient rehabilitation services.

Community services

The Trust provides a wide range of community services across North Lincolnshire, including district nursing, physiotherapy and psychology, podiatry and specialist dental services.

The community nursing and therapy services staff work with people of all ages and in a variety of settings from health, social care and educational settings as well as in people's homes.

The community and therapy staff recognise the importance of people being able to achieve and maintain their independence and health as far as possible.

Finances

The Trust has an operating income of around £350 million and has costs of around £400 million, meaning it delivered a deficit financial position for 2018/19, as it has for a number of previous years as well.

Working in partnership

The Trust delivers services by working in partnership with three local authorities, three clinical commissioning groups, and a range of other providers including voluntary organisations and the private sector, as well as patients, their carers and the public.

Strategy, values, and behaviours

Throughout 2018/19 the Trust Board spent much time discussing the Trust's purpose and strategic objectives.

These conversations will continue on a regular basis as the Trust's responds to what is happening nationally – such as the publications of the NHS Ten Year Plan towards the end of 2018 – and locally, with changes to how services are commissioned and delivered through the development, for example, of the Integrated Care Partnership Alliance in North East Lincolnshire.

The Trust Board agreed to this purpose:

'Committed to caring for you'

The Trust Board have, broadly, developed strategic objectives which fall into five areas:

- **To give great care**
  - Never compromise on safety
  - Give care which works and is clinically proven
  - Work on what matters to patients
  - Always seek to learn and seek improvements

- **To be a good employer**
  - Develop a skilled and motivated workforce
  - Promote staff wellbeing
  - Create a safe and nurturing environment
  - Listen to staff concerns and ideas

- **To live within our means**
  - Deliver value for money
  - Work to eliminate the deficit
  - Spend every pound wisely
  - Innovate and educate to save
  - Secure more investment

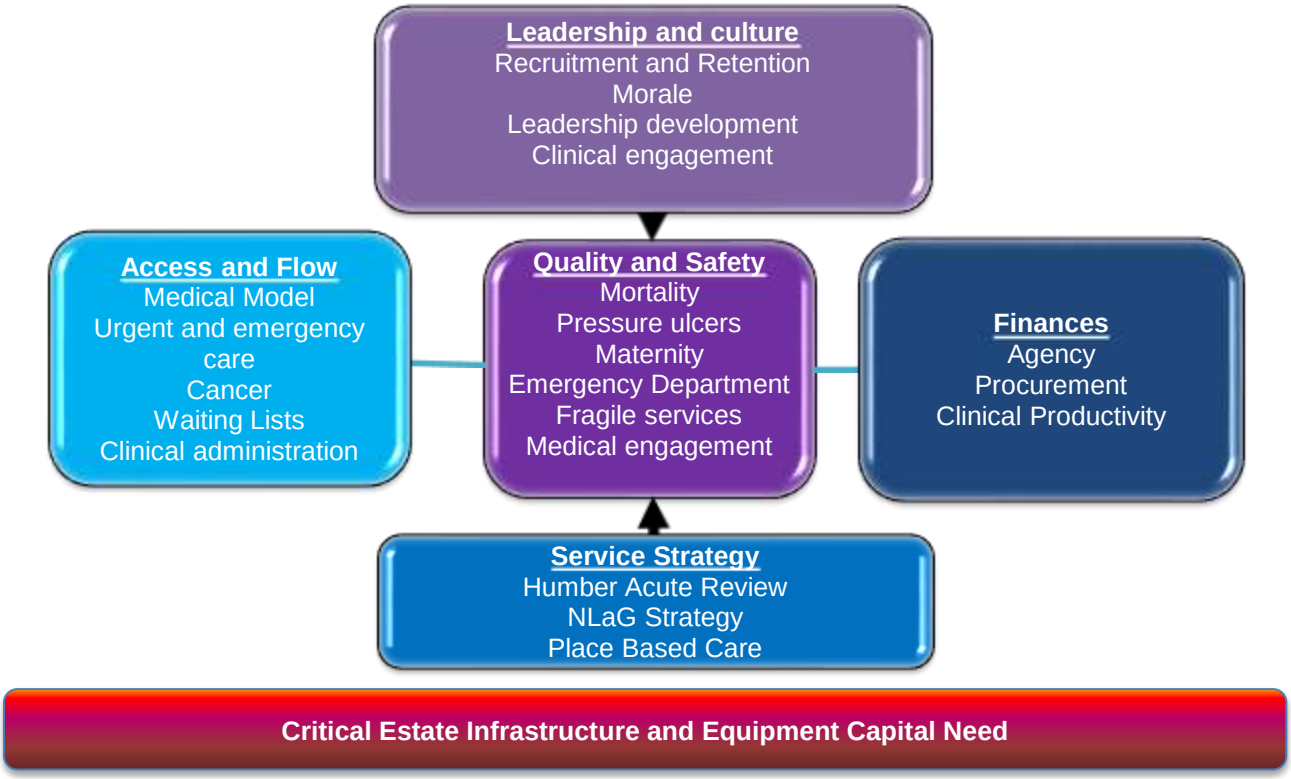
- **To work more collaboratively**
  - Sustainable services now and for the future
  - Reducing variation between tertiary and local services
  - Maximising the collaborative talent pool
  - Utilising available resources in the best way possible to achieve

- **To provide strong leadership**
  - Sustainable services now and for the future
  - Reducing variation between tertiary and local services
  - Maximising the collaborative talent pool
  - Utilising available resources in the best way possible to achieve

Each year the Trust is required to produce an Operating Plan, which sets out the activity it will deliver in year and as well as the other work it will be doing to improve its service and to work towards its strategic objectives. Versions of this plan are available on the Trust's website.

The approach to achieving these objectives, and to improve the Trust's services, is through a number of workstreams in its 'Improving Together' programme of work.

The diagram overleaf shows the different workstreams and the areas they are addressing.



Throughout the last year the Trust also spent, through its Pride and Respect programme to improve the culture of the organisation, a long time talking to staff about their values and how they matched, or not, with those of the Trust.

As a result of this work a decision was taken to change the values to reflect what staff said. More than 800 staff helped the Trust Board as it came up with what they might be. The new values and behaviours were agreed at the start of 2019 and are set out below.

Our values and behaviours

Kindness · Courage · Respect

We believe kindness is shown by caring as we would care for our loved ones	We believe courage is the strength to do things differently and stand up for what's right	We believe respect is having due regard for the feelings, contribution and achievements of others
- I will be compassionate, courteous and helpful at all times - I will be empathetic, giving my full and undivided attention - I will show I care by being calm, professional and considerate at all times	- I will be positively involved in doing things differently to improve our services - I will challenge poor behaviour when I see it, hear it or feel it - I will speak up when I see anything which concerns me	- I will be open and honest and do what I say - I will listen to and involve others so we can be the best we can be - I will celebrate and appreciate the successes of others

Key developments during 2018/19

Improvements recognised at the Trust

The Trust welcomed an improved Care Quality Commission (CQC) assessment in September 2018. In the report the Trust shifted its overall rating from 'inadequate' to 'requires improvement' and the CQC recognized the Trust is making steady progress to improve its services to local people.

The report is based on a full inspection of Trust services which was carried out in May 2018.All three hospitals the Trust runs – in Grimsby, Scunthorpe and Goole – as well as community services in North Lincolnshire were rated as 'requires improvement'. Inspectors noted there are a number of areas where the Trust needs to focus its efforts including improving staffing levels, especially doctors and nurses, and reducing waiting lists.

Caring across the Trust was rated as 'good' and the report notes 'staff work together as a team to benefit patients'. The Trust remains with a well led rating of 'inadequate', which reflects where it is on rebuilding leadership in the organisation. Scunthorpe General Hospital has improved from 'inadequate' to 'requires improvement' as has the hospital's A&E department. Maternity and children's services at both Scunthorpe and Grimsby have improved since the last inspection in 2016.

When the report was published Dr Peter Reading, Chief Executive of the Trust, said: "This report shows we are on track and doing the right things in the right way to improve what we do. Everyone, whether they are patients, staff or our partners, can see from this report the progress we have made to make improvements to our services.

"Our staff have been magnificent. Since the last inspection they have had to deal with a Trust in double special measures and cope with a couple of really hard and busy winters. Their commitment, determination and compassion humbles me on a daily basis and I cannot thank them enough.

"There is no doubt we have much more to do as we continue to work towards a 'good' rating. We have identified the things we need to change and we will get on and do that in the weeks and months ahead. This includes continuing to build the leadership capability across the organisation."

Leadership changes in 2018/19 included appointing Divisional Clinical Directors, two new deputy chief nurses, a number of new heads of nursing and a new associate director of clinical governance. The inspection team highlighted areas of outstanding practice in medical care at Scunthorpe General Hospital and Goole and District Hospital, and in community dental and end of life services, both in North Lincolnshire.

Inspectors also noted the Trust has: improved the way it identifies patients who may have sepsis; good procedures to safeguard vulnerable patients; support available for patients with dementia and learning difficulties; and started to see improvements in staff morale.

The full report is available on the CQC's website at: https://www.cqc.org.uk/provider/RJL

Trust received £940,000 as part of nationwide funding

Patients are set to benefit from safer and more convenient prescriptions thanks to a £940,000 slice of national funding to help rollout state-of-the-art technology.

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) was among one of 13 organisations to receive a share of £16million national funding from the Department of Health and Social Care (DHSC) to support the increased use of electronic prescribing and medicines administration (ePMA).

It is the first step in the distribution of a £78million fund to help hospitals move away from using handwritten prescriptions over the next three years.

Dr Steven Griffin, NLaG's director of digital strategy, said: "This is great news for our organisation as we can accelerate the introduction of electronic prescribing across our hospitals and community services."

"What it essentially means is hand written prescriptions will become a thing of the past.

"It will put an end to staff trying to read the notoriously difficult poor doctors' handwriting as it will all be done electronically."

Simon Priestley, chief pharmacist, said: "Patient safety will be enhanced as electronic prescribing has been shown to reduce medication errors.

"This electronic system will provide support to prescribers when checking the appropriate doses of medicines and cross-checking for allergies and interactions with other medicines."

Staff moved in to new £16.4million accommodation block

The Roost, the Trust's new staff accommodation at Grimsby, was officially opened by Sir Keith Pearson, chair of Health Education England, at a ceremony in December.

The £16.4 million modern 'key worker' accommodation constructed by Kier, consists of 96 student units and 124 studio apartments to house hard to recruit staff including doctors and nurses. Staff at the hospital were asked to put forward suggestions for names for the new building and then voted on their favourites. The winning name was The Roost, as chosen by consultant radiologist, Dr Joseph Alex. The first staff members moved in later in December.

John O'Callaghan, managing director for Kier Northern, commented: "The new accommodation at Grimsby Hospital provides high quality, modern and comfortable space for key workers that is ideally situated for NHS employees in Grimsby and we are thrilled to have completed this scheme for the Trust."

NLaG director of estates and facilities Jug Johal said: "We are delighted to be able to offer our staff such high standards of modern accommodation at affordable prices."

Multi-million pound investment to improve urgent and emergency care and diagnostics

Improvements to the urgent care, assessment and diagnostic services at Scunthorpe General Hospital and Diana Princess of Wales Hospital in Grimsby will be taking place over the next few years. The Trust secured £29.26 million to make the improvements from the latest round of capital funding announced by the Department of Health and Social Care in December 2018. Over the next few years the cash will enable the major upgrading and consolidation of the urgent care and assessment facilities in both hospitals to bring them up to the most modern standards and requirements and provide a better environment for patients to be treated. The rest of the funding will be invested in new diagnostic scanners on both sites.

Key issues and risks that affected the Trust in 2018/19

Risk type	Nature of risk	What was done
Insufficient capacity	Negative risk. Within key areas of resource the Trust does not have sufficient capacity to meet the demand.	The Trust worked with its partners to put into place actions to reduce demand, especially around urgent care. However the Trust still saw around a 7% increase in attendances, although it did manage to see more patients within four hours. The Trust invested in a temporary theatre at Goole to ensure elective activity could continue. Finally the Trust decided to maintain elective activity through the winter period, which was not the case in 2017/18.
Lack of sufficiently skilled and volume of workforce	Negative risk. The high vacancy rate across the spectrum of clinical staff is impacting upon capacity to deliver good care, consistently.	The Trust saw an improved fill rate for junior doctors and continued to recruit new nurses and doctors through proactive recruitment activities such as open days and targeted campaigns. It also continued its plan to Introduce new roles such as Physician Associates and Physician Assistants. The Trust built on its Apprenticeship programme to bring in new staff and train existing staff for different roles.
Culture	Negative risk. Through the results of national and local surveys, morale across our workforce needs to be improved.	A new Associate Director of Communications and Engagement started at the Trust with a strong focus on staff engagement, especially celebrating the work of staff through initiatives such as Team of the Week and 'ThumbsUpFriday' on social media.. The Trust ran a series of training events and conferences asking leaders and managers to think about how they engage and interact with their staff. The Trust introduced a new induction process to improve the experience of new staff.

Activity levels in 2018/19

	2018/19	2017/18
Emergency Department attendances at Grimsby and Scunthorpe	144,825	134,567
Admissions into hospital	124,905	119,564
Number of discharges (patients leaving hospital)	124,934	119,559
Outpatient appointments	405,203	410,790
Births	4,037	4,322
Patients who were admitted as an emergency	41,714	38,037
Total procedures	245,007	234,802
Total elective procedures	129,252	125,854

Going concern

Introduction

The accounting concept of going concern is fundamental in the way that the assets and liabilities of an organisation are recorded and included within the accounts. Under this concept the organisation is usually viewed as continuing in business for the foreseeable future to allow the accounts to be drafted.

If the organisation could not continue to operate in the way it has been operating, the assets and liabilities would be recorded in the accounts on a different basis reflecting their value on the winding up of the entity. As a result, the assets would be recorded at a much lower break-up value and medium and long-term liabilities would become short term.NHS Foundation Trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Financial Reporting Standards (IFRSs) and International Accounting Standards (IASs) as interpreted by the NHS Foundation Trust Annual Reporting Manual (ARM). The requirement to prepare accounts on a going concern basis is set out in IAS 1: Presentation of Financial Statements which states:

"An entity should prepare its financial statements on a going concern basis, unless:

- The entity is being liquidated or has ceased trading; or
- The directors have no realistic alternative but to liquidate the entity or to cease trading,

in which circumstances the entity may, if appropriate, prepare its financial statements on a basis other than going concern. When preparing financial statements, directors should assess whether there are significant doubts about the entity's ability to continue as a going concern."

Auditors will consider what the directors have done to satisfy themselves that the accounts should be prepared on a going concern basis.

This section of the Annual Report aims to consider the basis on which the accounts should be prepared and present evidence for the conclusion reached on the going concern issue. It is important to note that the going concern consideration applies to the Northern Lincolnshire and Goole NHS Foundation Trust as an entity, and not the services which it delivers.

Required action for North Lincolnshire and Goole NHS Foundation Trust

To comply with IAS 1 management must, in preparing the annual statement of accounts, undertake an assessment of the Trust's ability to continue as a going concern.

In making this assessment, management should take into account all information about the future that is available at the time the judgment is made. As a minimum, this assessment should cover at least a twelve month period from the date of approval of the accounts, although this period will need to be extended where management is aware of events and related business risks further in the future that may cast doubt on the going concern assumption. The Trust is required to consider performance against the finance use of resources theme under the regulator's Single Oversight Framework.

Financial and Quality Special Measures

The Trust delivered a financial deficit of £58.1m (including donated items and impairments) in 2018/19, based on draft accounts. This clearly represents a significant variance from the original planned control total deficit for the year (excluding STF) of £39m.

NHS Improvement (NHSI) formally placed the Trust in Financial Special Measures in March 2017. This was shortly followed by the Trust being placed in Quality Special Measures, following the November 2016 inspection by the CQC. NHSI has continued to set specific financial and service objectives for the Trust during 2018/19. Financial and Quality Special Measures do not result in the Trust ceasing trading within the next 12 months, or the requirement to face regulator action to cease or modify the trading status in that period. They are designed to support recovery of quality standards and financial and operational performance, supported by regulators.

Single Oversight Framework – Finance Use of Resources

The Finance Use of Resources metric aims to support providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure. When assessing the Trust against this metric NHS Improvement considers the financial metrics shown below to assess financial performance by:

- Scoring providers 1 (best) to 4 against each metric
- Averaging individual providers' scores across all the metrics to derive a use of resources score for the provider

Each of the results for the Trust at the end of 2018/19 are shown below, however the Trust will score a 4 across all measures while under financial special measures.

Financial use of resource	Metric	Rating
Capital service cover	(4.538)	4
Liquidity	(31.210)	4
I&E Margin	(17.10%)	4
I&E Margin variance from plan	(8.20%)	4
Agency	49.18%	3
Overall rating		**4**
Financial special measures override		**4**

Financial Sustainability – Going Concern

The Trust will be tasked with delivering financial improvement in 2019/20, following the 2018/19 financial setback, rather than being expected to meet the control total regime set by NHSI. This reflects the supportive approach taken by the regulator, and the recovery based nature of Financial Special Measures.

In 2019/20 the Trust will not be accepting its Control Total of a deficit of (£15.4m), but will instead target a deficit of (£54m). This will require a CIP of about 5% of cost. Delivery of this level of improvement will require improvement in productivity.

These are objectives which have been delivered in similar circumstances elsewhere, and reflect a reasonable though challenging financial target as anticipated by the regulator.

The Trust has worked to agree contract numbers with CCGs and therefore feels that this is risk has been reduced compared to previous years. However not accepting the control total potentially lays the Trust open to the level of fines. The agreement includes benefits from counting and coding changes. This work has been reset to ensure that it is delivered for 2019/20.

The Trust will face other risks around inflation, regulatory pressures, contract challenges and other potential unknowns. These are part of normal operation of the Trust, rather than forming existential threats.

Any judgment on going concern status should be made in the context of the ongoing dialogue with the regulator, and the absence of any indication from them of a need to consider any substantial ceasing of current operations within 2019/20.

At the point of consideration of this paper (April 2019) there was no indication of any degree of pressure to cease service delivery to the point at which the Trust's existence would be materially threatened within the 12 month timescale.

The Trust remains dependent upon central loan support to maintain cashflow. The experience of the Trust and other providers since 2014/15 is that this means of liquidity support is now established as a critical element of the central provider management system.

There are no grounds to expect such a system to be substantially altered during 2019/20.

The terms of loans are critical. At the point of maturity, the lender (the Department for Health and Social Care) is obliged to look at the affordability for the position of the organisation before deciding on the next step to take – conversion to PDC support, extension of the loan, or repayment.

The Trust Board has stated its reliance upon this clause in the regulations when approving loan agreements.

In the context of the flexibilities set out in the regulatory framework for revenue support, the presence of the loans themselves do not constitute a fundamental threat to going concern of individual organisations.

Basis of assessment

When concluding whether or not the accounts for 2018/19 should be prepared on a going concern basis, IAS 1 requires that the Board consider which of the following three basic scenarios is the most appropriate:

(i) The body is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis;
(ii) The body is a going concern but there are uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view;
(iii) The body is not a going concern and the accounts will need to be prepared on an appropriate alternative basis

Conclusions

Given the evidence presented in sections 3, 4 and 5 above, and the criteria stated in paragraph 1.2 above, it is clear that the Trust is a going concern and it is appropriate for the 2018/19 annual accounts to be prepared on this basis. It should be noted that, as stated above, there remain a number of risks attached to the Trust's financial and service plans. These are subject to active management through the Special Measures process, and as such do not represent a fundamental threat to operations through 2019/20. As such the risks outlined do not affect the decision to prepare accounts on a going concern basis

Performance analysis

The Well-led Framework used by NHS Improvement identifies effective oversight by Trust Boards as essential to ensuring trusts consistently deliver safe, sustainable and high quality care for patients. This includes robust oversight of care quality, operations and finance. At the Trust an Integrated Performance Report is submitted monthly to the Board for assurance.

For the purpose of reporting, indicators are grouped into the five domains of quality (caring, safe, effective, responsive and well led) identified by the Care Quality Commission. Data is reported using a scorecard approach and performance is assigned a Red or Green (RAG) rating based on achievement against pre-defined thresholds. Under these assessments the ratings are set out in the table below. The monthly report to the Trust Board identifies performance against: key operational and quality requirements mandated nationally; activity against planned levels; and finance.

The purpose of this approach is to ensure the Board is provided with robust and timely information on organisational and operational performance. Further information is provided to the Board on an exception basis where under performance in a particular area or against a specific target is identified.

2018/19 Performance compared to Trust performance in 2017/18

Status	Performance Description
Red (N)	**Declined:** 2018/19 has declined based on the 2017/18 performance position.
Green (Y)	**Improved:** 2018/19 has improved based on the 2017/18 performance position.
n/c	**No change in performance**

Performance Indicator	2018/19	2017/18	Improved Position?
Mixed sex sleeping accommodation breach	469	633	Y
Trust attributable MRSA infection cases	0	1	Y
Venous Thromboembolism (VTE) risk assessment of eligible in-patients	93.28%	90.49%	Y
NHS Safety Thermometer: harm free care	93.09%	92.19%	Y
A&E waiting times – admitted, transferred or discharged within 4 hours	85%	84%	Y
Trolley waits in A&E longer than 12 hours	3	0	N
Ambulance handovers >15 minutes from arrival	21,055	23,141	Y
Ambulance handovers >30 minutes from arrival	8,268	9,792	Y
Ambulance handovers >60 minutes from arrival	1,437	1,854	Y
Referral to Treatment (RTT): incomplete <18 weeks	20,495	19,468	N
Referral to Treatment (RTT): 92% incomplete pathways <18 weeks at specialty level	76.17%	66.23%	Y
Referral to Treatment (RTT): incomplete >52 week waits at month end	24	320	Y
Diagnostic waiting times: >6 weeks from referral for test	89.60%	91.50%	Y
Cancer: 2 weeks from urgent GP referral to 1st outpatient	96.9%	95.7%	Y
Cancer: 2 weeks from urgent GP referral for breast symptoms to 1st outpatient	92.3%	94.9%	N
Cancer: 31 days from diagnosis to first definitive treatment	98.7%	99.2%	N
Cancer: 31 days to subsequent treatment - surgery	98.2%	98.7%	N
Cancer: 31 days to subsequent treatment - drug	100%	99.8%	Y
Cancer: 62 days from urgent GP referral to first definitive treatment	73.8%	73.5%	Y
Cancer: 62 days from referral from NHS screening service to first definitive treatment	92%	92.1%	N
Last minute cancelled operations (non-clinical reasons) not re-booked within 28 days	32	67	Y
Urgent operations cancelled for a second time	0	0	n/c

Financial performance

As in the previous few years the 2018/19 year was a difficult one for the Trust, and the challenges facing the organisation through the year are reflected in the financial performance.

Financial Special Measures

The Trust Board had signed up to its plan for the year with NHS Improvement in November 2016, with a deficit forecast of £13m. However, the financial position deteriorated rapidly in the latter part of 2016/17. Activity delivery was slowed, affecting income, and temporary clinical staffing costs and expenditure on outsourced treatment capacity increased sharply.

As a result the Trust was placed in Financial Special Measures in March 2017, and entered 2017/18 in a position that made delivery of the financial targets set for the year impossible. Due to changes in the Trust's leadership team the Financial Special Measures process truly commenced in August 2017.

The Trust put in place a Turnaround Director, and a Service Transformation expert to support the rebuilding of management teams and to support the tightening of controls. The Trust also appointed Ernst Young (EY) as partners. These remained in place until the end of 2018/19. The Trust's regulator NHSI, has expressed significant concern over the Trust's financial position. Although the deficit run rate improved in March it continues to be a major cause for concern for the Trust and NHSI. The Trust is likely to be in Financial Special measures into 2019/20 and beyond. The Trust is working on opportunities to improve the financial position and continues to focus on its planned care productivity which is essential to improving the run rate going into 2019/20. The Trust continues to work with NHSI and local parters to maintain its financial viability and work towards financial balance in the medium term. The financial special measures in respect of discretionary spending and operational financial controls continue to be in place, especially in respect of the scrutiny and approval of business cases for additional spending.

Financial outturn 2018/19

The Trust's deficit for the year is £58.11m which is £26.82m adrift of the planned deficit of £31.3m. The key factors in the failure to achieve the target are as follows:

- Failure to earn the planned Provider Sustainability Fund payments, except for a general Provider Sustainability Fund Distribution of £2.33m in April,
- Non receipt of the additional capacity funding included in the 20th June plan resubmission,
- Clinical income behind plan and a significant number of contract challenges
- Increased pressures on clinical staffing costs despite an improved vacancy position, non-pay costs, linked to savings delivery in Orthopaedic prosthesis, increased Estates Maintenance costs and the continued need to outsource expensive diagnostic capacity.

The Trust continues to maintain its focus on the critical expenditure variables, and on increasing planned care productivity – this is a critical service and quality objective, as well as a key part of the financial delivery plan. Planned care productivity was essential to achieving the best forecast and improving the exit run rate going into 2019/20.

Income and contracting

The activity for 18/19 was behind plan but higher than in the previous year.

There were significant contract challenges in year that reduced the value of the clinical income received by the Trust that contributed to the overall Trust deficit.

Despite this the Trust has worked hard to establish strong contractual relationships with its commissioners and has agreed an aligned plan and contracts for 19/20 that realises the financial benefit of previous challenges and so puts the recognition of income in 19/20 in a more robust position.

Expenditure and savings delivery

The core savings programme has fully achieved its £15 million plan at year-end.

Although the procurement and nursing teams both found the financial year challenging. They were mitigated by a strong medical staffing recruitment performance, the on-going vacancy position across AHPs and the length of stay reduction on the medical wards.

The Trust has a full savings programme in place for 2019/20 and this includes working with local system partners.

Capital and infrastructure

The Trust ran a modest capital programme during 2018/19, except for the conclusion of the delivery of the new staff residences build on the Grimsby site called the Roost which was completed in November 2018.

The rest of the capital plan was mainly based on the Trust`s level of depreciation, however £1.3m was received as a donation to implement a cardiac project and £1.2m of urgent capital support funding for essential replacements.

Towards the end of the year the Trust confirmed it will receive £29.26m of capital funding over the next five years as part of the Humber Coast and Vale STP bids that were submitted, subject to formal bids to the Treasury.

At the time of writing work had started to progress the bids that need to go to Treasury in order to secure this money.

Looking Forward to 2019/20

The Trust continues to be in double special measures and faces significant service and financial challenges.

The financial position deteriorated significantly during 2018/19. The underlying budget for 2019/20 is a £53 million deficit, a modest improvement on 2018/19, but when Marginal Rate Emergency Tariff (MRET) and Provider Sustainability Fund (PSF) money is added to the position the agreed control total is a deficit of £25.4 million.

Social, community and human rights

Maintaining strong relationship with our local communities is an important priority for the Trust. The Chief Executive holds regular meetings with local MPs to keep them informed of progress and performance. Representatives from the Trust regularly attend meetings of the local Health and Wellbeing Boards and Trust performance is monitored by the overview and scrutiny committees of North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire councils. Regular communication takes place with Trust members in the form of email updates, and invitations to attend Trust Board meetings and governor events including drop-in sessions and discussion groups. The Trust magazine, News@NLaG is aimed at staff, members, as well as the general public and includes information about the Trust's services and our performance. The Trust also continues to engage with local education establishments to recruit healthcare and other students, and this has helped with nurse cadet, traineeship and apprenticeship schemes.

Details of any overseas operations

The Trust does not have any overseas operations.

Sustainability Report

Introduction

As an NHS organisation, and as a spender of public funds, the Trust has an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, and the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of the social, environmental and economic assets the Trust can improve health both in the immediate and long term even in the context of rising cost of natural resources.

Demonstrating the Trust considers the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met. In order to fulfil its responsibilities for the role it plays Northern Lincolnshire and Goole NHS Foundation Trust has created a sustainable development management plan (SDMP). The Trust's sustainability mission statement is: *"The Trust is committed to long term sustainability, it also recognises its Corporate Social Responsibility (CSR) both as one of the largest employers in the local economy and as an emitter of carbon in to the local environment. It seeks to use this position to engage, inform, persuade and influence staff, visitors, patients and contractors to reduce the emissions of carbon."*

As a part of the NHS, public health and social care system, it is the Trust's duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline) equivalent to a 28 per cent reduction from a 2013 baseline by 2020. The Trust aims to supersede this target by reducing carbon emissions to 34 per cent by using 2007/08 as the baseline year.

Policies

In order to embed sustainability within the Trust it is important to explain where in its process and procedures sustainability features. One of the ways in which an organisation can embed sustainability is through the use of a Self-Declared Maintenance Programme (SDMP).The Trust Board approved a Travel Plan in the last 12 months and the SDMP covers the period 2015-2020, therefore the Trust's plans for a sustainable future are well known within the organisation and are clearly laid out.

Climate change brings new challenges to the Trust, both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc. The Trust Board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events.

One of the ways in which the Trust can measure its impact as an organisation on corporate social responsibility is through the use of the Sustainable Development Assessment Tool (SDAT) tool. The last time this was in March 2018, scoring 55%. As an organisation that acknowledges its responsibility towards creating a sustainable future, the Trust helps achieve that goal by running awareness campaigns that promote the benefits of sustainability to staff. The Trust is *starting* to contribute to the following Sustainable Development Goals (SDGs):

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Green space and biodiversity

Currently the Trust does have a formal approach to unlock the opportunities and benefits of natural capital within a healthcare environment in supporting the health and wellbeing of staff, patients and the community and to protect biodiversity.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for the Trust as a healthcare provider, evidence of this commitment will need to be provided in part through contracting mechanisms. Strategic partnerships are already established with the following organisations:

- Centrica.

More information on these measures is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx

Trust performance on sustainability

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the table below helps to explain how both the organisation and its performance on sustainability has changed over time.

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS as a system by 28% (from a 2013 baseline) by 2020. The Trust has supported this ambition in relation to energy, travel, waste and water.

Context info	2014/15	2015/16	2016/17	2017/18	2018/19
Floor Space (m2)	142,522	147,524	142,100	138,598	141,284
Number of Staff	5,375	6,500	6,400	6,400	6,700

Energy

The Trust has spent £3,790,805 on energy in 2018/19, which is an 11 per cent increase on energy spending from 2017/18. The table below sets out the last five years:

Resource		2014/15	2015/16	2016/17	2017/18	2018/19
Gas	Use (kWh)	23,559,266	32,795,885	44,968,071	58,509,662	50,148,568
	tCO2e	4,943	6,864	9,398	12,405	10,652
Coal	Use (kWh)	5,803,531	3,582,240	4,335,570	3,779,215	4,630,926
	tCO2e	2,127	1,310	1,616	1,416	1,831
Electricity	Use (kWh)	15,717,738	18,949,354	13,661,699	14,499,282	16,521,374
	tCO2e	9,734	10,894	7,060	6,463	5,828
Total Energy CO2e		**16,830**	**19,086**	**18,096**	**20,284**	**18,311**
Total Energy Spend		**£3,225,824**	**£3,574,947**	**£3,542,219**	**£3,416,821**	**£3,790,805**

The Trust's gas consumptions have decreased 14 per cent from the previous year, the Trust datasets suggest that the baseload demand for both estates has decreased due to operational and weather-related factors.

Coal increased in usage at Goole and District Hospital, the major element of this increase includes the low calorific value of the coal.

The Combined Heat and Power unit (CHP) unit required a fossil energy input of 9,145,557 kWh (Gas) in order to produce 3,840,915 kWh of site utilised electricity at Grimsby Hospital.

The Energy Performance Contract (EPC) between the Trust and British Gas is entering year three of a 15 year contract and continues to deliver c£400k in savings per annum and is part of the contractual guarantee.

The Trust's energy consumption has also reduced due to a comprehensive estates rationalisation programme as outlined in the Trust's Estates Strategy.

Travel

The Trust is committed to the continuous development of strategies to reduce its impact on the environment, supporting the reduction of carbon emissions for England. Within the hospitals and communities, the Trust's activities providing healthcare has an impact on the sustainable development agenda and plans.

Travel forms a major part of its strategies and the Trust recognises this area as a key function in supporting its responsibilities. Through investment into its Travel Plan, promoting the plans into operational delivery, the Trust promotes the positive impact this plan can have on patients, staff, visitors and wider communities. By improving air quality, managing traffic levels, engaging with and promoting better public transport initiatives, the Trust aims to demonstrate and support healthy, sustainable travel modes using its plan to address its "movement strategy".

Category	Mode	2014/15	2015/16	2016/17	2017/18	2018/19
Patient and visitor own travel	miles	0	6,066,995	22,856,442	27,969,311	39,721,229
	tCO2e	0.00	2,194.04	8,260.56	9,966.16	14,646
Staff commute	miles	5,163,319	6,244,014	6,150,400	6,147,952	6,246,500
	tCO2e	1,897.15	2,258.06	2,222.82	2,190.67	2,303
Business travel and fleet	miles	0	0	0	4,519,564	2,872,011
	tCO2e	0.00	0.00	0.00	1,610.25	1002.63
Owned Electric and PHEV mileage	miles	0	0	19,717	22,033	38,043
	tCO2e	0.00	0.00	2.24	2.50	4.31
Total cost of business travel	**£**				**1,575,389**	**1,322,960**

The Trust is continually working towards a more carbon efficient fleet. It has introduced four electric vehicles and planning to increase the fleet percentage with further lower emission and hybrid vehicles. It is currently in the planning stages of introducing electric vehicle charge-points to enable staff and visitors to recharge their electric/hybrid vehicles.

Staff are actively encouraged to consider alternatives to travelling by, with cycling promotion heavily on the agenda, with upgrades on Scunthorpe and Grimsby Hospital site cycle shelters.

The Trust also runs a cross site shuttle service for staff to utilise for travelling between Grimsby and Scunthorpe hospitals which contributes to reducing the carbon footprint. Car Sharing is another initiative being worked up to encourage the reduction of vehicular traffic on site.

Waste

Waste		2014/15	2015/16	2016/17	2017/18	2018/19
Recycling	(tonnes)	160.00	293.00	341.00	573.00	673.00
	tCO2e	3.36	5.86	7.16	12.47	14.4
Other recovery	(tonnes)	561.00	583.00	564.00	938.00	903.00
	tCO2e	11.78	11.66	11.84	20.41	19.3
High Temp disposal	(tonnes)	72.00	92.00	93.00	0.00	0.00
	tCO2e	15.84	20.15	20.46	0.00	0.00
Landfill	(tonnes)	677.00	463.72	636.00	343.00	443.00
	tCO2e	165.47	113.34	197.16	118.16	153.00
Total Waste (tonnes)		1470.00	1431.72	1634.00	1854.00	2019.00
% Recycled or re-used		11%	20%	21%	31%	33%
Total Waste tCO2e		196.45	151.01	236.63	151.04	186.00

The Trust continues to work with its waste contractors to redirect landfill waste to either recycling and other recovery.

The Rust encourages staff to recycle across all sites and positively promotes the waste hierarchy. All Clinical Waste is currently sent to an incineration plant which uses the energy from the incineration process and converts it to energy from waste, to power the waste facility. Any excess energy is then sent to the national grid. Therefore this waste has been categorised as other recovery.

Future plans to improve waste management on all sites will be to identify what the current systems are and make improvements by:

- Improving efficiencies
- Moving waste up the hierarchy
- Reducing costs
- Optimising revenue
- Introduce closed loop materials
- Achieving zero to landfill status

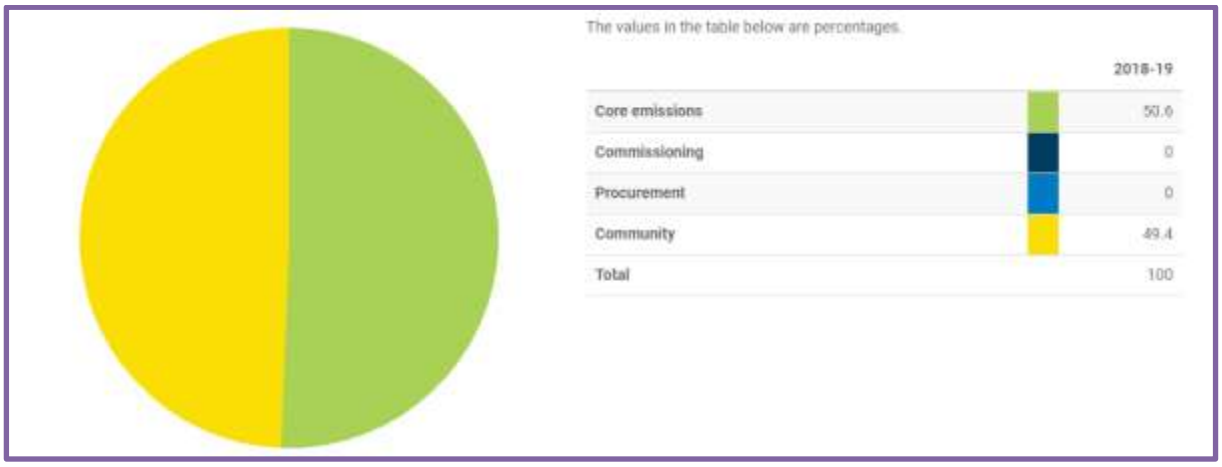
Finite resource use – Water

Water		2014/15	2015/16	2016/17	2017/18	2018/19
Mains Water	m3	122,010	100,114	245,980	311,572	194,431
	tCO2e	111	91	224	284	177
Water & Sewage Spend		£343,284	£323,655	£470,137	£468,393	£441,254

Though the Trust has a stringent water flushing routine, through repairs to leaks and upgrades to water infrastructure, there has been a significant decrease in water consumption over the financial year 2018/19.

Modelled Carbon Footprint

The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, this does not reflect the Trust's entire carbon footprint. Therefore, the following information estimates the impact of our supply chain from our spend. More information about this is available here: http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx



Carbon Reduction

The Trust has both a Trust Board approved Sustainable Development Management Plan (SDMP) and a Travel Plan, both of which are reviewed annually. These documents include risk assessments to ensure the Trust can attain its carbon reduction targets in accordance with emergency preparedness and civil contingency requirements.

These are based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has been nationally recognised by the Sustainable Development Unit (SDU) for the quality of the 2016/17 sustainability report contained within the Trust's annual report.

Chapter Two: Highlights of the Year

Endoscopy unit official opening

A £1.6million endoscopy unit at Scunthorpe hospital was officially opened in April 2018 as part of an open day for patients, visitors and staff to visit the unit.

The Trust said the new unit brings two benefits – improving patient care and helping to attract future nurses and healthcare assistants.

Clinical endoscopy lead, Mr Ramana Kallam, explained the importance of this introduction to the Trust. He said, "The new units have state-of-the-art equipment to do more complex treatments for the patient's benefit.

"Ultimately everything is for the patients benefit; without them we don't exist. It has been a fantastic journey to this point. We're able to treat more patients due to having more capacity and better equipment."

Scunthorpe hospital serves up seventh straight five-star success

It was a case of 'seventh heaven' for catering staff at Scunthorpe General Hospital, who were once again awarded a five-star food hygiene rating in May 2018.

North Lincolnshire Council assess against the Food Standards Agency ratings scheme. Inspectors look at food preparation, hygiene and cleanliness and confidence in management, leading to an overall score rating range from no stars (urgent improvement necessary) to five stars (very good).

Staff working in the kitchens serve up nearly 20,000 patient meals every month.

Keith Fowler, head of facilities services, said: "I am proud that once again our teams have excelled and this is the seventh consecutive year we have been awarded five stars.

"Food plays such an important part in our patients' recovery. Thank you to all the staff who have helped contribute to this achievement for their ongoing hard work."

Endoscopy unit recognised for high standards

Endoscopy staff at Grimsby hospital were recognised for delivering high quality services in June 2018. The unit was awarded JAG (Joint Advisory Group) accreditation following an assessment of four domains: clinical quality, patient experience, workforce, and training.

The scheme awards units which demonstrate high quality and safe services run by highly trained and motivated staff. Assessors congratulated staff on their 'outstanding patient centred booking service' the 'prominent displays of feedback' and the appointment of a training lead.

The unit provides a range of diagnostic and therapeutic services including colonoscopies, gastroscopies, cystoscopy and flexible sigmoidoscopy with around 1,800 procedures carried out every month. Tracey Broom, divisional general manger for clinical support services, said: "Achieving this has been the result of many months of hard work and I want to thank all staff involved. Ensuring our patients receive a high quality service is our number one priority and this accreditation gives people assurance that's what they'll get when they walk through our doors."

New roles help more patients receive treatment for eye conditions

Patients needing potentially sight-saving injections can now be seen by two recruits to the ophthalmology team at Scunthorpe hospital.

Former theatre operating department practitioner (ODP) Khine Aung and theatre nurse lead Lissa Binoy were put through their paces on an intensive six months training course to become ophthalmic injectors – a brand new role for Northern Lincolnshire and Goole NHS Foundation Trust.

They provide Anti-VEGF injections, which is a type of drug used to treat a number of eye conditions including wet age related macular degeneration, build-up of fluid in the eye caused by diabetes and blockages in the veins of the eye.

These injections are injected into the jelly-like substance of the eye. This was traditionally done by doctors at Scunthorpe hospital. Now Khine and Lissa have joined an army of ophthalmic injectors across the country who are providing this type of treatment.

Mr Sakkaf Ahmed Aftab, consultant ophthalmologist, said: “It has been shown that nurses can deliver injections for patients as safely and effectively as doctors, and many hospitals now have nurse injectors.

“By training Lissa and Khine it means more patients will be able to be treated as they are not reliant on just doctors giving the injections. This in turn has freed up two doctors who are now able to see more complicated cases in theatre and clinic.”

New nurses to swell the ranks at local hospitals

Seventy three new nurses joined the Trust in the autumn. The recruits – who were all newly qualified nurses – took up posts at Scunthorpe, Grimsby and Goole hospitals, as well as in the Trust’s community services from September.

Coming from both local universities and from further afield, the recruits all completed their nursing qualifications and have been given the option to choose a department/specialty to work in.

They joined the wards from September but had already been welcomed to the Trust at sessions held throughout the summer to help prepare them for their new roles. The recruitment team even made a special survival kit for each new starter which included information about the Trust and useful things like a phone charger, pen, sweets and tissues. The new nurses are now taking part in the Trust’s 12 month preceptorship programme. This includes a week-long intensive course which aims to ensure the care provided to patients is consistent in quality.

Special ‘wallet’ helping pregnant women

Beautiful bouncing baby Amelia Jackson is the apple of her parents’ eye. At six weeks old she is thriving – but that is only thanks to a special ‘wallet’ and the quick-thinking midwifery team at Scunthorpe hospital.

Proud parents Pete and Bev Jackson, of Winteringham, celebrated the birth of their rainbow baby after the tragic loss of her big sister Alicia who was born sleeping in February 2017.

It is thanks to a 50p plastic wallet that is now being given to all pregnant women who come through Scunthorpe, Grimsby and Goole hospitals that Pete and Bev sought help.

Pete said: “I am in no doubt that the wallet, and the amazing staff saved Amelia’s life. The wallet says to trust your instincts and that is exactly what we did. Bev had some pelvic pains so we went to the pregnancy assessment unit to get checked out.

“The midwife, Sarah Pedge, who saw us was fantastic. She did the necessary tests, and acting on her expertise, decided to get Bev scanned.”

The scan showed an abnormality with the placenta and Bev was rushed to the labour ward for further observations. Nick Kerry, bereavement midwife, had been caring for the couple through her rainbow clinic and came in on her day off to be with the couple.

Nick said: “Thankfully Pete and Bev had been in the hospital for an eye appointment. Bev had a niggling pain and acting on the information on the wallet popped into the midwifery unit. Amelia was in distress and needed to be delivered by emergency caesarean section. If they hadn’t of acted on the wallet, and had the care they did from the whole team, then Amelia would probably not be here today.”

The colourful plastic wallets, which have been bought by Scunthorpe and Grimsby League of Friends, feature easy to understand key advice regarding mum’s health, and that of the baby.

Staff, volunteers and fundraisers celebrated at awards night

A specialist centre for people with brain injuries and other neurological conditions were recognised for giving outstanding care to patients.

The Neuro Rehab Centre at Goole was named as the Patients’ Choice Award winner at the Trust’s staff awards ceremony, Our Stars, in November 2018 (see picture below).

Earlier in the year patients visiting hospitals in Scunthorpe, Grimsby and Goole and accessing the community services run by the Trust were asked to nominate their NHS heroes for the 'Patients' Choice Award'. The NRC was one of three finalists and went on to scoop the award.

They were nominated by a relative of a long term patient who said: "My son was taken to the NRC after seven and a half months in critical care. He'd had a traumatic brain injury after a motorbike accident and because of this was left with a PEG feed, no speech and only able to move his left thumb. This team is amazing and due to their hard work Lee can now speak, feed himself, dress himself and he can use his electronic wheelchair and walk with assistance."

Meanwhile Farmhouse Pub Managers Lee and Phil (pictured below) picked up the Health Tree Foundation Charity Champion Award for their contribution to the Maternity Bereavement Suite at Scunthorpe hospital.

Eighteen other winners were announced on the night with staff ranging from doctors and nurses to a pharmacist and administrative staff all celebrated for their innovation, compassion and dedication to local patients.

New role helping patients on their journey through hospital

A new role was rolled out to help patients flow through hospital from admission to discharge as smoothly and speedily as possible.

A total of 15 new apprentice patient care navigators are now walking the wards and corridors of Scunthorpe and Grimsby hospitals with one aim in sight – the safe and timely discharge of patients.

They are working alongside doctors, nurses and therapists on wards to provide administrative and clinical support to deliver a safe, streamlined journey for patients throughout their admission.

The care navigators will work with the shift leads to support a well-led board round, acting on the outcome of results, attending doctor's ward rounds and supporting the nursing staff. They will also help manage requests for diagnostics such as scans and help nursing staff with discharge planning.

Claire Horton (above right), one of the new navigators who works on ward 23 at Scunthorpe hospital, said: "I love the fact I am playing a key part in implementing discharges."

New nurse providing vital support for people with epilepsy

A new nurse, who has a wealth of experience caring for patients with brain injuries, took on a new role at Grimsby hospital in December 2018.

Natasha Garnett is the new epilepsy clinical nurse specialist working alongside neurologist Dr Jayam Lazarus in providing care for hundreds of local patients.

Epilepsy is a condition that affects the brain and means people diagnosed with it have a tendency to have epileptic seizures. It is one of the most common serious neurological conditions in the world affecting around 600,000 people in the UK. This means that almost one in 100 people in the UK have epilepsy.

It can start at any age and there are many different types of seizures depending on which part of the brain is affected. During some types of seizure the person may remain alert and aware of what's going on around them, and with other types they may lose awareness. They may have unusual sensations, feelings or movements. Or they may go stiff, fall to the floor and jerk. Natasha, who is no stranger to the hospital having previously worked as a rheumatology clinical specialist nurse and as a senior nurse at Goole Neuro Rehabilitation Centre, said: "I have always been absolutely fascinated in how the brain works. I started my career in neuro rehabilitation in Leeds before moving to this Trust.

"In this new role I play a key role in working alongside patients in empowering and helping them to manage their condition and live as normal a life as possible through appropriate medication and symptom management.

Opening of new community clinic

Patients requiring certain injections and infusions as part of their care for oncology, respiratory and dermatology are now being treated at a LloydsPharmacy Healthcare Centre in Scunthorpe thanks to a partnership developed with the Trust.

The community infusion clinic, the first of its type in the United Kingdom, is located adjacent to the LloydsPharmacy on Marsden Drive and is already proving to be a real success.

It was officially opened by Anne Shaw, NLaG chair, and Toby Anderson, CEO of McKesson UK (which includes LloydsPharmacy), at a ceremony on in January 2019. Until the clinic opened patients needing treatment had to visit the hospital which took time and, sometimes, made them anxious. Now they can be booked in to a slot at the clinic which suits them and means they spend less time getting their vital medicines.

A red bag: a simple change packing a difference

A simple initiative was rolled out across North East Lincolnshire to help people living in care homes receive quick and effective transfer and treatment should they need to go into hospital. The red bag initiative, or 'hospital transfer pathway', is being rolled out by the Trust in partnership with North East Lincolnshire Clinical Commissioning Group and care and nursing homes.

Under the new scheme, when a patient is taken into Grimsby hospital in an emergency they will have a Red Bag to take with them. The bag will contain: general health information, including any existing medical conditions; medication information so ambulance and hospital staff know immediately what medication they are taking; and personal belongings (such as clothes for day of discharge, glasses, hearing aid, dentures or other items).

Quality matron Rachel Greenbeck (above) said: "It is a simple initiative but one that will provide better communication between care homes and Grimsby hospital at all points of the resident's journey into hospital and back home again."

New pre-assessment room opens at Grimsby hospital

A new pre-assessment room for children opened at Grimsby hospital in February 2019 funded entirely by donations.

Staff and volunteers have been working hard getting the room ready ahead of its official opening which took place in February in the Child Development Centre (CDC). Pre-assessment is currently carried out in children's outpatients in a consulting room. The new room will free up this space and increase clinic capacity.

Art teacher Charlotte Eames and pupils from St James' School in Grimsby have helped paint the room, which will be used as an area for parents to discuss what is going to happen to their child, ask questions and alleviate any fears they might have.

Work started around four weeks ago and the estimated cost of donated materials and labour is about £2,000.

Pre-assessment takes place a few weeks before the patient's surgery/procedure. This new room is a relaxing area for children and their parents and has colourful artwork including a bear-themed wall.

National accreditation for cardiac service

Grimsby hospital was recognised as having one of the best cardiac rehabilitation services in the country.

The cardiac rehabilitation team at Diana, Princess of Wales Hospital has met the required standards to become a National Audit of Cardiac Rehabilitation (NACR) and British Association for Cardiovascular Prevention and Rehabilitation (BACPR) credited service.

This means it can carry the credited logo and patients will be signposted to the service from the Cardiac Rehabilitation Online Register.

The NACR/BACPR programme was launched in June 2015, with 16 sites taking part in the initial pilot.
It aims to ensure the quality delivery of cardiac rehabilitation against nationally agreed minimum standards.

Angie Arnett-Briggs, nurse specialist in cardiac rehabilitation, said: “There are 299 centres for the national audit in England, Ireland and Wales, and 46 centres have been found to be meeting the core quality standards. Only 36 centres have been certified. “We have been striving for this for a while. We are advertised nationally as a recognised centre for cardiac rehabilitation quality.”

Major investment in replacement hospital beds

Patients will be sitting more comfortably thanks to a £95,000 investment in replacement beds at Scunthorpe and Grimsby hospitals. Eighty new electric beds were delivered in March, 40 at each site, as part of a drive to replace all non-profiling beds by March 2020.

Jug Johal, Director of Estates and Facilities, said: “This is just one phase of our bed replacement programme which will see more than 180 beds replaced over the next four years and a total investment of £600,000.”

The beds allow patients to reposition themselves including raising them into a seated position and/or elevating their legs. They have multiple controls all within reach to meet the needs of patients including those who are visually impaired. The easy clean beds can also be raised and lowered to suit the patient’s height. With features including enhanced siderails and mattresses which minimise pressure, the investment should also improve patient safety at the Trust by helping to prevent falls and pressure ulcers.

Chapter Three: The Accountability Report

Directors' Report

This Director's report sets out how the Trust is run and the governance arrangements it has in place to ensure there is proper oversight and governance of the Trust's activities.

The Trust has a Board which meets in public and the meetings are open to anyone who wants to attend. Details, including agenda and papers are available on the Trust website.

The Trust Board is made up of six Non-Executive Directors, including the Chair, and five executive directors, including the Chief Executive, and each member brings a variety of individual skills and experience.

The Trust also has a further three executive directors, none of whom have voting rights. Brief details of all the current Non-Executive Directors and Executive Directors are available on the Trust website.

Non-executive directors are not employees of the Trust and are appointed to provide independent support and challenge to the Trust Board. All Board directors are required to comply with the Trust Standards of Business Conduct, including declaration of any actual or potential conflict of interest, and the requirements of the Trust's constitution.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Board of Directors as at 31 March 2019

NON-EXECUTIVE DIRECTORS
Anne Shaw, Chair
Tony Bramley
Sandra Hills, Senior Independent Director
Linda Jackson, Deputy Chair
Nick Mapstone
Jeff Ramseyer
EXECUTIVE DIRECTORS
Dr Peter Reading, Chief Executive
Richard Eley, Interim Director of Finance
Marcus Hassall, Director of Finance
Ellie Monkhouse, Interim Chief Nurse
Lawrence Roberts, Medical Director
Shaun Stacey, Chief Operating Officer
Kate Wood, Acting Medical Director
NON-VOTING EXECUTIVE DIRECTORS
Jayne Adamson, Director of People and Organisational Effectiveness
Pam Clipson, Director of Strategy and Planning
Jug Johal, Director of Estates and Facilities

Directors who left the Trust in 2018/19

NON-EXECUTIVE DIRECTORS
Sue Cousland
Stan Shreeve
EXECUTIVE DIRECTORS
Tara Filby, Chief Nurse
Richard Sunley, Deputy Chief Executive and Director of Operations

Registers of interest

All Directors and Governors are required to declare their interests, including company directorships, on taking up appointment and as appropriate Board of Governors and Board Directors meetings in order to keep the register up to date. The Register of Directors' Interests and the Register of Governors' Interests are available on the Trust website at www.nlg.nhs.uk

The Board of Directors considers the balance and breadth of skills and experience of its members to be appropriate with the needs of the Trust. A formal skills matrix was completed during 2018/19.

All non-executive directors are considered to be independent, meeting the criteria for impendence as laid out in NHS Improvement's Code of Governance. Non-executive directors are appointed and removed by the Council of Governors. A committee consisting of the Chairman, the Chief Executive and the other non-executive directors appoints or removes the other executive directors.

The chair, Anne Shaw, has no other significant commitments.

Balance of the Board

Non-executive Directors are appointed to bring particular skills to the Board, ensuring the balance, completeness and appropriateness of the Board membership.

Attendance at Trust Board meetings in 2018/19

Name	Number (number attended/ possible number could have attended)
Anne Shaw, Chair	10/10
Tony Bramley, NED	10/10
Sandra Hills, NED	9/10
Linda Jackson, Deputy Chair, NED	10/10
Nick Mapstone, NED	7/8
Jeff Ramseyer, NED	8/8
Dr Peter Reading, Chief Executive	9/10
Richard Eley, Interim Director of Finance	2/2
Marcus Hassall, Director of Finance	7/10
Ellie Monkhouse, Interim Chief Nurse	2/2
Lawrence Roberts, Medical Director	0/10
Shaun Stacey, Chief Operating Officer	9/9
Dr Kate Wood, Acting Medical Director	10/10
Jayne Adamson, Director of People and Organisational Effectiveness	10/10
Pam Clipson, Director of Strategy and Planning	1/4
Jug Johal, Director of Estates and Facilities	4/4
Tara Filby, Chief Nurse	6/10
Wendy Booth, Trust Secretary	9/10
Elaine Coghill, Acting Chief Nurse	2/2

Operation of the Board

The Trust is run by a Board of Directors, comprising of a non-executive director who is the chair, and five other Non-Executive Directors and five Executive Directors. The Executive Directors are the: Chief Executive; Chief Operating Officer; Chief Nurse; Medical Director; and Director of Finance.

The Trust Secretary and Director of People and Organisational Effectiveness attend meetings but cannot vote, which has been the case for a number of years. The Director of Strategy and Planning and Director of Estates and Facilities, both of whom hold no vote, were reinstated as Board attendees during the course of 2018/19.

The Chief Executive leads the executive team and is accountable to the Board for the operational delivery of all the Trust's activities. The Chair of the Board is also the Chair of the Council of Governors (coG).

The Non-Executives scrutinise the performance of the executive management team in meeting agreed goals and objectives, and they receive adequate information to monitor the performance of the organisation.

The Non-Executive Directors play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the executive directors while helping to develop proposals on strategy.

The Board sets the Trust's strategic aims and provides active leadership of the Trust. It is collectively responsible for the exercise of its powers and the performance of the Trust, for ensuring compliance with the Trust's Provider Licence, relevant statutory requirements and contractual obligations, and for ensuring the quality and safety of services.

It does this through the approval of key policies and procedures, the annual plan and budget for the year, and scheme for investment or disinvestment above the level of delegation. The Board meets bi-monthly and its role is to determine the overall corporate and strategic direction of the Trust and to ensure the delivery of the Trust's goals and targets.

The Board has agreed a scheme of reservation and delegation which sets out those decisions which must be taken by the Board and those which may be delegated to the executive or to board sub-committees.

The Board of Directors has reserved powers to itself covering:
Regulation and control

- The determination of board committees and membership
- Strategy, plans and budgets
- Policy determination
- Audit
- Annual report and accounts
- Performance monitoring.

The Board is also responsible for promoting effective dialogue between the organisation and the local community on its plans and performance, ensuring that the plans are responsive to the community's needs.

The Board receives feedback from Governors and members about the Trust, through attendance at meetings of the CoG and its sub-groups, direct face-to-face contact, surveys of members' opinions and consultations.

The Board is also responsible for ensuring proper standards of corporate governance are maintained. It accounts for the performance of the Trust and consults on its future strategy with its members through the CoG.

The Board works closely with the Trust's CoG. The Trust Chair is also Chair of the CoG and works closely with the Lead Governor to review all relevant matters. The Chair, Chief Executive, Trust Secretary and Membership Manager meet before each meeting of the CoG to set the agenda and review key issues. The Non-Executive and Executive Directors of the Board attend the CoG meetings as observers and take part in open discussions for part of each meeting. Executive Directors or their deputies, and Non-executive Directors, are assigned to and are integral members of each of the CoG sub-groups. Participation in each quarterly sub-group ensures an understanding of the views of the governors and subsequently members of the public.

The Trust Constitution details how disagreements between the Board of Directors and the Council of Governors will be resolved. Should a disagreement arise between the Board of Directors and the Council of Governors, such as would impair the decision making process or the successful operation of the Trust, then the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute.

Should this meeting not resolve the issue then the Chair shall have the authority to make a decision on behalf of the Trust. This decision, and the reasons supporting it, will be communicated in writing to all members of both the Board of Directors and the Council of Governors. This has not been required during the period April 1 2018 to March 31 2019.

The Board ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of local healthcare delivery. The Trust Devolution Policy including Reservation of Powers to the Board and Scheme of Delegation details which types of decisions are to be taken by the Board, and which decisions are to be delegated to the management by the Board of Directors.

The Board of Directors also has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The Board of Directors keeps the performance of its committees under regular review and requires that each committee considers its performance and effectiveness during the year. The Trust has arranged appropriate insurance to cover the risk of legal action against its directors and is insured through the NHS Litigation Authority.

Deputy Chair

Good practice suggests that the Trust should have a Deputy Chair to stand in during any periods of absence of the Chair. NHS Improvement's guidance states that this should be a Council of Governors appointment although it would be expected that the Chair would make a recommendation to governors. Linda Jackson, Non-Executive Director, is the Deputy Chair. The Trust Constitution makes provision for this.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director appointed by the Board as a whole in consultation with the Council of Governors. The Senior Independent Director has a key role in supporting the Chair in leading the Board and acting as a sounding board and course of advice for the Chair. They also lead the performance evaluation of the Chair. Sandra Hills, Non-Executive Director, is the Senior Independent Director.

Board meetings

Public board meetings are held every other month and follow a formal agenda which includes an update from the Chief Executive, a patient story presented by the Trust's Patient Experience Practitioner, updates on the Trust's improvement plans, monthly capacity and capability on our wards, as well as minutes from sub-committees.

Non-Executive Directors

Non-Executive Directors (NEDs) are appointed for a period of two or three years, this can be extended for a further period. Any term beyond six years is subject to rigorous review. Arrangements for the appointment and termination of Non-executive Directors are set out in the Trust Constitution. The Constitution states that the Council of Governors has the power to appoint and remove the Chairman of the Trust and other NEDs. Removal can only happen if three quarters of the Council of Governors members approve the motion.

The Board determines whether each NED is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could affect, the person's judgement. All of the Trust NEDs are considered to be independent by the Board of Directors as per the Code of Governance for NHS Foundation Trusts. The Chair is responsible for the leadership of both the Board of Directors and the Council of Governors.

As Chair of the Board of Directors the Chair is responsible for ensuring the Board's effectiveness and setting its agenda. As Chair of the Council of Governors the Chair provides a pivotal link between Governors and Directors, especially the NEDs. Listening to the governors is one of the ways the Chair can hear the views of the local community. She regularly provides feedback to the Board of Directors on the views of the governors and the local community.

NEDs, including the Chair, Deputy Chair and Senior Independent Director, are appointed by the Council of Governors with the process being led by the Appointments and Remuneration Committee (ARC) for Non-Executive Directors.

The Chair, other NEDs, and the Chief Executive are responsible for deciding the appointment of executive directors. NEDs regularly attend the Trust Board meetings, the Council of Governors and also meet regularly with the Chair without executives present.

Evaluation of the Board/its committees/directors and Chair

Comprehensive arrangements are in place for reporting to the Trust Board on performance and key risks to future performance against a raft of targets/contractual obligations and indicators.

Risks in respect of compliance with other statutory requirements are escalated to the Trust Board via established governance and performance management frameworks including receipt by the Trust Board of quarterly Trust Assurance Framework and Risk Register reports. More urgent risk issues are escalated directly to the Executive Team and the Trust Board via the relevant Executive Director.

The Scheme of Delegation, which defines accountabilities for the delivery of performance, is monitored via the performance management framework led by the Chief Executive. The Board ensures that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. The Trust Board receives assurance through a suite of financial and non-financial performance reports including:

- The submissions of a monthly integrated performance report
- The submission of a monthly Improving Together progress report
- The submission of a monthly mortality report.

The Trust undertakes an annual evaluation of the Board and its sub-committees.

During 2018/19 the Trust commissioned a Well Led Review. The Trust has continued to implement the findings and recommendations from the Well Led Review.

This has included a review of the Trust's meeting structures to ensure a clear separation between Board assurance sub-committees and day to day management meetings and the implementation of a comprehensive Board Development Programme which is well underway and the completion of a formal Board skills matrix. The Trust has moved to bi-monthly meetings of the Trust Board, with the intervening months being used for board development activities, briefings on key risks topics and focussed discussion regarding future strategy.

An assessment of whether services are well led under NHS Improvement's well led framework will be undertaken as part of the Trust's next CQC inspection. The Board Development Programme which is supported by Deloitte UK, includes specific sessions on well led.

Each of the Board sub-committees completes an annual review of effectiveness, and the outcome including agreed actions, are reported to the Trust Board.

Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust including following the Well Led Review.

The Board is also satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the Trust.

In compliance with the Code of Governance for Foundation Trusts, no Executive Director holds more than one Non-executive directorship of an NHS foundation trust or other organisation of comparable size and complexity.

Assistance of Directors

The Trust Board and Council of Governors are both provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. They receive assurance through a suite of financial and non-financial performance metrics including the quality report, mortality report and monthly finance report. The Board ensures that directors, especially Non-Executive Directors, have access to independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities or to provide additional assurance. New Directors receive a full, formal and tailored induction on joining the Board. They also have access, at the Trust's expense, to training courses and/or materials that are consistent with their individual and collective development.

Directors, governors and members are all supported by the Trust Secretary and the Trust Membership Officer. Where Directors have concerns that cannot be resolved about the running of the Trust or a proposed action, any concerns are recorded within the Trust Board minutes. Minutes of the Trust Board are comprehensive and are published in the public domain on the Trust's website.

The Trust Board, and in particular the Non-Executive Directors, may reasonably wish to challenge assurances received from the executive management team. The executive directors ensure, wherever possible, that the Non-Executive Directors receive sufficient information and understanding to enable challenge and to take decisions on an informed basis. The Board minutes reflect any challenges of the executive management. There is also in place a schedule of Non-Executive Director challenge roles whereby individual non-executives provide challenge in respect of specific areas of risk.

Code of conduct for the Trust Board

All members of NHS Boards and clinical commissioning group governing bodies should undertake and commit to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities. To this end, in November 2012, the Professional Standards Authority (PSA) published new standards for members of NHS boards and CCG governing bodies in England. The standards cover three domains: personal behaviour, technical competence and business practices, and puts compassion and respect at the heart of NHS leadership. The standards also aim to capture existing standards, codes and principles (the Nolan Principles) by which NHS Board members are currently bound.

In May 2013 the Trust Board formally signed up to these standards. All Board directors meet the 'fit and proper persons' test as described in the provider license as confirmed annually by each individual Director and collectively within the annual chairman's declaration to the Trust Board. The Trust Board has maintained its support of the Nolan Principles of public life and has continued to make the majority of its decisions at Board meetings held in public. To support this there is the Directors Code of Conduct, which applies to all directors and has been adopted by all Board members.

Board committees

The Board has established a number of formal sub-committees that support the discharging of the Board's responsibilities. In addition to meeting the statutory requirements of having an Audit Committee and Remuneration Committee, the Trust also has a Finance and Performance Committee, Quality and Safety Committee, a Workforce Committee and a Charitable Funds Committee (known as the Health Tree Foundation Trustees Committee). Minutes of the sub-committees are presented to the Trust Board as is a monthly highlight report which provides escalation of issues and concerns for the attention of the Trust Board. Each sub-committee comes under the remit of an executive director and is chaired by a non-executive director. Appropriate resource is allocated to ensure these sub-committees can undertake their duties.

Arising from the Well led Review commissioned by the Trust during 2017/18, changes have been made to the Trust's meeting structures (including the Board assurance sub-committees) in order to provide clear reporting lines and separation of management decision making from assurance. As at March 31 2019, the current sub-committee structure is as follows:

Audit, Risk and Governance Committee

The Audit, Risk and Governance Committee is a standing committee of the Board of Directors. Its remit is to:

- consider the effectiveness of internal controls and the management arrangements established by the Trust to deliver its stated objectives;
- seek assurance that the Trust complies with the law, guidance and codes of conduct; and
- monitor the integrity of the public disclosure statements made by the Trust.

The Committee meets five times each year. Its three members are appointed by the Board of Directors from among the Non-Executive Directors. Minutes of Committee's meetings are submitted to the Board of Directors and the Council of Governors. Internal Audit services are provided by Audit Yorkshire who replaced KPMG on June 1 2018, following a competitive procurement exercise in early 2018. Audit Yorkshire was appointed for an initial period of three years with the option to extend for a further year. Internal Audit provides an independent and objective opinion on the extent to which risk management, controls and governance arrangements support the effective operation of the Trust.

The Head of Internal Audit produces an annual audit opinion on the effectiveness of the system of internal control. The Head of Internal Audit and/or the Internal Audit Manager for the Trust will normally attend Audit, Risk and Governance Committee meetings and has a right of access to all Audit, Risk and Governance Committee members, the Chair and Chief Executive of the Trust. The Head of Internal Audit is accountable to the Director of Finance.

Throughout 2018/19, the Committee received progress reports from internal audit on the planned work for the year, and the outcome of the individual reviews performed with associated recommendations.

The annual Head of Internal Audit Opinion, which forms part of the Annual Governance Statement, contains details of high risk recommendations made during the year. The Committee monitors the implementation of all internal audit recommendations and receives reports at each meeting to monitor progress on agreed actions. The Trust's external auditor is PwC who have been the Trust's external auditor since 2012. PwC was re-appointed for a further three years in 2016 after a competitive tendering exercise. Representatives of the Audit, Risk and Governance Committee acted as advisors to the Council of Governors in relation this tendering exercise. The Council of Governors convened a sub-committee to oversee the process and make a recommendation to the full Council of Governors. The value of external audit services is disclosed in the Trust's financial statements (note 5.1) and is circa £82k per annum. An annual review of effectiveness of external audit is performed.

For 2018/19, the external auditors reviewed the Trust's financial statements on the basis of a 'going concern', notwithstanding that NHS Improvement placed the Trust in 'financial special measures' in March 2017. The Committee considered this in detail and note 1.1.2 of the financial statements refer to the accounts being prepared on a going concern basis. The Committee endorsed this as appropriate. There is a policy for the engagement of the external auditor for non-audit work to safeguard objectivity and independence. The value of any non-audit services is routinely disclosed in the Trust's financial statements at note 5.2, as was the case for such work performed by PwC during 2018/19.

The Committee received and reviewed the draft financial statements and the audited accounts, as well as the Annual Governance Statement. Due to the extremely challenging financial deficit position of the Trust at the end of 2018/19, as with the previous four years, and coupled with being placed into Financial Special Measures in March 2017 one of the significant issues given full consideration by the Audit, Risk and Governance Committee as part of the accounts preparation process was the Trust's ability to continue as a going concern. The Audit, Risk and Governance Committee considered this in detail and note 1.1.2 of the financial statements refer to the accounts being prepared on a going concern basis. The Audit, Risk and Governance Committee endorsed this as appropriate.

Each year, the Committee reviews its own effectiveness in line with the latest NHS Audit Committee Handbook (HFMA, 2018). A review of the Committee's terms of reference was undertaken to assess whether they remain fit for purpose. Minor changes were approved by the Board of Directors.

In line with the Foundation Trust Code of Governance, the Committee also has a role in reviewing the organisation's arrangements for staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. In order to discharge this function the Audit, Risk and Governance Committee has received periodic updates from the Trust's Freedom to Speak Up Guardian, most recently in November 2018.

Schedule of Attendance at Audit, Risk and Governance Committee meetings 2018/19

Member / Attendee	Apr-18	May-18	Jul-18	Nov-18	Jan-19
Members:					
Stan Shreeve – NED / Chair (to June18)	Y	Y	-	-	-
Nick Mapstone – NED / Chair (from July18)	-	-	N[1]	Y	Y
Anthony Bramley – NED / Deputy Chair	Y	Y	Y[1]	Y	Y
Linda Jackson – NED	Y	Y	Y	Y	N
Regular Attendees:					
Marcus Hassall – Director of Finance	Y	Y	Y	Y	N[2]
Richard Eley – Interim Director of Finance	-	-	-	-	Y
Wendy Booth – Director of Governance and Assurance / Trust Secretary	Y	Y	N	Y	Y
Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y
LCFS	Y	N/A[3]	N[4]	Y	Y
Head of Procurement	Y	N/A[3]	Y	Y	Y
Internal Audit	Y	Y[5]	Y[6]	Y	Y
External Audit	Y	Y	Y	Y	Y
Head of Quality Assurance	N	Y	Y	Y	Y
Ad-hoc Attendees:					
Asst. DoF – Process & Control (NP)	Y	Y	-	-	Y
Head of H&S and Fire (BP)	Y	-	Y	-	-
NED (JR)	-	-	Y	-	-
Lead Governor (Governor Observer)	-	-	Y	-	-
Emergency Planning & LSMS (MO)	-	-	Y	-	-
Resilience Manager (GJ)	-	-	Y	-	-
Director of Strategy, Planning and Performance (PC)	-	-	Y	Y	-
Divisional Clinical Director – Medicine (SB)	-	-	Y	-	-
Director of People and Organisational Effectiveness (JA)	-	-	Y	Y	-
Deputy COO – Improvement & Productivity (KH)	-	-	Y	-	-
Director of Estates & Facilities (JJ)	-	-	-	Y	-
Associate Director of IM&T (SM)	-	-	-	Y	-
Freedom to Speak Up Guardian (MH)	-	-	-	Y	-
Data Protection Officer / Lead for IT (SM)	-	-	-	Y	Y
Deputy Chief Nurse (MG)	-	-	-	y	-
AGM – Surgery & Critical Care (SJT)	-	-	-	Y	-

Notes:

[1] Anthony Bramley, NED, Chaired the meeting in the absence of Nick Mapstone, Chair

[2] Interim Director of Finance (DoF) in attendance in absence of substantive DoF

[3] Not required to attend, Final Accounts meeting only

[4] Sally Stevenson, Assistant Director of Finance – Compliance and Counter Fraud in attendance to present report

[5] Last meeting of KPMG as Internal Auditor

[6] First meeting for Audit Yorkshire as Internal Auditor

Quality and Safety Committee

This committee was established as a formal sub-committee of the Trust Board. Its purpose is to provide assurance to the Board all aspects of the delivery of safe, personal and effective care are being appropriately governed and the evidence to support that assurance is scrutinised in detail on behalf of the Board. Its membership includes: three Non-Executive Directors, the Chief Operating Officer, Medical Director and Chief Nurse. Its minutes are shared with the Trust Board.

Finance and Performance Committee

This committee was established as a formal sub-committee of the Trust Board. It submits copies of its minutes for inclusion on the Trust Board agenda, and significant issues are escalated to the Trust Board via a 'highlight' report.

Its core membership includes three Non-Executive Directors, the Chief Operating Officer, Director of Finance and Turnaround Director. Its remit includes:

- Reviewing the annual and longer term financial plans, for revenue, capital and cash management, in line with the Trust's business planning cycle and obtaining assurance they are fit for purpose
- Reviewing the agreement of service contracts to secure Trust income
- Providing assurance to the Trust Board that appropriate budgetary control arrangements are in place to monitor and deliver annual financial plans]
- Reviewing the Trust's performance against its annual financial plan and budgets, and monitoring any necessary corrective action plans, highlighting any significant concerns to the Trust Board.

Remuneration Committee

This committee was established as a formal sub-committee of the Trust Board.

It reviews and approves leadership needs and succession planning to ensure the Trust can fulfil its own strategic and statutory requirements for the two levels below the executive level. It reviews and approves the overall structure of the executive team in terms of structure, size, skills, knowledge, experience and diversity.

It also reviews and agrees on the remuneration of senior directors and commissions recruitment exercises to fill any vacancies amongst the executive team. It reports to the Trust Board through updates provided to the Non-Executive Directors by the Trust Chair and the Council of Governors and members of the public through a committee and remuneration report included as part of the Trust's statutory annual report and accounts.

Its membership is made up of three Non-Executive Directors who are appointed by the Board.

In regular attendance are the Trust Chair, Chief Executive, Director of People and Organisational Effectiveness and the Board Secretary.

The above officers of the Trust will remove themselves from the committee when their own remuneration or performance is discussed.

Workforce Committee

The specific objective of the Workforce Committee is to ensure risks pertaining to the strategy and transactions of workforce and organisational development are identified and managed. The committee's specific objectives include:

- To provide a positive working environment for staff and to promote supportive and open cultures that help staff do their job to the best of their ability
- To provide all staff with clear roles and responsibilities and rewarding jobs for teams and individuals that make a difference
- To provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential
- To provide support and opportunities for staff to maintain their health, wellbeing and safety
- To promote staff involvement in research as a means of both improving patient care and staff satisfaction
- To promote the delivery of quality education by and for all staff

Health Tree Foundation Trustees Committee

This committee is a formal sub-committee of the Trust Board, under the Trust Constitution Part IV Section 6.8 d. Its membership is appointed by the Board from among the Non-Executive and Executive Directors. The committee consists of these voting members: an independent Chair, three Non-Executive Directors, Chief Executive, Medical Director, Chief Nurse, Director of Finance and two independent trustees. It is tasked with overseeing and managing the affairs of the Trust's charitable funds, the working name of which is The Health Tree Foundation. The committee ensures the charity acts within the terms of its declaration of trust, and all appropriate legislation on behalf of the Trust Board as the corporate trustee.

Cost allocation and charging

The Trust has complied fully with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance. Payment by Results (PbR) provides a transparent, rules-based system for paying trusts; it rewards efficiency, supports patient choice and diversity and encourages activity for sustainable waiting time reductions. Payments are linked to activity and adjusted for casemix. Importantly, this system ensures a fair and consistent basis for hospital funding rather than being reliant principally on historic budgets and the negotiating skills of individual managers.

Income disclosures to auditors

The directors confirm that, as required by the Health and Social Care Act 2012, the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The Trust has processes in place to ensure that this statutory requirement will be met in future years.

The directors also confirm that the provision of goods and services for any other purposes are not materially impacted on our provision of goods and services for the purposes of the health service in England.

Better Payment Practice Code

The Trust's measure of performance in paying suppliers is the Better Payment Practice Code (BPPC). The code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

	2018/19		2017/18	
	Number	£000	Number	£000
Total Non -NHS trade invoices paid in the year	92,156	212,064	88,145	183,178
Total Non-NHS trade invoices paid within target	27,794	27,163	27,316	39,017
Percentage of Non-NHS trade invoices paid within target	30%	13%	31%	21%
Total NHS trade invoices paid in the year	3,452	25,242	3,560	24,256
Total NHS trade invoices paid within target	1,058	15,140	1,706	15,496
Percentage of NHS trade invoices paid within target	31%	60%	48%	64%

Statement as to disclosures to auditors

So far as each director is aware, there is no relevant audit information of which the NHS foundation trust's auditor is unaware and they have taken all steps that they ought to have taken as a director in order to make themselves aware of any relevant audit information and to establish that the Trust auditor is aware of that information.

'Relevant audit information' means information needed by the NHS foundation trust's auditor in connection with preparing their report.

A director is regarded as having taken all the steps that they ought to have taken as a director In order to do the things mentioned above, and:

- Made such enquiries of his/her fellow directors and of the company's auditor for that purpose; and
- Taken such other steps (if any) for that purpose, as are required by his/her as a director of the company to exercise reasonable care, skill and diligence.

Donations

As an NHS foundation trust, the Trust makes no political or charitable donations. It has launched its own charity – The Health Tree Foundation – and it continues to benefit from charitable donations received and is grateful for the efforts of fundraising organisations and members of the public for their continued support.

Trust Board approach to clinical governance

The Trust adheres to the Code of Governance for Foundation Trusts and the Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The effectiveness of the Trust governance arrangements continued to be tested during 2018/19 via internal and external testing including internally via the annual internal audit programme.

An improvement plan is in place and ongoing in response to the findings and recommendations arising from that review including agreed support.

These improvements are captured as part of the Trust's Improvement Programme – Improving Together; specifically the Leadership and Culture workstream.

Monitoring occurs via regular Improving Together progress reports discussed at the Trust Board.

More detailed updates are provided quarterly to the Trust Board.

Changes have been made in the 2018/19 year to the configuration of the Trust's (central) governance team, including the appointment of a new Associate Director for Clinical Governance.

Work started in May 2018, supported by KPMG, to strengthen the clinical governance arrangements at divisional level and building on recent changes to divisional leadership with the appointment of five new Divisional Directors, which will put clinicians firmly in charge of how the Trust plans and delivers services.

The Divisional Clinical Directors have authority and responsibility for quality, the use of resources (including staffing and finances), performance and governance.

The Chief Executive as the Accountable Officer for NLaG follows the procedures set out by NHS Improvement in advising the Board and the CoG and for recording and submitting objections to decisions.

The Trust ensures there is regular reporting to and dialogue with NHS Improvement. This includes monthly accountability meetings (MAM) in respect of the Trust's position on performance and quality and financial special measures.

Stakeholder relations

Collaborative working is key to the local health community.
The Trust's approach is, and always has been, based on openness, honesty and a genuine desire to listen and act on feedback to improve services and our patients' experience.

The Trust works with partners in the local 'health and care community' to continually progress services which includes GPs, community healthcare providers, social care providers, charities, the ambulance service, mental health providers, local health scrutiny panels and the clinical commissioning groups across the Trust's population footprint.

In 2018/19 the Trust continued to work in partnership as part of the Humber Coast and Vale Health and Care Partnership (HCP).

Within the HCP the Trust is working particularly with Hull University Teaching Hospitals (HUTH, formerly Hull and East Yorkshire Hospitals) on planning services different across both trusts. This work comes under the umbrella of the Humber Acute Services Review (HASR).

Within the STP work programmes are specific clinical networks such as Urology and ENT, Endoscopy and Diagnostics where the partners in the health system are working together on:

- improved access and egress to / from services at the right time
- improved operating consistency
- improved outcomes for patients
- increased productivity
- Sustainable services from a quality, standards and financial perspective

Patients and other stakeholders have been updated on this work through regular briefing sessions run in conjunction with local CCGs.

There have also been targeted patient engagement events for HASR covering the following specialities: Cardiology, Stroke, Neurology, Complex Rehab and Critical Care

Patient experience – complaints and concerns

This year has seen the Complaints and Patient Advice and Liaison Service become part of the Patient Experience team. The whole ethos of the team (pictured below) is centred around providing patients, families and carers with a service that delivers their expectations within national and local frameworks.

This is a challenge at times but the team remain committed to striving for a quality service, one that is built on listening, responsiveness and constant improvement.

When patients, families and carers feel the Trust's services have not met their expectations then the team is there to support them in each step of the process to find an agreed resolution.

Complaints, concerns or compliments are all feedback that the Trust uses to celebrate or shape improvements and all of these are viewed as opportunities. All this information is combined with additional feedback in the Trust, including the Friends and Family test, National Surveys and local surveys, this helps the Trust to understand what is being said by its wider communities.

During 2018/19 the Trust collected thousands of pieces of patient feedback. Between 1 January 2018 and 31 December 2018. the Patient Advice and Liaison Service received: 1887 concerns. Of these 279 were resolved within one day. A further 830 (43%) of the concerns were responded to in the expected three to five working days, which is a 29% percent decrease on the previous year.

The complexity of both concerns and complaints has impacted on response times. Work has begun to address this and will continue over the next year.

The Trust's Complaints Team received 562 formal complaints on behalf of the Trust, which is an 18% increase. Of these:

- 279 were related to Diana Princess of Wales Hospital
- 252 were related to Scunthorpe General Hospital
- 17 were related to Goole District Hospital
- 7 were related to community based services

The Team closed 157 of these within its timescales, which is a 28% decrease from last year. The team has adopted a co-located model of working to improve outcomes and timeframes for complainants. This has involved them working specifically for a division and being able to access teams. There is more information about complaints in Chapter Six.

The Trust also received nearly 17,000 pieces of feedback via the Friends and Family Test, with 95.8% of those responding recommending our services. In addition to this the Trust saw a 28% rise in recorded compliments to 324 , and is continuing to look at methods of capturing these, as these provide a valuable balance for staff and are vital to improving morale.

A "Thank you " card is signed by our Chief Executive Dr Reading and sent to a staff member who has been shown through patient feedback to have gone above and beyond.

Recent comments have included:

"My sister has been an inpatient on Ward 16 for several weeks, as a complex case with Multiple Sclerosis and added complications including pneumonia, sepsis, a poor kidney function and weak heart. Staff on Ward 16 could not have been kinder or more caring towards her and her worried partner. Today my sister and her partner arranged a special license and were officially married on Ward 16. Staff went over and above to accommodate and join in the ceremony…I cannot give enough praise or thank them enough...this is certainly an example of how NHS staff go over and above their job role…": Ward 16 Scunthorpe Hospital

"I am a nurse myself in Sheffield and am aware of how easy people find it to write and complain, not so many people write to say thank you. So for the amazing job you do and for making our sad time more bearable a huge thank you from us 3 grandchildren.": AMU Diana, Princess of Wales Hospital

The coming year will see the Trust review its policy and processes to ensure they reflect a person-centred service that is responsive and compassionate and that is built on being open and transparent for all.

Patient experience - patient and carer information

The Trust continues to look at how it involves patients and public as part of having an active patient voice.

The Patient Panel has been running for four years now and the members have contributed to many aspects of the Trust, from service redesign, audit and readers panel. Their contribution to ensuring 'What Matters Most' to patients, carers and families is ongoing and invaluable.

They have influenced the process of Patient Information leaflets by challenging wording and design, and building effective relationships with authors.

They used this to completely redesign the Information for Patient templates. They have recently built on this by looking at the Trust external website and by Mystery Shopping, identified areas for improvement in how the information is found and what information matters.

This is being addressed by the Trust's Communication and Marketing team.

Working alongside patients, carers and families helps the Trust to ensure its resources are focussed in the right direction whenever possible.

The Trust has various transformation boards in progress where Patient Representation is part of this, providing challenge and additional user information to help shape future changes and address current issues.

The Trust has also signed up to a co – design model of service improvement led by NHS England and the Picker Institute.

'Always Events' are centred on creating an experience that always happens as part of the patient journey and which patients, carers and families deem important.

By working with patients to create a pathway for surgical ambulatory patients which is person centred and has the patient voice driving the changes.

The Patient and Public Involvement agenda is also supported by a new policy and procedure which embraces the principles of working in partnership.

Active relationships with our Healthwatch colleagues ensure additional intelligence is captured and that ultimately all organisations are working in a joined approach to ensure the best outcomes for the Trust's local communities.

Governors' report

Council of Governors

As a foundation trust, NLaG has a Council of Governors (CoG).

The Board of the Trust is directly responsible for the performance and success of the Trust, and satisfying the CoG that the Board is achieving its aims and fulfilling its statutory obligations.

Governors act as a link to the local community and report matters of concern raised with them, to the Board, via their quarterly CoG meetings.

It receives and considers all appropriate information required to enable it to discharge its duties, and is provided with high-quality information appropriate to its function and relevant to the decisions it has to make.

Role of Governors

The CoG has a number of statutory roles and responsibilities, which are set out in a document, and are as follows:

- Appoint and, if appropriate, remove the Chair
- Appoint, and if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and other terms and conditions of office of the Chair and other Non-Executive Directors
- Approve (or not) the new appointment of a Chief Executive
- Approve, and if appropriate, remove the Trust's auditor
- Receive the Trust's Annual Report and Accounts at a general meeting of the CoG
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Board of Directors
- Represent the interests of the members of the Trust, and public
- Approve Significant Transactions as defined by NHSI guidance
- Approve an application by the Trust to enter into a merger or acquisition
- Approve amendments to the Trust's Constitution.

The council takes the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors.

When the council ends an external auditor's appointment in disputed circumstances, the Chair will write to NHS Improvement informing it of the reasons behind the decision.

There is a clear policy and a fair process, agreed and adopted by the council, for the removal of any Governor who consistently and unjustifiable fails to attend the meetings of the council or has an actual, or potential conflict of interest, which prevents the proper exercise of their duties.

Members of the Council of Governors during 2018/19

Name	Initial date elected	Date re-elected	Term of office	Term of office ends	Date of retirement	Political party
Public governors – East and West Lindsey						
Jeremy Baskett	19.04.16	19.04.19	3 years	19.04.22	-	
Christopher Bayne	19.04.16	21.10.16	3 years	21.10.19	11.06.18	
Public Governors - Goole and Howdenshire						
Janthea Capitani	19.04.16	-	3 years	19.04.19	19.04.19	
Barbara Jeffreys	28.7.17	16.11.18	3 years	16.11.21	-	
Rob Pickersgill	03.12.15	16.11.18	3 years	16.11.21	-	
Public Governors – North East Lincolnshire						
Julie Grimmer	16.11.18		3 years	16.11.21		
Ann Maggs	13.12.16	-	3 years	13.12.19	16.08.18	
Brian Page	03.12.15	27.11.18	3 years	27.11.21	-	
Ian Reekie	16.11.18		3 years	16.11.21		
Jeff Shaw	23.11.08	21.10.16	3 years	21.10.19	-	
Liz Stones	23.11.11	13.10.17	3 years	13.10.20		
Public Governors – North Lincolnshire						
Carol Anscombe	17.11.17	-	3 years	17.11.20	23.10.18	UKIP
John Anscombe	17.11.17	-	3 years	17.11.20	23.10.18	UKIP
John Balderson	16.11.18		3 years	16.11.21		
Judith Bett	17.11.17	-	3 years	17.11.20	31.05.18	
Maureen Dobson	28.11.07	21.10.16	3 years	21.10.19	-	
Paul Grinell	04.11.09	16.11.18	3 years	16.11.21	-	
Staff Governors						
Elaine Coghill	16.11.18		3 years	16.11.21		
Mr Makani Hemadri	28.07.14	28.07.17	3 years	28.07.20	20.08.18	
Andrew Karvot	16.11.18		3 years	16.11.21		
Tim Mawson	21.10.14	28.07.17	3 years	28.07.20	-	
Tony Whyte	28.07.14	28.07.17	3 years	28.07.20	-	

Members of the Council of Governors during 2018/19 (continued)

Name	Initial date elected	Date re-elected	Term of office (years)	Term of office ends	Date of retirement	Political party
Stakeholder governors						
Vacancy – Lincolnshire Council						
Vacancy – North Lincolnshire Council						
John Barrett – East Riding Council	20.07.16	-	3	20.07.18	29.05.18	Conservative
Melanie Dickerson – North East Lincolnshire Council	20.07.15	-	3	20.07.18	29.05.18	Conservative
Cllr Debbie Rodwell – North East Lincolnshire Council	06.06.18		3	06.06.21		
Eddie McCabe – North East Lincolnshire CCG	19.04.16	-	3	19.04.19		
Alex Seale – North Lincolnshire CCG	29.11.18		3	29.11.21		
Richard Young – North Lincolnshire CCG	01.09.16	-	3	01.09.19	29.05.18	
Vacancy – Hull York Medical School						

Composition of the CoG and CoG meetings

The CoG comprises of the following constituencies:

- ***Elected Public Governors***

The CoG has 15 Governors elected from its membership that represent the four main catchment areas of the Trust.
Public Governors are elected from within local authority areas. The number of Governors for each constituency is in proportion to the population within the area using NLaG services, as detailed here:

Area	Number of governors
North Lincolnshire	Five
North East Lincolnshire	Five
Goole and Howdenshire	Three
East and West Lindsey	Two

- ***Elected Staff Governors***

There are four staff Governors who are elected by staff members.

- ***Appointed Stakeholder Governors***

The Trust has a further seven Governors vacancies who are appointed by partnerships or stakeholder organisations.

Annual elections ending November 2018

Annual Governor elections were held in November 2018, as a result of one governor reaching the end of their term of office, and two Governors resigning. The results of election are detailed in the table on the previous pages. For Goole and Howdenshire one public governor was re-elected , two new public governors were elected for North East Lincolnshire, one new governor for North Lincolnshire and two staff governors were elected all for a term of three years

The Council of Governors meets sufficiently regularly to discharge its duties. During the year April 1 2018 to March 31 2019 attendance at the Council of Governor meetings was as follows:

Governors	Council of Governor meetings						
		AR		AMM			
Constituencies	18.04.18	12.06.18	10.07.18	11.09.18	23.10.18	14.01.19	Total
East and West Lindsey							
Jeremy Baskett	P	P	P	A	P	P	**5 out of 6**
Christopher Bayne	P	A					**1 out of 2**
Goole and Howdenshire							
Janthea Capitani	P	P	P	P	P	P	**6 out of 6**
Rob Pickersgill	P	P	P	A	P	P	**5 out of 6**
Barbara Jeffreys	P	P	A	P	P	P	**5 out of 6**
North East Lincolnshire							
Ann Maggs	A	A	A	A	A		**0 out of 5**
Brian Page	P	A	P	P	P	P	**5 out of 6**
Julie Grimmer						P	**1 out of 1**
Ian Reekie						P	**1 out of 1**

KEY
AR – Annual Review ***AMM – Annual Members Meeting***
A – Absent ***P – Present***

During the year April 1 2018 to March 31 2019 attendance at the Council of Governor meetings continued:

		AR		AMM			
	18.04.18	**12.06.18**	**10.07.18**	**11.09.18**	**23.10.18**	**14.01.19**	**Total**
Jeff Shaw	A	P	P	P	P	A	**4 out of 6**
Liz Stones	A	P	P	P	P	A	**4 out of 6**
North Lincolnshire							
Carol Anscombe	P	P	P	P	P		**5 out of 5**
John Anscombe	P	P	P	P	P		**5 out of 5**
John Balderson						P	**1 out of 1**
Judith Bett	A						**0 out of 1**
Maureen Dobson	P	P	P	P	P	P	**6 out of 6**
Paul Grinell	P	P	P	P	P	P	**6 out of 6**
Staff Governors							
Elaine Coghill						P	**1 out of 1**
Andy Karvot						P	**1 out of 1**
Makani Hemadri	A	A	A	A	A		**0 out of 5**
Tim Mawson	P	P	A	P	P	P	**5 out of 6**
Anthony Whyte	A	A	A	A	A	A	**0 out of 6**

KEY
AR – Annual Review ***AMM – Annual Members Meeting***
A – Absent ***P – Present***

During the year April 1 2018 to March 31 2019 attendance at the Council of Governor meetings continued:

		AR		AMM			
	18.04.18	12.06.18	10.07.18	11.09.18	23.10.18	14.01.19	Total
Stakeholder Governor							
Cllr John Barrett East of Riding of Yorkshire Council	P						**1 out of 1**
Cllr Melanie Dickerson North East Lincs Council	P						**1 out of 1**
Eddie McCabe North East Lincs CCG	P	A	P	A	A	A	**2 out of 6**
Cllr Debbie Rodwell North East Lincs Council			P	A	A	P	**2 out of 2**
Alex Seale North Lincs CCG						A	**0 out of 1**
Richard Young North Lincs CCG	A	A	A	A	A		**0 out of 5**

KEY

AR – Annual Review ***AMM – Annual Members Meeting***

A – Absent ***P – Present***

During the year April 1 2018 to March 31 2019 attendance by Non-Executive Directors (NED) and Directors at the Council of Governor meetings was as follows:

Name	18.04.18	12.06.18	10.07.18	11.09.18	23.10.19	14.01.19	Total
Anne Shaw - Trust Chair	A*	P	P	P	A*	P	**4 out of 6**
Dr Peter Reading - Chief Executive	P	P	P	P	A*	P	**5 out of 6**
Jayne Adamson - Director of People and Organisational Effectiveness	A*	A	A	A*	A*	P	**1 out of 6**

KEY

A* - Absent with representative attending ***A – Absent*** ***P – Present***

During the year April 1 2018 to March 31 2019 attendance by Non-Executive Directors (NED) and Directors at the Council of Governor meetings continued:

Wendy Booth - Trust Secretary	P	A*	P	A*	P	P	**4 out of 6**
Pam Clipson - Director of Strategy and Planning	A*	A	P	A	P	A	**2 out of 6**
Elaine Coghill – Interim Chief Nurse					P	P	**2 out of 2**
Mr Richard Eley - Interim Finance Director						P	**1 out of 1**
Tara Filby - Chief Nurse	A*	A	A*	P			**1 out of 4**
Marcus Hassall - Director of Finance	P	A	A*	P	A*	A*	**2 out of 6**
Jug Johal - Director of Estates and Facilities	A*	A	P	P	P	A	**3 out of 6**
Ellie Monkhouse – Interim Chief Nurse						A*	**0 out of 1**
Mr Lawrence Roberts - Medical Director	A	A	A*	A*	A*	A*	**0 out of 6**
Shaun Stacey – Chief Operating Officer			P	A	P	P	**3 out of 4**
Dr Kate Wood – Acting Medical Director	P	A	P	P	P	P	**5 out of 6**
Tony Bramley - Non-Executive Director	P	A	P	P	P	P	**5 out of 6**
Sandra Hills - Non-Executive Director	A	P	A	A	P	A	**5 out of 6**
Linda Jackson - Non-Executive Director	P	P	A	A	P	P	**5 out of 6**
Nick Mapstone - Non-Executive Director			A	A	P	P	**2 out of 4**
Jeff Ramseyer - Non-Executive Director			A	A	P	A	**1 out of 4**
Stan Shreeve - Non-Executive Director	P	P					**2 out of 2**

KEY

A* - Absent with representative attending ***A – Absent*** ***P – Present***

Lead Governor

NHS Improvement (NHSI) requires that a CoG elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to NHSI if circumstances required direct communication between the CoG and the regulator. The Lead Governor from April 1, 2018 to July 24, 2018 was Paul Grinell, a public Governor for North Lincolnshire. Brian Page, a public Governor for North East Lincolnshire was elected as Lead Governor on July 25, 2018.

Governor engagement

There are four CoG business meetings and a CoG Annual Members' Meeting held in public each year. The Governors invite members of the Trust Board to attend to update them on specific items and each meeting includes reports from Governors, the Chair and from the Board.

A review of the collective performance of the CoG is held annually in June and members of the Board of Directors are invited to attend and support this process. The review is led by the Trust Chair, supported by the Trust Secretary and Membership Manager, and utilises a framework document that incorporates NHS Improvement's Code of Governance. This meeting was held on June 12, 2018.The CoG has a number of active and vibrant sub-groups including Governor Assurance Group, Governor Assurance Group and Healthwatch, Membership and Patient Engagement Group, Quality Review Group and Staff Governor Working Group. In addition to this, Governors also have an Appointments and Remuneration sub-committee.

NHS Improvement requires foundation trusts to provide forward planning for each financial year, prepared by the Board of Directors. Governors are consulted on the development of these plans and are able to input views from the members they represent.

Governors are supported and involved in many aspects of the Trust including undertaking Patient Led Assessments of the Care Environment (PLACE) visits, along with 15 Step Ward Reviews, hospital walkabouts with the Trust Chair and assist in the preparation of Care Quality Commission (CQC) Inspections by undertaking 'mock inspections' with members of staff.

The Chair offers Governors one-to-one meetings and invites to take up these opportunities, along with undertaking the Annual Developmental Governor Reviews, where they are encouraged to attend Trust Board meetings. During the course of the year governors have also received Governor and Non-Executive Director briefings and training sessions, with or without the Executive Directors in attendance, where they receive detailed updates and are able to discuss matters amongst themselves. Seven such briefings were held during 2018/2019 on topical health matters which included:

- Sustainability And Transformation Partnerships (STPs) and Humber Acute Services Review
- Operational plan
- Finance training including:
    - the forward plan
    - financial recovery plan
    - capital funding
    - cost improvement programme
    - simplified NHS finance and Trust update

- Winter pressures update (including winter plan progress)
- Workforce Development (including staff retention)
- Inpatient and outpatient waiting lists
- Care Quality Commission updates
- Quality Account and various quality updates
- Patient administration progress and update
- Waiting List update
- Governor role and holding to account
- Staff engagement and morale including Vision and Values and Pride and Respect
- Freedom to Speak Up Guardian

Governors supported a series of public engagement events and drop-in sessions throughout 2018/19.

They also utilised the Trust staff and member magazine, Trust website, membership portal website, news releases, posters and e-mails to communicate with members.

During the year Governors also supported various member recruitment events.

Holding the Non-Executive Directors to account for the performance of the Trust Board

Governors have an important role in making an NHS Foundation Trust accountable for the services it provides.

They bring valuable perspectives and contributions to its activities. Governors are expected to hold Non-Executive Directors to account for the performance of the Trust Board of Directors and the following sets out the principles of how Governors discharge this responsibility:

- To ensure that the process of holding to account is transparent and fulfils the statutory duties of the CoG
- To make the most effective and efficient use of time and resources, and to avoid duplication
- To reflect the NHS Improvement guidance that Governors should, via the Non-Executive Directors, seek assurance that there are effective strategies, policies and processes in place to ensure good governance of the Trust
- To be proportionate, recognising that Governors are volunteers and that Non-Executives are contracted.

The council has established a policy for engagement with the board of directors for those circumstances when they have concerns.

At no time during 2018/19 has the CoG exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust.

Non-Executive Directors are invited to attend all CoG meetings and attend the CoG sub-groups which they are aligned to, based on the Trust Board sub-committees Chair role they hold. Governors can hold them to account at any of the sessions as required and appropriate.

The CoG is satisfied with its interaction and relationship with the board of directors and that it is appropriate and effective.

Appraisal and appointment

The CoG has an Appointments and Remuneration Committee (ARC), for the appointment of Non-Executive Directors (including the Chair, Deputy Chair and Senior Independent Director). The committee has delegated authority to consider these appointments on behalf of the CoG, and provide advice and recommendations to the full council in respect of these matters.

The committee also periodically reviews the process to be followed for the appointment of the Chair, Deputy Chair, Senior Independent Director and Non-Executive Directors, including the means by which views will be obtained from the Trust Board on the qualifications, skills and experiences required for each position when considering potential candidates.

On an annual basis the committee reviews the remuneration of Non-Executive Directors in context to changes to the cost of living and in reference to remuneration levels in comparable organisations.

It also considers and makes recommendations for the Council of Governors for the reappointment of the Lead Governor.

The council will only exercise its power to remove the Chair or any Non-Executive Director after exhausting all means of engagement with the Board. The Chair and other NED appraisals for 2018 have been undertaken and reported to the full Council.

Key items discussed in 2018/19

Various key items were discussed by the CoG during the year, which included:

- Trust Board minutes
- Strategy and planning
- Sustainability And Transformation Partnerships (STPs)
- Humber Acute Services Review
- Care Quality Commission (CQC)
- Finance - special measures planning and recovery plan, contracting, cost improvement programme, capital investment
- Internal sustainability plan
- Overview and ratification of the external auditor contract
- Monthly staffing report, staff morale and staff engagement including Pride and Respect updates (now incorporating Listening Into Action) and Freedom to Speak Up Guardian
- Performance compliance with evolving Integrated Performance Report
- Board Assurance Framework
- Quality development plan and performance indicators
- Patient Administration Update., Referral to Treatment Improvement Plan, Mortality progress and updates
- Feedback from CoG sub-groups
- Reports from Board committees:
    - Finance and Performance Committee (FIPC)
    - Audit, Risk and Governance Committee (ARGC)
    - Quality and Safety Committee (QSC)
    - Quality and Safety Patient Experience
    - Mortality Assurance and Clinical Improvement
    - Workforce and Organisational Development Committee (now subsumed within QSC)
    - Infection and Prevention Control

Membership

Membership Strategy

The Trust Membership Strategy is currently being updated with the help of the Governor's Membership and Patient Engagement Group and will cover the period 2019 to 2021. This strategy acknowledges that it is the responsibility of a foundation trust to recruit, communicate and engage with members and the broader public as a way of ensuring service provision meets the needs of service users. The Trust's strategy aims to recruit a representative membership base that is actively engaged in working for the good of the Trust. The key priorities of the strategy are:

- Membership community – to uphold our membership community by addressing natural attrition and membership profile short-fallings with member recruitment
- Membership engagement – to develop and implement best practice engagements methods with our members and the wider public
- Governor development – to support the developing and evolving role of our Governors.

Recruiting new members and supporting recruitment events within the hospitals and community venues is a key governor role. Governors spend time at these events describing the role of a Trust member and gathering feedback on services across the Trust and its future plans. Governors can be contacted via the Trust Membership Office by emailing: nlg-tr.foundationoffice@nhs.net, or by ringing (03303) 302852 or writing to: The Membership Office, Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH. Currently the Trust has 6,327 public members. All staff are offered the opportunity to be enrolled as members, when commencing employment with the Trust. Members of the Trust must live within one of the four constituencies and be aged 16 or above. As at March 31 2018, the Trust had a membership of 13,181 (including 28 public members with no date of birth declared and recorded). The number of new members for the period of 2018/19, including staff members was 2,175. The number of members leaving was 2,327 again, including staff.

Membership for 2018/19 and the planned membership for 2019/20	2018/19 planned	2018/19 actual	2019/20 planned
Public constituency: At year start (April 1)	6,300	6,327	6,300
New public members	550	959	550
Leaving public members	200	754	200
Minimum required under Constitution	1,400		1,400
Staff constituency: At year start (April 1)	7,200	6,854	6,500
New staff members	850	1216	850
Members staff leaving	800	1573	800

Total membership overview	
Public members	6,327
Members (public) with no DOB recorded	28
Staff members	6,854
Total members	**13,181**

Age group – public members	Number	Percentage	Population*
0 to 16**	100	1.58%	19.51%
17 to 21	667	10.54%	5.85%
22 +	5,532	87.43%	74.64%
DoB not stated	28	0.44%	n/a
Total	**6,327**	**100.00%**	**100.00%**

* Persons under the age of 16 have been excluded from the calculation of population percentages as they are not eligible for Trust membership
** - this only applies to members aged 16 years old

Membership constituency	Male	Female	Not stated	Total
Goole and Howdenshire	238	360	0	598
North East Lincolnshire	766	1,721	0	2,487
North Lincolnshire	947	1,623	0	2,570
East and West Lindsey	232	416	0	648
Staff	1,425	5,379	50	6,854
Total	**3,623**	**9,508**	**50**	**13,181**

Ethnicity of membership	Number	Percentage	Population	Percentage
White	5,946	93.98%	372,737	97.63%
Mixed	30	0.45%	1,854	0.49%
Asian or Asian British	111	1.75%	5,529	1.45%
Black or Black British	27	0.43%	882	0.23%
Other	0	0%	786	0.21%
Not stated	213	3.39%	0	0%

Trust membership generally reflects the demographic of the population served, and is representative for the majority of categories. Membership recruitment events will continue to be undertaken in 2019/20, some of which will target various groups to further ensure representative membership (e.g. 16-year-olds through schools and colleges etc).

Keeping in touch with members

Ensuring effective two-way communication with our members, via a combination of Trust and Governor managed formal and informal communications is very important to our organisation.

We issue a 'welcome' email or letter to all new members, which provides an outline of the Trust and what we do.

Our membership office strives to maintain contact with members using a variety of methods including:

- The Trust magazine which is aimed at staff, members and the public is sent out bi-monthly and includes news from across our three hospitals and community services that we think we will be of interest to people, as well as event dates
- Trust website with a designated section for members
- Members' portal – an external website specially designed for member engagement
- Email – newsletters, invites to meetings and volunteer opportunities
- Face-to-face through informal governor drop-in sessions, membership recruitment and engagement events, and attendance at Engagements & Listening Events
- Posters around the Trust sites and publicised with our partner organisations
- Twitter and Facebook
- Engagement events provide members with an opportunity to listen to presentations and debate the hot topics of the day, and our governor drop-in sessions give people the chance to speak to Governors in private about any issues they may have

It is also an opportunity for people to pass on their praise for the services they have received.

Feedback from the drop-in sessions is shared with the Membership Office who forward on queries or seek responses on behalf of Governors as appropriate and feedback to the Governors.

Disclosures and declarations of interests

The Chair of the CoG has not declared any other significant commitments that require disclosure.

The Chair submits an Annual Declaration of Interest Statement and Fit and Proper Person Declaration which are reported in public at the Trust Board.

Governors are required to complete individual Declaration of Interest forms, which are held on a Trust Register and available from the Trust Secretary upon request.

Resolution of disputes

The Trust Constitution sets out the process for dealing with any dispute between the Council of Governors and the Trust Board.

The Council and Trust Board have a positive working relationship, and the process has not been used during the 2018/19 year.

Remuneration Report

Introduction

The terms and conditions of employment for most of NLaG's employees are linked to the agreed national frameworks, for example Agenda for Change.

The exceptions to this are the Executive whose terms and conditions of employment and remuneration are determined by the Remuneration Committee.

The details of this are set out in this chapter of the Annual Report. The NHS Foundation Trust Annual Reporting Manual indicates this means those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or services.

For the purpose of this remuneration report the description of "senior manager" will refer to the Executive Directors and the Non-Executive Directors holding positions on the Trust Board of Directors.

The remuneration report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2018/19) as required by NHSI's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager of the Trust during the periods 2018/19 and 2017/18.

The information in this section is not subject to audit by our external auditors, but they will read the narrative to ensure it is consistent with their own knowledge of the Trust. The auditable section starts on page 89.

Annual statement on remuneration

The committee took a view on remuneration of each member of the executive team individually based on performance, job evaluation, external advice and guidance, internal relativities, market consideration and comprehensive benchmarking. Remuneration levels of other staff groups within the Trust, and in the wider NHS, were also taken in consideration.

The key decisions made on senior managers' remuneration in 2018/19 were as follows:

- The Remuneration Committee made its decisions concerning the chief executive and executive directors and there were no substantial changes to the policy or approach.
- There was one uplift during 2018/19 in recognition for the post holder continuing an 'acting up' role and in line with the NHS Improvement Senior Mangers Remuneration benchmarking tool.

Requirements from the Secretary of State in respect of salaries higher than that of the national salary of the Prime Minister, state that any salary over the threshold must receive ministerial approval. We received ministerial approval for the Chief Executive salary.

We have not paid out any compensation to any director during the year due to early termination of their contract. Loss of office is determined on a case by case basis.

Appointment and Remuneration Committee – Non-Executive Directors' remuneration

The overarching policy for the remuneration of the Non-Executive Directors is to award levels of remuneration in line with other comparable NHS foundation trusts, using benchmarked figures from a number of sources. The work of the committee is also in line with the requirement of paragraph 18(2) of Schedule 7 of the Health and Social Care Act 2006.

The Council of Governor's Appointment and Remuneration Committee decide on Non-Executive Director pay and terms and condition.

Senior managers' remuneration policy

All directors' performance is subject to an annual appraisal, the outcome of which is reported to the Remuneration Committee by the Chief Executive. This is prior to any decision being made on executive remuneration.

The Trust had a number of Executive movements during 2018/19 which resulted in this being postponed until 2019/20.

The Chief Executive had their appraisal during 2018/19; this was undertaken by the Chair of Trust. From the appraisal a report was compiled and submitted to the Remuneration Committee and also the Council of Governors. The report relates to the Chief Executives performance over the previous year.

This did not result in an uplift in the Chief Executive's remuneration. This was purely due to the Chief Executive not having accrued over one years' service with the Trust at the time of the appraisal.

The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from non-executive directors.

In coming to any decision on remuneration, the committee takes account of the circumstances of the Trust, the size and complexity of the role, any changes in the director's portfolio, the performance of the individual and any appropriate national guidance. Senior managers are remunerated based on these decisions.

In considering senior managers pay the committee has moved away from benchmarking senior managers pay against 22 comparator Trusts moving instead to using the NHS Improvement Senior Managers benchmarking tool and guidance framework from 2018/19 onwards.

Final decisions on any recommendation to uplift remuneration are taken by the committee. It also took note of the requirement to consider any pay above a threshold of £150,000.

This is a requirement from the Secretary of State in respect of salaries higher than that of the national salary of the Prime Minister. All salaries above this threshold have been sanctioned by their office.

Future policy tables

This section describes the policy narrative relating to the components of the remuneration packages for senior managers (Executive and Non-Executive Directors). Each of the components detailed in those tables supports the Trust in terms of its long term strategic objectives.
Setting and reviewing pay is not a simple matter. It is vital to recruit and retain talent and to operate the pay system fairly; but it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money.

In the case of executive jobs the Remuneration Committee made the decision that, from 2018/19, to move from the Hay Group Method of job evaluation and remuneration and to move to the NHS Improvement guidance on the job evaluation and remuneration for Senior and Very Senior Managers. The Trust is identified as a medium sized acute Trust for the purpose of this tool.

The Trust also includes a performance discussion at the same time as the annual review of roles and salary but does not apply a performance related pay process.

No new elements were added within the remuneration packages during 2018/19 and no changes to the current elements were made.

Element	Policy
Base pay	Base pay is determined through job evaluation, market benchmarking and internal relativities and is used to attract and reward the right calibre of leadership to deliver the Trust's short, medium and long term objectives.
Pension	Executive directors are able to join the standard NHS pension scheme that is available to all staff.
Retention premium	A retention premium is paid to reflect the nature of the individual contribution of the post holder and encourage retention in the face of a difficult recruitment market. And in some cases in difficult to recruit into roles.
Bonuses	Bonuses were not given to staff, including senior managers.
On call payment	In relation to executive pay, no board members receive on call payment
Benefits	The Trust operates a number of salary sacrifice schemes including cycle scheme, child care vouchers, a car lease scheme and a computer scheme. These are open to all members of staff. The individual foregoes an element of their basic pay in return for a defined benefit.
Travel expenses	Appropriate travel expenses are paid for business miles.
Declaration of gifts	As with all employees senior managers must declare any gifts or hospitality according to Trust policy with a value in excess of £25.

Base salaries are set in line with the NHS Improvement benchmarking tool and guidance and are designed to ensure retention, recruitment, of the calibre and experience required to deliver the aims of the Trust. Salaries are revised annually and uplifted only if:

- There is demonstrable evidence that an uplift is required to keep in line with the market
- A change of portfolio necessitates uplift.

The maximum value of each pay element is determined on a case-by-case basis with NHSI guidance being used for positioning of salaries using the tables and guidance produced.

Remuneration policy for Non-Executive Directors

Remuneration of the Chair and Non-Executive Directors for 2018/19 is as follows and is determined by the Council of Governors Appointments and Remuneration Committee (ARC):

Name	Salary 2018/19	Salary 2017/18
Anne Shaw (Chair)	£50,000	£50,000
Linda Jackson	£12,500 £2,426 for Vice Chair	£12,500 £2,426 for Vice Chair
Neil Gammon	n/a	£12,500 (left July 2017)
Stan Shreeve	£12,500 (left June 2018) £2,426 for Chair of Audit Committee	£12,500 £2,426 for chair of Audit Committee
Sue Cousland	£12,500 (left March 2018)	£12,500
Anthony Bramley	£12,500	£12,500
Sandra Hills	£12,500	£12,500
Jeffrey Ramseyer	£12,500 (Commenced June 2018)	n/a
Nicholas Mapstone	£12,500 (Commenced June 2018) £2,426 for Chair of Audit Committee	n/a

Future Policy Table for Non-Executive Directors

Element	Policy
Fee payable	They receive a base salary based on the number of days they work.
Additional fees	They can claim a subsistence allowance.
Percentage uplift (cost of living increase)	This is reviewed, although not applied.
Travel	Appropriate travel expenses are paid for business miles.
Uplift	The Vice Chair and Chair of the Audit Committee receive an uplift for these additional responsibilities.

Service contract obligations

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval. Alongside this NHS providers have issued 'Guidance on pay for very senior managers in NHS Trusts and Foundation Trusts' in February 2017.

All contracts are permanent with no fixed end date. However, six executive positions were Acting or Interim at various points throughout 2018/19.

There are no contractual provisions for payments on termination of contract. This is the case on a substantive or interim basis.

Policy on payments for loss of office

There is currently no provision within the Remuneration Policy for payment for loss of office on senior managers' contracts and no payments have been made during 2018/19. There is a clause which enables the Trust to reclaim relocation monies if the individual leaves within an agreed period of their appointment. None have been claimed during 2018/19.

Statement of consideration of employment conditions elsewhere in the Trust

There has been no formal consultation regarding senior managers' remuneration policy.

Policy on notice periods

Executive Directors have to provide a period of three months' notice should they wish to terminate their employment with the Trust.

Annual report on remuneration

This section includes a description of the work of the committees that are involved in the appointments of both the Executive and Non-Executive Directors, and in determining their respective salaries and remuneration. These are:

- The Remuneration Committee
- The Appointments and Remuneration Committee.

The Remuneration Committee (a sub-committee of the Board of Directors)

The Remuneration Committee is a sub-committee of the Trust Board and was established in accordance with the Trust Constitution and Monitor's NHS Foundation Trust Code of Governance (July 2014) for the purpose of setting the remuneration of Executive Directors of the Trust Board and those reporting directly to the Chief Executive.

It is responsible for determining the pay and terms of service for Executive Directors and is accountable to, and reports directly, to the Trust Board.

Its key objective is to ensure that remuneration packages are sufficient to attract, retain and motivate executive directors of the quality required for the successful operation of the Trust, while avoiding paying excessively for this purpose.

Remuneration includes pay, all contractual terms and conditions, pensions and redundancy or settlement entitlements.

The committee also has delegated responsibility for recommending and monitoring the level and structure of remuneration of its senior managers.

The definition of senior manager for this purpose will include the first layer of management below board level (see NHSI's Code of Governance D2.2).

The committee is comprised of three Non-Executive Directors. Other Directors attend meetings or parts of meetings by invitation as required for specialist advice including the Chief Executive and Director of People and Organisational Effectiveness.

In accordance with NHI's Code of Governance no Director is involved in deciding his/her remuneration (Para D2a).

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2018/19 the committee has taken advice internally from the Director of People and Organisational Effectiveness (POE).

Between April 1 2018 and March 31 2019, the Remuneration Committee met seven times. The table overleaf illustrates the attendees and their attendance.

Appointment of Executive and Non-Executive Directors in 2018/19

There was one Executive appointment during 2018/19. There were two Non-Executive Director appointments in 2018/19.

Name	Title	Date of attendance
Anne Shaw	Trust Chair, and Chair of Remuneration Committee from March 2018	**2018:** 31 May, 30 August, 14 November, 26 November **2019:** 14 February, 05 March, 27 March
Jayne Adamson	Director of People And Organisational Effectiveness	**2018:** 31 May, 30 August, 14 November, 26 November **2019:** 14 February
Wendy Booth	Trust Secretary	**2018:** 31 May, 30 August, 14 November, 26 November **2019:** 14 February, 05 March, 27 March
Anthony Bramley	Non-Executive Director	**2018:** 31 May, 14 November **2019:** 14 February, 05 March, 27 March
Sandra Hills	Non-Executive Director	**2018:** 14 November, 26 November **2019:** 14 February, 05 March
Linda Jackson	Non-Executive Director	**2018:** 31 May, 30 August, 14 November, 26 November **2019:** 14 February, 05 March, 27 March
Nicholas Mapstone	Non-Executive Director	**2018:** 14 November **2019:** 14 February, 05 March, 27 March
Jeff Ramseyer	Non-Executive Director	**2019:** 14 February, 05 March, 27 March
Wendy Stokes	Exec PA to Director of People and Organisational Effectiveness – taking minutes	**2018:** 31 May, 30 August, 14 November **2019:** 14 February
Heidi Forster	Exec PA to Chief Exec – taking minutes	**2018:** 26 November

Advice to the committee

External advice to the Remuneration Committee is provided by the NHS Improvement benchmarking tool and guidance for Senior and Very Senior Managers.

NHS Improvement guidance provides both job evaluation and remuneration benchmarking from comparison of the size of the Trust, based on annual budget, against comparator Trusts of an equivalent size (budget). For the purposes of this exercise the Trust is classified as a medium sized Trust

Directors' contracts

Details of the contract start date for the Chief Executive and other members of the Executive Team who served during 2018/19 are set out in the table below and overleaf.

Name	Title	Date of contract	Notice period from the Trust	Notice period to the Trust
Richard Sunley	Interim Deputy Chief Executive/Director of Operations	August 14 to May 31 2018	Left May 31 2018	
Dr Karen Dunderdale	Deputy Chief Executive/Director of Operations	June 29 2015	Left July 23 2018, following secondment to NHSI from 14 July 2017	
Dr Peter Reading	Chief Executive	August 14 2017		
Jayne Adamson	Director of People and Organisational Effectiveness	August 1 2016	Three months	Three months
Claire Low	Acting Director of People and Organisational Effectiveness	March 13 2019	Acting up arrangements continue into 2019/2020	
Tara Filby	Chief Nurse	October 9 2015	On secondment from February 18 2019	
Elaine Coghill	Acting Chief Nurse	October 1 2018	Arrangements ended November 18 2018	
Ellie Monkhouse	Interim Chief Nurse	November 15 2018	n/a	n/a
Mr Lawrence Roberts	Medical Director	July 7 2015	Three months	Three months
Kate Wood	Acting Medical Director	October 1 2017 to March 31 2019	Three months	Three months
Wendy Booth	Director of Performance and Assurance	August 2012	Left August 31 2018	

Name	Title	Date of contract	Notice period from the Trust	Notice period to the Trust
Wendy Booth	Trust Secretary	October 1 2018	Three months	Three months
Marcus Hassall	Director of Finance	August 2014	Three months	Three months
Richard Eley	Interim Director of Finance	December 17 2018	n/a	n/a
Pam Clipson	Director of Strategy and Planning	June 2014	Three months	Three months
Jug Johal	Director of Estates and Facilities	August 2014	Three months	Three months
Shaun Stacey	Chief Operating Officer	May 29 2018	Three months	Three months

Details of the non-executive directors who have served during the course of 2018/19 are shown in the table below, along with details of their current terms of appointments.

The tenure (length) of employment for Non-Executive Directors is set out in the Trust's Constitution and is for three years, and then subject to reappointment.

Any terms beyond six years is subject to rigorous review by the Council of Governors (CoG) and Non-Executive Directors serving beyond this are subject to an annual reappointment.

Name	Appointment date	Start of current term	End of current term
Anne Shaw	14/09/2016	14/09/2016	14/09/2019
Linda Jackson	29/09/2016	29/09/2016	29/09/2019
Tony Bramley	03/01/2017	03/01/2017	03/01/2020
Sandra Hills	03/01/2017	03/01/2017	03/01/2020
Nick Mapstone (resigned May 2019)	26/06/2018	26/06/2018	26/06/2020
Jeff Ramseyer	26/06/2018	26/06/2018	26/06/2020
Stan Shreeve	07.06.2012	07.06.2015	07.06.2018

The Appointments and Remuneration Committee (a sub-committee of the Council of Governors)

The Appointment and Remuneration Committee (ARC) is a sub-committee of the Council of Governors. It sets the remuneration and terms of service for the Non-Executive Directors (NEDs), and it plays a role in the appointment of NEDs.

The table below shows the number of Appointments and Remuneration Committee meetings in 2018/19 that were attended by each member of the committee.

Meeting dates					
Public Governors	**05.06.18**	**04.09.18**	**04.12.18**	**12.03.19**	**Total**
Jeremy Baskett	Present	N/a	Present	Present	3 out of 3
Paul Grinell (Chair for March meeting only)	Present	N/a	Present	Present	3 out of 3
Brian Page (Chair from December meeting)	Absent	N/a	Present	Present	2 out of 3
Rob Pickersgill	Present	N/a	Present	Present	3 out of 3
Barbara Jeffreys	Present	N/a	Present	N/a	2 out of 2
Tim Mawson	Absent	N/a	Absent	Present	1 out of 3
Liz Stones	Absent	N/a	Absent	Absent	0 out of 3
Anne Shaw Trust Chair	Present	N/a	Present	Present	3 out of 3
Jayne Adamson Director of POE	Absent	N/a	Present	Absent	1 out of 3
Wendy Booth, Trust Secretary and Director of Performance Assurance	Absent	N/a	Present	Present	2 out of 3

Off-payroll engagements

Table 1: Off-payroll engagements longer than six months

For all off-payroll engagements as of 31 March 2019, greater than £245 per day and that last for longer than six months:

	Number
Total number of existing engagements as of 31 March 2019	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

Table 2: New Off-payroll engagements

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019	0
Of which:	
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to Trust) and are on the Trust payroll	0
Number of engagements reassessed for consistency / assurance purposes during the year.	0
Number of engagements that saw a change to IR35 status following the consistency review	0

Table 3: Off-payroll board member/senior official engagements

For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Total number of individuals on payroll and off-payroll that have been deemed ‘board members, and/or, senior officials with significant financial responsibility’, during the financial year. This figure should include both on payroll and off-payroll engagements	23

Directors' and governors' expenses

The following tables set out the total paid to directors (Executive and Non-Executive) and Governors for out-of-pocket expenses resulting from incurring costs of travel and subsistence during 2017/18 and in 2016/17.

Directors and Governors expenses 2018/19*

	Total in office	Total receiving expenses	Total expenses £00's
Directors	23	17	£444
Governors	19	9	£45

Directors and Governors expenses 2017/18*

	Total in office	Total receiving expenses	Total expenses £00's
Directors	20	18	£382
Governors	22	9	£35

*Note: The numbers includes all Directors, Non-Executive Directors or Governors who served for any part of the financial year.

Remuneration of all other staff

Agenda for Change (AfC), the nationally introduced pay reform for the NHS which was introduced in October 2004, covers all directly employed staff, except very senior managers and those covered by the Doctors Dentists Pay Review Body.

For all local pay arrangements not determined by AfC, pay increases were consisted with AfC increases.

A robust system of appraisal and personal development planning has been adopted for all staff.

A different approach is adopted in relation to the Trust Executive because all other staff are on national terms and conditions and the executive team members' remuneration is determined locally.

AfC staff have clear incremental progression, which is performance related, and medical and dental staff are on a separate contractual agreement which also allows for incremental progression and the award of substantial additional payments for clinical excellence.

They are also able to benefit from an annual cost of living award, if this is agreed nationally.

It was not felt appropriate for executive team members to be on an incremental scale unless this involved performance related assessments.

The priority was to provide a simple, clear and transparent model in which senior posts are operating.

Salaries are inclusive and there is no additional cost of living award. Strategically, this strategy is designed to enable the Trust to recruit and retain the level of skills and expertise we cannot effectively function without. The remuneration policy for senior managers is determined independently to that for employees of the Trust.

Expenditure on consultancy

During 2018/19 the Trust has spent £2,660k on consultancy fees compared to £3,230k in the previous financial year.

Pay multiple statement

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in Northern Lincolnshire and Goole NHS Foundation Trust in the financial year 2018/19 was £190,000-195,000 (2017/18,£190-195,000).

This was 8.2 times (2017/18, 8.6 times) the median remuneration of the workforce, which was £24,000 (2017/18, £23,000). The change in the ratio relates to the effects of the three year pay deal which was implemented in the 2018/19 financial year, the impact of which was to increase the salaries of lower banded staff within the Trust.

In 2018/19, five employees received remuneration in excess of the highest-paid director. Remuneration ranged from £252,000 to £350,000 in 2018/19.

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions.

Pay policy

The Trust continues to adhere to national pay and terms and conditions of service but also utilises provisions related to recruitment and retention premia where necessary and in order to assist staffing and service delivery.

Salary and pension entitlements of senior managers 2018/19

			Salary	Benefits in kind	Pension Related benefit	Total
Name	**Notes**	**Title**	**(bands of £5,000)**	**(£s, to the nearest £100)**	**(bands of £2,500)**	**(bands of £5,000)**
			£000's	**£'s**	**£000's**	
Mrs A Shaw		Chair	£50 - £55	-	-	£50 - £55
Dr PR Reading	1	Chief Executive	£195 - £200	12,100	-	£215 - £220
Mr R Sunley		Deputy Chief Executive (resigned 31/5/18)	£20 - £25	-	-	£20 - £25
Mr S Stacey		Chief Operating Officer (appointed 29/5/18)	£100 - £105		£202.5 - £205.0	£310 - £315
Miss C Low		Acting Director of People and Organisational Effectiveness (from 13/3/19)	£0 - £5	-	-	£0 - £5
Mrs VJ Adamson		Director of People and Organisational Effectiveness	£125 - £130		£18.5 - £20.0	£145 - £150
Mrs E Monkhouse		Interim Chief Nurse (from 15/11/18)	£45 - £50	-	-	£45 - £50
Miss E Coghill		Acting Chief Nurse (1/10/18 to 14/11/18)	£10 - £15	-	£77.5 - £80.0	£90 - £95
Mrs T Filby	1,4	Chief Nurse (on secondment from February 18 2019)	£60 - £65	5,500	£222.5 - £225.0	£285 - £290
Mr L Roberts		Medical Director	£190 - £195	-	-	£190 - £195
Mrs KA Wood		Acting Medical Director	Disclosure omitted			
Mrs W Booth	1,4	Director of Performance Assurance & Trust Secretary	£80 - £85		-	£80 - £85
Mr R Eley		Interim Director of Finance (from 17/12/18)	£65 - £70		-	£65 - £70

Salary and pension entitlements of senior managers 2018/19 (continued)

			Salary	Benefits in kind	Pension Related benefit	Total
Name	**Notes**	**Title**	**(bands of £5,000)**	**(£s, to the nearest £100)**	**(bands of £2,500)**	**(bands of £5,000)**
			£000's	**£'s**	**£000's**	
Mr M Hassall	1	Director of Finance	£120 - £125	6,800	£845 - £847	£975 - £980
Mrs P Clipson		Director of Strategy & Planning	£110 - £115	-	£7.5 - £10.0	£120 - £125
Mr J Johal	1	Director of Estates & Facilities	£120 - £125	11,300	£15.0 - £17.5	£140 - £145
Mr A Bramley		Non Executive Director	£10 - £15	-	-	£10 - £15
Mrs S Cousland		Non Executive Director	£0 - £5	-	-	£0 - £5
Mrs S Hills		Non Executive Director	£10 - £15	-	-	£10 - £15
Mrs L Jackson		Non Executive Director	£10 - £15	-	-	£10 - £15
Mr N Mapstone		Non Executive Director	£5 - £10	-		£5 - £10
Mr J Ramseyer		Non Executive Director	£5 - £10	-	-	£5 - £10
Mr S Shreeve		Non Executive Director	£0 - £5	-	-	£0 - £5
			£000	**£'s**		
GROSS REMUNERATION INCLUDING NATIONAL INSURANCE AND PENSION CONTRIBUTIONS			**2,000**	**35,700**		

Salary and pension entitlements of senior managers 2017/18

			Salary	Benefits in kind	Pension Related benefit	Total
Name	Notes	Title	(bands of £5,000)	(£s, to the nearest £100)	(bands of £2,500)	(bands of £5,000)
			£000's	£'s	£000's	
Mrs A Shaw		Chair	£50 - £55	-	-	£50 - £55
Dr PR Reading	1	Chief Executive	£125 - £130	3,800	-	£130 - £135
Mr R Sunley		Deputy Chief Executive	£145 - £150	-	-	£145 - £150
Dr K Dunderdale	1	Deputy Chief Executive	£35 - £40	12,000	£20.0 - £22.5	£65 - £70
Mrs C Phillips	1	Interim Chief Operating Officer	£0 - £5	2,000	£17.5 - £20.0	£20 - £25
Mrs VJ Adamson		Director of People and Organisational Effectiveness	£125 - £130	-	-	£125 - £130
Mrs T Filby	1, 4	Chief Nurse	£115 - £120	10,200	-	£130 - £135
Mr L Roberts		Medical Director	£190 - £195	-	£52.5 - £55.0	£240 - £245
Mrs KA Wood		Acting Medical Director	Disclosure omitted			
Mrs W Booth	1, 4	Director of Performance Assurance & Trust Secretary	£120 - £125	7,500	£65.0 - £67.5	£190 - £195
Mr M Hassall	1	Director of Finance	£120 - £125	5,500	£37.5 - £40.0	£160 - £165
Mr R Toole		Acting Director of Finance	£70 - £75	-	-	£70 - £75
Mrs P Clipson		Director of Strategy & Planning	£110 - £115	-	£20.0 - £22.5	£130 - £135
Mr J Johal	1	Director of Estates & Facilities	£110 - £115	10,100	£17.5 - £20.0	£140 - £145
Mr A Bramley		Non Executive Director	£10 - £15	-	-	£10 - £15
Mrs S Cousland		Non Executive Director	£10 - £15	-	-	£10 - £15
Mr N Gammon		Non Executive Director	£0 - £5	-	-	£0 - £5
Mrs S Hills		Non Executive Director	£10 - £15	-	-	£10 - £15

Salary and pension entitlements of senior managers 2017/18 (continued)

			Salary	Benefits in kind	Pension Related benefit	Total
Name	**Notes**	**Title**	**(bands of £5,000)**	**(£s, to the nearest £100)**	**(bands of £2,500)**	**(bands of £5,000)**
			£000's	**£'s**	**£000's**	
Mrs L Jackson		Non Executive Director	£10 -£15	-	-	£10 - £15
Mr S Shreeve		Non Executive Director	£15 - £20	-	-	£15 - £20
			£000	**£'s**		
GROSS REMUNERATION INCLUDING NATIONAL INSURANCE AND PENSION CONTRIBUTIONS			**1,788**	**51,100**		

Pay multiple table

	2018/19	2017/18	Notes
Band of highest paid director's total remuneration (£000)	190-195	190-195	
Median remuneration (£000)	24	23	2
Ratio	8.2	8.6	3

Notes to salary and pension entitlements and pay multiple tables

1 - Benefit in kind relates to Lease Cars
2 - The median remuneration is the middle item salary when the annualised salaries of all members of staff including agency and seconded staff (excluding bank staff and the highest paid director) are arranged in descending order.
3 - The ratio is obtained by dividing the highest paid director's salary by the median salary.
4 - Where the calculation of the pension related benefit results in a negative value, this has been shown as zero.

Pension benefits – Executive Directors

Name	Title	Real Increase/(Decrease) in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2019 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase/(Decrease) in Cash Equivalent Transfer Value
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Dr PR Reading	Chief Executive	-	-	-	-		-	0
Mr R Sunley	Deputy Chief Executive Officer	-	-	-	-	-	-	0
Mrs VJ Adamson	Director of People and Organisational Effectiveness	0 - 2.5	-	20 - 25	-	332	274	58
Mrs W Booth	Director of Performance Assurance & Trust Secretary	-	-	-	-	-	-	-
Mrs P Clipson	Director of Strategy & Planning	0 - 2.5	(0 - 2.5)	30 - 35	75 - 80	479	400	79
Miss E Coghill	Interim Chief Nurse (part year)	2.5 - 5.0	7.5 - 10	25 - 30	75 - 80	518	-	518
Ms T Filby	Chief Nurse (part year)	10 - 12.5	30.0 - 32.5	60 - 65	185 - 190	1,238	744	494
Mr M Hassall	Director of Finance	37.5 - 40.0	100.0 - 102.5	40 - 45	100 - 105	764	44	720
Mr J Johal	Director of Estates & Facilities	0 - 2.5	(0 - 2.5)	15 - 20	30 - 35	267	220	47
Mr L Roberts	Medical Director	-	-	-	-	-	-	-
Mr S Stacey	Chief Operating Officer	7.5 - 10	22.5 - 25.0	10 - 15	25 - 30	233	-	233
Mrs KA Wood	Acting Medical Director	Disclosure omitted						

* The above table includes full year pension costs

Pension benefits

The Chairman and Non-Executive Directors do not receive pensionable remuneration.

Therefore there are no entries in respect of pensions for the Chairman and Non-Executive Directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time.

The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies.

The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

The basis of CETV calculations are based in the Department of Work and Pensions regulations which came into force on October 13 2008.

This year the CETV's shows reduction in real term in most cases due to not having any inflation factors applied.

Real Increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period.

No inflation factors have been applied this financial year as per the guidance from NHS Pensions Agency.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Staff report

Staff at NLaG

The Trust can only deliver the care it strives to provide through an enthusiastic, innovative, hardworking and engaged workforce. How staff feel about working here and their commitment to their patients and the Trust are all essential if they are to provide outstanding care to patients.

It is absolutely crucial the Trust recruits and retains the right people, and it is crucial that the organisation supports their health and wellbeing, enables them to maintain the highest knowledge and skills, and supports them in doing their jobs.

The Trust cannot underestimate the drivers and impact of double special measures on its workforce and what it will take to change the culture within the organisation.

The morale across staff has been low as demonstrated through the national staff survey and the medical engagement scale over the previous few years.

Since these were undertaken in the, the Trust has launched its Pride and Respect Programme (formerly known as its anti-bullying campaign). There has been a fantastic response from staff across all disciplines wanting to be involved: more than 100 staff have signed up to be Pride and Respect Champions; around 800 staff took part in training looking at how culture and behaviour can impact on both staff and patient experience; and a number of staff have taken advantage of the Trust's mediation service to overcome issues with their colleagues.

The Trust's quality improvement programme – Improving Together - has a focus on delivering safe staffing levels across all services at the Trust. The Trust is facing critical workforce shortfalls across its workforce, medical and nursing staffing in particular.

From April 2018 to February 2019, vacancies fell from 540.39 whole time equivalents (wte) to 370.17 wte, despite an increase in budgeted establishment of 91 wte. Over that period vacancies for doctors fell by 58 for registered nurses by 21 and for Health Care Assistants by 43.

The medical vacancy position is the best in the Trust in the past four years, and is expected to improve further due to recruitment in the pipeline. The Deanery Training Rotation 'fill rate' improved from 69% in August 2017 to 77% in August 2018.

Staff turnover (12 month moving average) improved from 11.43% to 9.5% (January 2018 to January 2019).

Apprenticeships

The Trust has used Apprenticeships for a number of years in traditional areas such as business administration but has not had a strategic approach to the utilisation of apprenticeships.

This has now changed and the Trust is recognised as one of the best trusts in the country for the use of its Apprenticeship Levy and one of the top 200 employers in the UK. The team behind this work has been recognised nationally and now the Trust is sharing its experiences with other organisations across the NHS.

Staff policies and actions

Polices for giving full and fair consideration to applications for employment made by disabled persons, having regard to their aptitudes and abilities	The Trust has a recruitment and selection policy, which sets out how the Trust ensures fair recruitment practices throughout the attraction, selection and recruitment of candidates, including compliance with the JobCentre Plus “Disability Confident” standards. This is reviewed through the Trust’s electronic tracking ‘TRAC’ recruitment system.
Policies applied for continuing the employment of, and for arranging appropriate training for, employees who become disabled during the period	The Trust adheres to the Equality Act 2010, and has has introduced an Equality Impact Assessment Policy and Procedure that supports, line managers to make reasonable adjustments and use referrals to the occupational health team to ensure the continued employment of employees who become disabled persons. In addition, the HR team provides direct support to staff affected and managers. Going forward plans are in place to introduce a new Workforce Disability Equality standard which will help to measure the experience of our disabled staff.
Policies applied during the year for the training, career development and promotion of disabled employees	There is equality access to training for all staff. Policies applied during the year for the training, career development and promotion of disabled employees are: • Personal Development Review Policy • Recruitment Policy • Attendance Management Policy • Managing Employee Performance • Special Leave Policy • Safeguarding Policy All our policies have an equality impact assessment.
Actions taken in the year to provide employees systematically with information on matters of concern to them as employees	The Trust uses a variety of internal communications channels to inform staff including: all staff emails; a weekly team brief which is emailed to all staff; bulletins posted on the Intranet; chief executive monthly senior leadership community briefing; face-to-face channels and the staff/members magazine.
Actions taken to consult staff on a regular basis so that the views of staff can be taken into consideration in making decisions which are likely to affect their interests	The Trust has regular meetings with its Joint Negotiating Consultative Committee for formal discussions relating to staffing issues. Collective consultations would be enacted where there are more specific issues affecting employees i.e. restructures. In addition an initiative called Pride & Respect, which launched in 2017, is involving employees in a cultural change programme designed to improve engagement with all staff.

Fraud, bribery and corruption statement

Fraud costs the NHS millions of pounds a year that could have been spent on patient care, so everyone has a duty to help prevent it. NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS.

The Trust is committed to deterring and detecting all instances of fraud, bribery and corruption as far as possible within the Trust and ensuring that losses are reduced to an absolute minimum, therefore ensuring that valuable public resources are used for their intended purpose of delivering the best possible care and patient experience.

The NHS Counter Fraud Authority (NHSCFA) provides the national framework through which NHS trusts seek to minimise losses through fraud. The Director of Finance is nominated to lead counter fraud work and is supported by the Trust's Local Counter Fraud Specialist (LCFS). The Trust follows the guidance contained in the NHS Provider Standards and ensures our contractual obligations with our local clinical commissioning groups are adhered to.

The Trust has a robust Local Counter Fraud, Bribery and Corruption Policy and Response Plan which provides a framework for responding to suspicions of fraud and provides advice and information on various aspects of fraud investigations.

The Trust also has a Standards of Business Conduct Policy which contains a statement from the Trust's Chief Executive in relation to ensuring that our organisation is free from bribery and corruption.

There are references to counter fraud measures and reporting processes in various other Trust policies and procedures.

The Trust has an in-house collaborative counter fraud arrangement with two other local acute NHS trusts, which allows us to have a LCFS permanently on site, supported by a small team of counter fraud specialists dedicated to combatting fraud within a secondary care setting.

An annual work plan, approved by the Director of Finance with oversight from the Trust's Audit, Risk and Governance Committee, has been in place over the last year. The key aims are to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and ensure that allegations of fraud are appropriately and professionally investigated to a criminal standard.

Progress reports on all aspects of counter fraud work and details of investigations are received at each meeting of the Trust's Audit, Risk and Governance Committee. The Trust has a well-publicised system in place for staff to raise concerns if they identify or suspect fraud.

They can do this via our LCFS, the Director of Finance, the Trust's electronic anonymous reporting system 'Bad Apple', via the NHS fraud and corruption reporting line on 0800 028 40 60 or online at www.cfa.nhs.uk/reportfraud

Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels with the exception of the 'Bad Apple' reporting system which is an internal staff system.

Information on health and safety performance

Health and safety compliance is managed by the health, safety and fire team. The Health, Safety and Fire Group is a sub-group of, and reports to, the Trust Audit, Risk and Governance (ARG) Committee, which is a sub-committee of the Trust Board.

Governance and Health and Safety Groups are established as well as those existing with other groups such as ARG, Security Group and Joint Negotiating Consultative Committee (a Senior Management Team from Estates and Facilities attends JNCC). Highlight reports are submitted where appropriate to the relevant groups and board briefings on health and safety are undertaken at appropriate times.

Working with the Estates and Facilities directorate has strengthened the input of fire, health and safety advice into projects at an early stage to ensure projects are delivered on time and meet requirements when returned to operational use. The Health, Safety and Fire Sub Group continues to review reports, policies and accident data on issues relating to the following areas of health and safety: fire, manual handling, security, training, estates and facilities, occupational health, staff incidents, stress, radiation protection and non-clinical risk management.

Health and safety incidents are logged on the Trust's Datix incident reporting system, while risk assessments are carried out and logged on the Safety, Health and Environment (SHE Assure) software package.
Health and safety training is mandatory for all staff on induction and additional health and safety training is delivered to staff where required.

As reported at the end of March there were seven RIDDOR reportable accidents confirmed during 2017/18.

Information on occupational health

Occupational Health (OH) is concerned with the impact of health on work and work on health, with a focus on keeping Trust staff healthy and at work. The service accepts referrals from members of staff, managers and recruitment. Over the last year OH has worked hard to streamline its processes and work in different ways to increase efficiency and productivity and this has been reflected in the significant improvements to waiting times for appointments and pre-employment health clearances.

A major contributor to the improved time to recruit (from an Occupational Health perspective) has been the success pilot of Occupational Health Technicians and the team is hopeful these will be made substantive in the foreseeable future. Another major success for the Trust as a whole has been the use of Peer Vaccinators and subsequent achievement of 78% uptake of the influenza vaccine in frontline workers in the shortest ever time.

This means that a greater proportion of frontline staff have helped to protect themselves, their families and patients than ever before. Over the coming year OH will consolidate the improvements made and the service will also begin to change the way it works to help to keep staff healthy and well physically, emotionally and mentally. It is looking to work differently with line managers to become more responsive and better support members of staff who become ill to remain in or return to work.

Involvement of employees

Staff at the Trust have a number of ways to get involved in the work and development of the Trust, and to be consulted on any changes. These are:

- A monthly JNCC (Joint Negotiating and Consultation Committee Meeting) for Staffside representatives
- A monthly JLNC (Joint Local Negotiating Committee) for medics
- Fortnightly policy sub-group meetings with representatives to discuss and agree policy updates.
- A Black and Minority Ethnic (BAME) staff network group which was launched in 2018 and a LGBT+ network is also in the early stages of development.
- A Pride and Respect Steering Group, chaired by a clinician, to work on cultural change in the Trust. This group led the work to develop the Trust's new vision and values.
- Staff Governors who meet regularly with senior management and take part in the Council of Governors meetings throughout the course of the year

Trade union facility time

Relevant union officials

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
16	13.2

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours	4.2%

Percentage of time spent on facility time

Percentage of time	Number of employees
0%	0
1-50%	13
51%-99%	1
100%	2

Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£59,404
Total pay bill	£247,245,000
Percentage of the total pay bill spent on facility time	0.024%

Volunteers

The enormous contribution made by volunteers continues to humble the Trust as they dedicate their time for free. The Trust is truly grateful to the 500 volunteers who helped out across the three hospital offering support and help to patients and staff. They tirelessly work in the hospitals providing a range of services from 'meet and greet', which sees them escorting patients and visitors around the hospital sites, to assisting patients at mealtimes and helping in clinics. Many more opportunities for volunteering are available and the Trust will endeavour to place each individual in the most appropriate area to suit their skills and expertise. Volunteers from external agencies including the League of Friends and Hospital Radio also provide services that enhance a patients' hospital experience.

Staff sickness absence

Figures converted by DH to Best Estimates of Required Data Return		Statistics published by NHS Digital from ESR Data Warehouse	
	Expected sign	**2018/19 Number**	**2017/18 Number**
Total days lost	+	86,330 (FTE days lost)	85,968 (FTE days lost)
Total staff years	+	5,612 (Total staff FTE)	5,316 (Total staff FTE)
Average working days lost (per WTE)	+	15	16

Staff engagement and communications

During the year the Trust appointed to a new Associate Director of Communications and Engagement role to improve how the Trust engages and communicates with both staff and the wider general public.

Since the appointment the Trust has worked hard to introduce new ways to recognise and thank staff and celebrate their achievements.

This work has included:

- Involving staff in the creation of new Trust values and behaviours
- Creating new ways to celebrate staff achievements e.g. ‘Thumbs Up Friday’ and ‘Team of the Week’
- Continuing with the monthly briefing of the Senior Leadership Community

- Putting in place ways for staff to contact the Chief Executive such as: ‘Ask Peter’; ‘Meet the Chief’ where staff have the opportunity to sit with and talk about issues and concerns; and a new staff briefing session following on from the Senior Leadership Community.

Staff survey results

The NHS staff survey is conducted annually. From 2018 onwards the results from questions are grouped to give ten indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those.

The results of the 2018 National Staff Survey were published in February 2019. More than 2,000 staff took part in the survey, which ran from September 2018 to December 2018.

The response rate was 35 per cent, which is 1.5% up from the previous year. Scores for each indicator together with that of the survey benchmarking group (acute trusts) are presented on the table overleaf.

The survey gives staff the opportunity to provide feedback to the Trust on a range of areas such as culture, managers, safety, and workload.

The results showed some improvement across the majority of questions compared to the 2017 survey, but also showed a clear picture of much more work needing to be done. Around 72% of staff surveyed said they were enthusiastic about their job and more of them would recommend the Trust as a place to work and receive treatment.

Reading the comments showed the Trust is starting to see the signs of positive culture change. More staff felt confident about raising concerns and reporting incidents and felt more confident the Trust would act on feedback from staff and patients.

Fewer staff are suffering from work related stress compared to the 2017 survey. However the results also highlight that staff morale remains low with concerns around adequate staffing levels, the quality of appraisals and a lack of opportunity for progression.

Future priorities and targets

Like most Trusts a crucial issue is having enough staff to do everything needed to be done and to lessen the pressure staff face on a daily basis because some areas do not have enough staff. The Trust will do more to reduce the vacancy rate and its reliance on agency staff.

The Trust is expecting another high fill rate for junior doctors, building on the improvement last year, and 20 nurses from the Philippines in the recruitment pipeline which should be joining by the end of September 2019. The Trust also has plans to bring in 65 newly qualified nurses around the usual time at the end of the 2019 calendar year.

The Trust is planning to bring in more new roles –introducing Physician Associates on a two year rotational preceptorship programme, for example, and a plan to introduce six Band 3 Physician Assistants – as well as build on its successful Apprenticeships work. The Trust has set three priorities for 2019/20 to improve culture and morale. These are:

- Further roll out and embed the Trust's culture change work
- Improve staff appraisals – both compliance and quality
- Publish and start implementing a Leadership Development Strategy

Progress against these priorities will be monitored through the Trust's Workforce Committee.

Staff survey results

	2018/19		2017/18		2016/17	
	Trust	Benchmarking group	Trust	Benchmarking group	Trust	Benchmarking group
Equality, diversity & inclusion	9.0	9.1	9.0	9.1	9.2	9.2
Health and wellbeing	5.5	5.9	5.5	6.0	5.7	6.1
Immediate managers	6.4	6.7	6.3	6.7	6.5	6.7
Morale	5.8	6.1	n/a	n/a	n/a	n/a
Quality of appraisals	4.6	5.4	4.7	5.3	4.8	5.3
Quality of care	7.2	7.4	7.1	7.5	7.4	7.6
Safe environment – bullying / harassment	7.6	7.9	7.8	8.0	8.1	8.0
Safe environment – violence	9.4	9.4	9.3	9.4	9.3	9.4
Safety culture	6.2	6.6	5.9	6.6	6.4	6.6
Staff engagement	6.5	7.0	6.4	7.0	6.7	7.0

Trust staff in numbers

Staff costs

	Group			
			2018/19	2017/18
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	203,220	323	**203,543**	188,996
Social security costs	20,346	-	**20,346**	19,435
Apprenticeship levy	1,057	-	**1,057**	999
Employer's contributions to NHS pensions	22,622	-	**22,622**	21,458
Temporary staff	-	23,366	**23,366**	26,247
Total gross staff costs	**247,245**	**23,689**	**270,934**	**257,135**
Recoveries in respect of seconded staff	-	-	**-**	-
Total staff costs	**247,245**	**23,689**	**270,934**	**257,135**

Average staff numbers based on Whole Time Equivalent (WTE)

	Group			
			2018/19	2017/18
	Permanent	Other	Total	Total
Medical and dental	539	92	**631**	598
Ambulance staff	-	-	**-**	-
Administration and estates	1,290	28	**1,318**	1,283
Healthcare assistants and other support staff	1,140	35	**1,175**	1,118
Nursing, midwifery and health visiting staff	1,500	296	**1,796**	1,747
Scientific, therapeutic and technical staff	1,043	16	**1,059**	1,057
Total average numbers	**5,512**	**467**	**5,979**	**5,803**

Analysis of ethnicity of staff

	2018/19	%	2017/18	%
Asian	446	6.7	362	5.7
Black	125	1.9	96	1.5
Mixed	39	0.6	35	0.6
Other	40	0.6	35	0.6
Unknown	249	3.7	236	3.7
White	5806	86.6	5576	87.9
Total	**6705**		**6340**	

Number of people

	2018/19	2017/18
Other	56	76
Medical	602	506
Band 9	10	6
Band 8	218	203
Band 7	503	472
Band 6	815	787
Band 5	1303	1252
Band 4	337	325
Band 3	848	750
Band 2	1581	1524
Band 1	423	413
Apprentices	9	26
Total	**6705**	**6340**

Age profile of staff

	2018/19	2017/18
< 25	505	508
26 - 35	1585	1408
36 - 45	1427	1364
46 - 50	935	926
51 - 55	992	980
56 - 60	769	719
61-65	395	350
65+	95	83
Unknown	2	2
Total	**6705**	**6340**

Staff profile

	Number of people	
	2018/19	2017/18
Add prof scientific and technical	182	177
Additional clinical services	1488	1377
Administrative and clerical	1433	1361
Allied health professionals	377	351
Estates and ancillary	655	642
Healthcare scientists	212	206
Medical and dental	602	506
Nursing and midwifery registered	1735	1702
Students	12	11
Unknown	9	7
Total	**6705**	6340

Analysis of gender distribution of staff 2018/19

	Female	Male	Total	% Female	% Male
Directors	2	5	7	29	71
Other Senior Managers	153	75	228	67	33
Employees excluding the above categories	5280	1190	6470	82	18
Total	**5435**	**1270**	**6705**		

Exit Packages agreed in 2018/19 and 2017/18

Exit package cost band	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
2018/19			
< £10,000	-	-	-
£10,001 - £25,000	1	1	1
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	**£23,000**	**-**	**£23,000**
2017/18			
< £10,000	-	-	-
£10,001 - £25,000	-	-	-
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
> £200,000	-	-	-
Total	-	-	-

Exit Packages – Other departures analysis

	2018-19 Agreements	2018-19 Total value of agreements	2017-18 Agreements	2017-18 Total value of agreements
	Number	**£000s**	**Number**	**£000s**
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

NHS Foundation Trust Code of Conduct

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014. The purpose of the Code of Governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance.

The code is issued as best practice advice, but imposes some disclosure requirements. Northern Lincolnshire and Goole NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012. For the year ending March 31 2018, the Board considers that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

The Board of Directors is committed to high standards of corporate governance, understanding the importance of transparency and accountability and the impact of Board effectiveness on organisational performance.

The Trust carries out an ongoing programme of work to ensure that its governance procedures are in line with the principles of the Code, including:

- Supporting governors to appoint non-executive directors and external auditors with appropriate skills and experience
- Ensuring a tailored and in-depth induction programme for new non-executive directors and governors
- Facilitating internal and external reviews of the Trust's governance arrangements and acting on the findings. This included during 2018/19 a review of the governance arrangements within clinical divisions. Further details can be found in the Annual Governance Statement section of the report
- Working with governors to ensure they can engage with and hold the Board to account. The mechanisms in place are captured within a 'Governor Engagement Policy'.
- Ongoing review of compliance with the Code of Governance by the Council of Governors and Board of Directors when making decisions which impact on governance arrangements. This includes review and refresh of relevant policies and procedures and the Trust's Constitution
- Implementation of a development programme for the Trust Board and Executive Directors which include the governance requirements for Board

Full details on the disclosure required by the Code of Governance are set out in the following pages.

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
2: Disclose	Board and Council	A.1.1	Clear statement detailing roles and responsibilities of the council of governors. Should also describe how any disagreements between the CoG and the board of directors will be resolved. Statement on how the board of directors and the CoG operate, including a summary of the types of decisions taken by each of the boards and which are delegated to the executive management of the board of directors.	Governor report – role of the governors Governor report – resolution of disputes Directors' report – operation of the Board
2: Disclose	Board, Audit Committee and Remuneration Committee	A.1.2	Identify the chairperson, the deputy chair, the CEO, the senior independent director and the chair of the audit and REMCOM. Also set out the number of meetings of the board and those committees and individual attendance by directors.	Directors' report Directors' report
2: Disclose	Council of Governors	A.5.3	Identify the members of the council, including a description of the constituency or organisation they represent, whether they were elected or appointed, and the duration of the appointments. Should identify the lead governor.	Governor report – members of the Council of Governors

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Additional requirement of FT ARM	Council of Governors	n/a	Statement about the number of meetings of the CoG and individual attendance by governors and directors.	Governor report – governor attendance at Council of Governors
2: Disclose	Board	B.1.1	Identify each non-executive director it considers to be independent, with reasons where necessary.	Directors' report
2: Disclose	Board	B.1.4	A description of director's skills, expertise and experience. Alongside this a clear statement about the board's balance, completeness and appropriateness to the requirements of the FT.	Directors' report – brief details of serving executives and non-executives Directors' report – balance of the board
Additional requirement of FT ARM	n/a	n/a	Brief description of the length of appointment of the non-execs, and how they may be terminated.	Directors' report
2: Disclose	ARC	B.2.10	Describe the work of the Appointments and Remuneration Committee (ARC), including the process it has used in relation to board appointments.	Governor report

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Additional requirement of FT ARM	Council of Governors	n/a	Statement about the number of meetings of the CoG and individual attendance by governors and directors.	Governor report – governor attendance at Council of Governors
Additional	ARC	n/a	An explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-exec director	n/a for 2018/19
2: Disclose	Chair / Council of Governors	B.3.1	Chair's other significant commitments should be disclosed. Changes to such commitments should be reported to the CoG as they arise, and included in the next annual report.	Directors' report
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors. The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	Governor report – governor engagement

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Additional requirement of FT ARM	Council of Governors	N/A	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. *Power to require one or more of the directors to attend a governors meeting for the purpose of obtaining information about the foundation trust's performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors performance). ** As inserted by section 151(6) of the Health and Social Care Act 2912).	Governor report – holding the Non-Executive Directors to account for the performance of the Trust Board
Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chair, has been conducted.	Directors' report – operation of the Board

Disclose	Board	B.6.2	Where there has been external evaluation of the board and/or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Directors' report – Evaluation of the Board/its committees/directors and Chair
Disclose	Board	C.1.1	The directors should explain their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	Directors' report
			Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors' report - Statement as to disclosures to auditors

Disclose	Board	C.1.1	The directors should explain their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	Directors' report
			Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors' report - Statement as to disclosures to auditors
Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Directors' report - Trust Audit, Risk and Governance Committee Annual Governance Statement

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Disclose	Audit committee / control environment	C.2.2	A trust should disclose in the annual report: a)If it has an internal audit function, how the function is structured and what role it performs; or (b)If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes	Director's report – Trust Audit, Risk and Governance Committee
Disclose	Audit Committee/ Council of Governors	C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include a statement in the annual report from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: (a)The significant issues that the committees considered in relation to financial statements, operations and compliance, and how these issues were addressed (b)An explanation of how it has addressed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenures of the current audit firm and when a tender was last conducted (c) If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence.	Director's report – Trust Audit, Risk and Governance Committee

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Disclose	Board / Remuneration Committee	D.1.3	Where an NHS FT releases an executive director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
Disclose	Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership report
Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Membership report

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Disclose	Board / Remuneration Committee	D.1.3	Where an NHS FT releases an executive director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
Disclose	Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership report
Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Membership report

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Additional requirement of FT ARM	Membership	N/A	The annual report should include: (a) A brief description of the eligibility requirements for joining different membership (b) Information on the number of members and the number of members in each constituency (c) A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members.	Membership report - membership strategy
Additional requirement of FT ARM	Board / Council of Governors	N/A	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possible seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors; interests which are available to the public, and alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	Membership report – disclosures and declarations of interests Directors' report – Registers of interest

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS FT's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Comply
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Comply
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance .	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement for advising the board and the council and for recording and submitting objections to decisions.	Comply
2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS FT, for example through attendance at meetings of the CoG, direct face-to-face contact, surveys of members' opinions and consultations.	Directors' report – Operation of the Board

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
Additional requirements of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members	Membership report
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	Comply
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Comply
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Comply
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	Comply
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Directors' report - How the Directors are assisted in their roles
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	Comply
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy.	Comply
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Comply
6: Comply or explain	Council of Governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Comply
6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Comply
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Comply
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Comply
6: Comply or explain	Board/Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	ARC(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Comply: Directors' report
6: Comply or explain	Board/Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Directors' report – Code of Conduct for the Trust Board. Membership report - Disclosures and declarations of interests
6: Comply or explain	Remuneration Committee	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Comply
6: Comply or explain	Nomination Committee(s)/ Council of Governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Comply Remuneration Report - The Appointments and Remuneration Committee (a sub-committee of the Council of Governors) and the Appointments and Remuneration Committee Terms of Reference (which state a core membership of six governors)
6: Comply or explain	Council of Governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Comply Membership report – appraisal and appointment
6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	Comply Membership report – appraisal and appointment
6: Comply or explain	Remuneration Committee	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Comply Remuneration report

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Comply Directors' report
6: Comply or explain	Board/Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Comply Directors' report – Operation of the Board Governor report – Council of Governors
6: Comply or explain	Board	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Comply. NED challenge roles in place and reviewed annually

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Comply Directors' report - How the Directors are assisted in their roles
6: Comply or explain	Board/ Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Comply Directors' report – Board Committees
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	Comply Directors' report – Senior Independent Chair
6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Chair/Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Comply Governor report – governor engagement
6: Comply or explain	Council of Governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Comply Governor report – role of governors
6: Comply or explain	Board/ Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Comply

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.	Comply Performance report - Going Concern
6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Comply Directors report – Non-Executive Directors

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Comply - Council of Governor's Engagement Policy

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board/Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Comply Directors' report – Trust Audit and Risk Governance Committee
6: Comply or explain	Council of Governors/ Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Comply Governor report – role of governors
6: Comply or explain	Council of Governors/ Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Comply Director's report – Trust Audit, Risk and Governance Committee
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	Comply, n/a in 2018/19

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Comply Director's report – Trust Audit, Risk and Governance Committee
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Comply Remuneration report
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Comply Remuneration report

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Comply Remuneration report
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Comply Remuneration report
6: Comply or explain	Council of Governors/ Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Comply Governor report – appraisal and appointments

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
6: Comply or explain	Board	E.1.2	The board should clarify in writing how the public interests of patients and the local community will be represented, including its approach for addressing the overlap and interface between governors and any local consultative forums.	Comply Trust Constitution
6: Comply or explain	Board	E.1.3	The chairperson should ensure that the views of governors and members are communicated to the board as a whole.	Comply Governor report – Governor engagement
6: Comply or explain	Board	E.2.1	The board should be clear as to the specific third party bodies in relation to which the NHS foundation trust has a duty to co-operate.	Comply Directors' report
6: Comply or explain	Board	E.2.2	The board should ensure that effective mechanisms are in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority in each.	Comply Directors' report

Statement of the chief executive's responsibilities as the accounting officer of Northern Lincolnshire and Goole NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the *NHS Foundation Trust Accounting Officer Memorandum* issued by NHS Improvement. NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require Northern Lincolnshire and Goole NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Northern Lincolnshire and Goole NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health and Social Care Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS foundation trust's performance, business model and strategy
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act.

The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in the *NHS Foundation Trust Accounting Officer Memorandum*.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

NHS Improvement Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

This segmentation information is the Trust's position as at 31 March 2019. NHS Improvement placed the Trust in segment 4 and the Trust is in special measures for both quality and finance. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance.

These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Area	Metric	2018/19 scores			
		Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	4	4	4	4
	Liquidity	4	4	3	4
Financial efficiency	I&E margin	4	4	4	4
Financial controls	Distance from financial plan	4	4	4	4
	Agency spend	2	3	4	3
Overall scoring		**4**	**4**	**4**	**4**

Annual Governance Statement

SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Northern Lincolnshire and Goole NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me.

I am also responsible for ensuring that the Northern Lincolnshire and Goole NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accountable Officer Memorandum.*

THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Northern Lincolnshire and Goole NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Northern Lincolnshire and Goole NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

CAPACITY TO HANDLE RISK

Leadership & Accountability

During 2018/19, the Trust further strengthened its senior leadership structure with the appointment of a new Chief Operating Officer. Up to the point of publication of this report, the Trust has also made appointments to the substantive Chief Nurse and Medical Director posts, following a period of acting and interim arrangements.

The Chief Nurse and Medical Director structures, in turn, have been strengthened by the appointment of two new Deputy Chief Nurses and two Deputy Medical Directors. In respect of the Deputy Medical Directors, one has a focus on clinical / quality governance and patient safety and the other on improved productivity and performance e.g. consistent pathway implementation.

As part of the strengthening of the Trust's clinical leadership structure, new Divisional Clinical Directors were appointed early in 2018/19 to lead each of our five Clinical Divisions, supported by a Divisional General Manager and Divisional Head of Nursing reporting to them. This shift gives greater strength to our Divisions and puts clinicians firmly in charge of how we plan and deliver clinical services.

The Divisional Clinical Directors have authority and responsibility for quality, the use of resources (including staffing & finance), performance and governance. Three new Divisional Heads of Nursing have also been appointed and a revised matron structure has been implemented.

The Senior Leadership Community, which brings together on a monthly basis all of the organisation's senior clinical and managerial leaders, is now well embedded. During 2018/19, the invite to these sessions was extended to all Band 7's within the organisation.

From September 2018, following the retirement of the Director of Governance & Assurance and Trust Secretary, responsibility for clinical governance was re-aligned to the portfolio of the Medical Director ensuring greater clinical engagement with and ownership of these arrangements across the Trust. A new Associate Director of Quality Governance was appointed. The Associate Director of Quality Governance will work with the Clinical Divisions to strengthen their governance structures; not least in response to the findings of the KPMG review of divisional governance arrangements undertaken during 2018/19.

The Associate Director of Quality Governance is also reviewing the arrangements and processes in place in respect of quality assurance to the Quality & Safety Committee. The Deputy Medical Director with a focus on clinical / quality governance and patient safety will work on improving clinical engagement with the Trust's clinical / quality governance arrangements. Responsibility for corporate governance remains with the remit of the (now) standalone Trust Secretary portfolio.

The Trust has continued to implement the findings and recommendations from the Well Led Review undertaken during 2017/18. This has included a review of the Trust's meeting structures to ensure a clear separation between Board assurance sub-committees and day to day management meetings and the implementation of a comprehensive Board Development Programme which is well underway and the completion of a formal Board skills matrix. The Trust has moved to bi-monthly meetings of the Trust Board, with the intervening months being used for board development activities, briefings on key risks topics and focussed discussion regarding future strategy. An assessment of whether services are well led under NHS Improvement's well led framework will be undertaken as part of preparations for the Trust's next CQC inspection. The Board Development Programme which is supported by Deloitte UK includes specific sessions on well led.

The Trust has in place a Performance Management Framework, which outlines the approach to holding Directorates and Divisions to account for delivery of objectives and improvements including those relating to governance and risk management.

The above arrangements and changes made during 2018/19 reflect the Trust's ongoing commitment to effective governance and quality governance including risk management processes. The Trust's Internal Audit Programme continues to be used to test key aspects of the Trust's governance and risk management arrangements annually.

Training

The Trust has in place a mandatory training programme which includes training on specific risk topics such as fire safety, moving & handling, infection control etc. There is also regular raising of awareness of the responsibilities of staff in respect of incident reporting and duty of candour. Whilst not currently mandatory, training is also provided on Root Cause Analysis in support of the Trust's arrangements for investigating and managing incidents.

External Training is also provided, as required, e.g. risk register training. Further training needs – particularly those within Clinical Divisions – will be identified and addressed as part of the strengthening of the divisional governance arrangements already referred to above – in order to ensure that staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The Trust's mandatory training programme is regularly reviewed to ensure that it remains responsive to the needs of Trust staff.

There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis and the duty of staff to complete training deemed mandatory for their role and in order to mitigate risk.

The Trust's Training Needs Analysis is regularly reviewed to ensure that mandatory training remains targeted and appropriate as well as manageable for staff. The Trust continues to work hard to achieve good levels of compliance with mandatory training requirements – with compliance at March 2019 being 80% against a target of 85% – but this focus continues. Monitoring and escalation arrangements are in place to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

Leadership development programmes are in place and ongoing including for our clinical and ward leaders.

Control Mechanisms including 'Learning Lessons'

A single IT Risk Management System (Datix) is in place which links key risk elements (including incident reporting, complaints / PALS and claims management) and which, in turn, informs the Trust's Risk Register (which is also held on Datix).

Lessons learned when things go wrong are shared throughout the organisation via a range of mechanisms including safety alerts, 'learning lessons' newsletters, safety huddles / handovers and governance forums.

However, this remains an area of focus for the Trust as these arrangements are not as well embedded in some areas of the organisation.

The new Associate Director of Quality Governance has plans to implement a Serious Incident (SI) Review Group during 2019/20.

This will provide a further mechanism for the sharing of transferrable lessons and for testing that this learning and agreed actions have been implemented. There is NED oversight of the SI process.

The Trust Board routinely considers specific risk issues and receives minutes and highlight reports from Board Sub-Committees including the Audit, Risk and Governance Committee, Finance & Performance Committee, Workforce Committee and the Quality & Safety Committee. These committees provide oversight & challenge in respect of key areas of Trust business and in turn provide assurance and / or escalate concerns to the Trust Board.

The Quality and Safety Committee, on behalf of the Trust Board, routinely receives information on SIs including lessons identified and learned. The Trust is also a member of and provides assurance to commissioners on its arrangements for investigating and learning from SIs via a community-wide SI Collaborative Group. The Quality & Safety Committee and the external Patient Safety Group also continue to receive updates on the outcome of clinical harm reviews. The clinical harm review process in turn dovetails in to existing governance processes including the SI and Being Open (Duty of Candour) Policy & Procedures with instances of harm being escalated as SIs, as required.

The Trust actively encourages networking and has strong links with relevant central bodies, e.g. NHS Resolution (NHSR), Health and Safety Executive (HSE), and acts on recommendations / alerts from these bodies as appropriate.

The Trust has continued to develop its relationship with the CQC - escalating risks / concerns in respect of patient safety / quality as they occur, together with the actions taken or proposed, and in order to provide assurance that the Trust and Trust Board has appropriate oversight of its quality governance / patient safety risks. Monthly relationship meetings are held.

The Trust also routinely considers and acts upon the recommendations of relevant national high level enquiries through the use and monitoring of robust action plans.

THE RISK AND CONTROL FRAMEWORK

The Management of Risk

The Northern Lincolnshire & Goole NHS Foundation Trust is committed to the management of risk (both clinical and non-clinical) in order to improve the quality of care; provide a safe environment for the benefit of patients, staff and visitors by reducing and, where possible, eliminating the risk of loss, harm or damage; and protecting its assets and reputation. This is achieved through a process of identification, analysis, evaluation, control, elimination and transfer of risk.

The Trust has in place a Governance & Risk Management Strategy which provides a framework for the ongoing monitoring and review of risks, although this document is being reviewed and updated.

The Trust's Governance & Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key quality objectives by ensuring that staff understand and act on the risks to the achievement of those objectives as well as ensuring compliance with external standards, duties and legislative requirements.

Risks are identified routinely from a range of reactive and pro-active and internal and external sources including workplace risk assessments, analysis of incidents, complaints / PALS, claims, external safety alerts and other standards, targets and indicators etc.

Risks are appropriately graded and included on the Trust's Risk Register and, in respect of those strategic risks which threaten the achievement of the Trust's strategic objectives, also within the Board Assurance Framework (BAF). The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process.

A Risk Register – 'Confirm or Challenge' Group is in place to review and monitor risks added to the Risk Register and to ensure that the appropriate mitigation actions are in place. The Audit, Risk and Governance Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place and are effective.

The BAF and risk register are used to inform the agenda of the Trust Board and Board assurance sub-committees with the relevant risks being aligned to and reviewed by the relevant committees quarterly.

The Trust Board undertakes an annual deep dive into the BAF and, as part of this process, also annually reviews the organisation's 'Risk Appetite'.

There is annual Internal Audit review of the BAF and the risk management processes supporting it to ensure they are fit for purpose and comply with good practice. A rating of 'significant' assurance was received following the 2018/19 Internal Audit review although some recommendations for further strengthening the BAF were made and are currently being acted on.

This included a review by the Trust Board of current strategic risks, which are outlined below, in order to ensure that they are an accurate reflection of the organisation's current risk profile and to ensure that the Board and the sub-committees are focussing on the areas of strategic importance ie. those which have the potential to threaten the achievement of the Trust's strategic objectives.

- Risk of non-delivery of the financial improvement plan including the decreasing market share and linked to HASR.
- Risk of non-delivery of constitutional performance targets, specifically:
  - Cancer 62 day;
  - A&E;
  - RTT – 18 weeks.
- Risk of non-delivery of agreed quality and clinical improvements (includes the risk of non-delivery of a reduction in the mortality ratio). Further detail is provided below (on page 6) on the range of mechanisms the Trust has in place for managing and monitoring risks in respect of quality specifically.
- Risk of failure of the Trust's infrastructure; specifically:
- Ageing estate and equipment: the inability to maintain legislative compliance and improve the current estate and equipment due to a lack of capital and backlog maintenance (includes Legionella);

- Longer term estate sustainability: failure to secure a sustainable estate future for SGH (and to a lesser extent DPOWH which may give rise to buildings or parts of buildings becoming unsafe to occupy;
- IT / Digital Strategy / Cyber Security: failure of the IT infrastructure and adverse impact on the delivery of the Digital Strategy and on business continuity and the delivery of safe care; and the lack of adequate controls to defend the Trust's IT systems when a cyber-attack occurs.
- Adverse impact of the EU Exit (Brexit) on business continuity and the delivery of safe care.
- Inability to secure sufficient numbers of appropriately skilled staff in the short, medium and longer term.
- Lack of staff engagement and ownership of the Trust agenda, affecting morale and a risk of failure to change and improve the culture.
- Risk of failure to invest in and develop the Trust's leadership (including clinical leadership) – capacity and capability.
- Lack of a clear Trust / Organisational Strategy.
- Lack of a clear clinical strategy for the area to ensure long term service sustainability (includes the risk of not developing the required external relationships and linked to HASR).
- Risk of not managing external relationships resulting in damage to the Trust's reputation.

The controls and assurances in response to the above strategic risks will be captured within the BAF and within the Trust's risk register.

In line with the principles of devolution within the Northern Lincolnshire and Goole NHS Foundation Trust, and in accordance with the Scheme of Delegation, responsibility for the management / control and funding of a particular risk rests with the Directorate / Division concerned.

However, where action to control a particular risk falls outside the control / responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the Executive Team / Trust Management Board or Trust Board for a decision to be made.

Supporting this devolved structure are central Non-Clinical Directorates. These Directorates have a nucleus of experienced and appropriately qualified staff to support and advise staff at all levels across the organisation with the identification and management of risk – clinical and non-clinical.

Risk Management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which were further reviewed and strengthened during 2018/19 as outlined above.

Of fundamental importance to the early identification, escalation and control of risk is the Trust's commitment to the ongoing development of a 'fair blame' culture, where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong'.

The Trust also has in place long standing 'speaking out' and safeguarding policies and procedures. The Trust has a Freedom to Speak Up Guardian (FTSUG) in place.

The Trust continues to embed and build on the changes arising from the review of the Trust's speaking up arrangements undertaken by the National Guardian's Office during 2017/18, with support from the NHSI Complaints and Whistleblowing Team. This has included a dedicated board development session, facilitated on behalf of the Trust by NHSI, the output of which will inform the Trust's first Freedom to Speak Up Strategy and objectives for the coming year.

The Pride and Respect Project: an employee driven and owned programme which aims to improve the standard in which Trust staff deliver care and interact with each other, has become the vehicle for driving forward the Trust's culture change programme.

Relevant governance / risk management Key Performance Indicators (KPIs) are shared through the performance management framework and are reported up to the Trust Board through the integrated performance report.

Business Planning and Service Development proposals do not proceed without an appropriate assessment of and therefore recognition / acceptance of the risks involved and the involvement of the relevant risk management expertise e.g. health and safety and fire, infection control.

In respect of the control of risk, Directors individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to identify, manage and mitigate risks to compliance with the Trust's licence.

The sub-committees of the Trust Board in turn have responsibility for providing assurance in respect of the effectiveness of those controls.

A system of 'highlight' reports to the Trust Board is in place to highlight any risks to compliance. Board sub-committees are attended by Non-Executive Directors as core members, with relevant Executive Directors as well as by other key Trust staff, being 'in attendance'. There is a clear separation between Board assurance sub-committees and day to day management meetings.

Patient & Public Involvement (PPI)

The Trust ensures that public stakeholders are involved in understanding the risks which impact upon them by a variety of means: the principal amongst these being the operation of the Council of Governors and the holding of Board meetings in public.

The Council meets at least five times per year in public and receives a comprehensive report on performance (and risks of non-delivery) on each occasion.

These reports are published along with the rest of the council papers on the Trust internet site.

A PPI Policy & Procedure is also in place and reflects the requirements of the DOH guidance 'Real Involvement' and the comments from PPI representatives.

Additionally, the Trust engages actively with three Overview and Scrutiny Committees and continues to collaborate closely with the three local Health Watch organisations. A Protocol for joint working with Health Watch is in place and is reviewed annually and opportunities for joint working are agreed. The Trust's comprehensive internet website provides the public with ready access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest.

Quality Risks

The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust agrees annual quality priorities. For 2019/20 these are: Mortality, Deteriorating patients, Medication safety, including EPMA, Patient flow (particularly SAFER and seven day services) and Cancer, including diagnostic reporting.
- The Trust has in place a Quality and Safety Committee (a sub-committee of the Board) which meets monthly and is chaired by a Non-Executive Director.

  The Quality and Safety Committee is responsible for monitoring performance against the agreed annual quality priorities and other quality issues. The minutes of the Quality & Safety Committee are submitted to the Trust Board.

  The Quality Governance Group – the management and delivery group – in turn provides assurance on quality and safety activities to the Quality and Safety Committee.
- The Trust publishes an Annual Quality Account, which is subject to consultation with key external stakeholders.
- Performance against key quality indicators are reported up to the Trust Board through the Integrated Performance Report, although this report is currently being revised.
- The Trust Board has approved a Quality Improvement Strategy and has introduced a Quality Improvement Training Faculty.
- Quality improvements – including the response to CQC inspection visit findings and recommendations are progressed through the Trust's Improvement Programme – Improving Together. Improving Together was first introduced in January 2017 and provides a more holistic approach to improvement than has previously been the case.

  The programme is periodically refreshed to ensure its remains responsiveness and effective and is supported by a central Improvement Team which provides hands on, delivery support. The Trust Board receives a monthly Improving Together progress report.
- The Trust has in place arrangements and monitoring processes to ensure ongoing compliance with other service accreditation standards e.g. CPA, MHRA (for blood products) and HTA licences for mortuary and post mortems etc.

- The Trust's Quality & Safety Committee monitors performance with NICE guidance implementation and minutes of that committee are submitted to the Trust Board.

  Compliance with NICE guidance is also monitored, internally via the performance review process and externally via the Commissioner Quality Contract Group.
- The Medical Director has the lead for mortality supported by two site clinical leads. A Mortality Improvement Group, reporting to the Quality Governance Group, is in place and includes relevant external stakeholders. A mortality improvement plan including how the Trust learns from deaths is also in place.

  The Quality and Safety Committee retains a challenge and assurance role in respect of mortality. Reporting on mortality improvement to the Trust Board occurs through the Integrated Performance Report and, where relevant, through the highlight report from the Quality and Safety Committee.

  As a result of the implementation of the Mortality Strategy and improvement work, the Trust's mortality rate is reducing (particularly at Grimsby) with latest figures for the period January – December 2018 (yet to be published) showing a SHMI of 112, putting the Trust in the 'as expected' range, and work continues to ensure the improvements seen are sustained.

  A key part of the Mortality Strategy centres on the NQB guidance on learning from deaths. Whilst Structured Judgement Reviews are being undertaken in the organisation, there is more to be done to ensure that reviews are being undertaken consistently and that there is feedback and implementation of learning across the organisation. This remains a quality priority for 2019/20.
- The Trust has introduced a checklist for wards & departments, based on the 15 steps and aligned to the CQC Key Lines of Enquiry, with visits being scheduled throughout 2019/20 to ensure ongoing monitoring of key standards and the early identification and escalation or risk issues. This work has involved training of staff – including Board members – to be able to conduct peer review visits.
- Informal visits to wards and departments are undertaken by both executive and non-executive directors. More formal Trust Board walkabouts are also being reinstated on Board days. These arrangements enable staff to showcase good practice but also talk directly to members of the Trust Board on quality & safety and other issues or concerns.
- Non-Executive Directors have oversight and assurance roles in respect of specific aspects of governance, quality governance and risk. These roles are reviewed annually.
- The Medical Director is the Trust Board lead for quality and safety although in discharging this responsibility works closely with the Chief Nurse, the Trust Board Lead for patient experience and the Chief Operating Officer.
- The Chief Nurse has developed and implemented 'The Future 5' – the 5 priorities for nursing for 2019/20.

- A nursing dashboard is in place to monitor the nursing contribution to safety and quality. This is supported by a Nursing Metrics Panel which ensures the early identification and mitigation of risk issues.
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, e.g. National patient surveys.
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient & Public Involvement (PPI) representatives (e.g. Health Watch).
- Patient Stories are presented to the Quality & Safety Committee and the Trust Board monthly and actions and lessons learned are widely shared. There are plans to introduce Staff Stories during 2019/20.

The effectiveness of the Trust's governance, quality governance and risk management arrangements also continued to be tested during 2018/19 via internal and external testing including internally via the Annual Internal Audit Programme (see Appendix I, page 161) and externally via relevant external reviews and visits including the CQC inspection visit in May 2018.

These arrangements will be further tested during the 2019 CQC inspection visit – *date to be confirmed.*

CQC: Registration and Essential Standards of Quality & Safety

In May 2018, the Trust underwent a CQC inspection visit. In June 2018, the Trust received a Letter of Intent from the CQC under Section 31 of the Health and Social Care Act 2008 raising concerns regarding the Trust's outpatient's service; specifically that there was insufficient management, oversight and governance of the risks to patients on the Trust's waiting list and asking for assurance that the risks identified had already been removed or were immediately being removed. Section 31 allows the CQC to serve a Notice of Decision if it has reasonable cause to believe that, unless it acts any person will or may be exposed to the risk of harm.

Such a notice if issued would have imposed conditions on the Trust's registration. The Trust responded to the Section 31 Letter and through that response and through the updates and assurance provided via the Patient Safety Group of the System Improvement Board and the monthly engagement meetings received confirmation in February 2019 that the CQC are not currently considering any further enforcement action in relation to the above concerns.

This Trust is however required to provide quarterly update reports to the Patient Safety Group of which the CQC is a member.

The Trust's next inspection visit will test the effectiveness of the arrangements in place for the management, oversight and governance in relation to the management of patients on the waiting list.

The full visit report was published in September 2018 and the Trust received an overall rating of 'Requires Improvement'; although the Trust received a rating of 'Inadequate' in the well led domain.

The CQC acknowledged the improvements seen since the previous visit, although it was also recognised that the Trust remains on its improvement journey and the Trust remained in quality 'special measures'.

The Trust continues to benefit from the support package put in place by NHSI; specifically support from an NHSI Improvement Director to implement and embed the required improvements.

The Trust's response to the CQC findings and recommendations forms a key part of the Improving Together Programme. The Trust Board receives a monthly 'Improving Together' progress report – although this report is being reviewed alongside the Integrated Performance Report, not least to remove areas of duplication and provider greater assurance as to the delivery and embedding of improvement actions.

The Patient Safety Group of the System Improvement Board, which brings together all relevant stakeholders to support the Trust in the delivery of its improvement plan, also continues to have oversight of delivery of the required improvements.

The Trust's next inspection – date to be confirmed – will test the effectiveness of the improvements put in place. Given the current position, the Trust is not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC).

Workforce

The Trust has in place a Workforce Committee (a sub-committee of the Trust Board), whose remit includes ensuring that short, medium and long term workforce strategies and staffing systems are in place which assure the Board that staffing processes are safe, sustainable and effective.

The Trust Board also receives a monthly staffing report which includes workforce KPIs. In respect of compliance with the Developing Workforce Safeguards recommendations, the Trust is working with departments to identify new roles and role redesign. The Trust has HR business partners in place to support these changes and developments.

There are new roles evolving which will change the skill mix of teams to ensure we have the right people in the right place with the right skills.

New roles so far currently in training include Advanced Clinical Practitioners, Patient Care Navigators and Nursing Associates.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has an Equality and Diversity Strategy which encompasses our Equality Objectives.

Our Equality Objectives focus on achieving legal and contractual compliance, and progress against them is reported to Trust Board, and our commissioners bi-annually by our dedicated Equality and Diversity lead.

The organisation has an Equality Impact Assessment (EIA) policy and procedure which ensures the integration of EIAs into Trust core business and to support this a training course on completing EIAs is now in place.

Carbon Reduction

The Trust has both a Trust Board approved Sustainable Development Management Plan (SDMP) which takes account of UK Climate Projections 2018 (UKCP18) and a Travel Plan, both of which are reviewed annually.

These documents include risk assessments to ensure the Trust can attain its carbon reduction targets in accordance with emergency preparedness and civil contingency requirements. These are based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Conflicts of Interest

The Trust maintains a register of Directors' interests which is reviewed by the Trust Board annually and is published through the Trust Board public meeting papers. The Trust has not yet published an up-to-date register of interests for other decision making staff within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance. There is a plan to publish this information by the end of August 2019.

REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust's clinical activities are managed under a devolved management structure, governed by a Scheme of Delegation renewed and refreshed annually. The Trust has in place a clinical management structure to support effective leadership of clinical services and ensure effective care.

The Medical Director is supported by two part time Deputy Medical Directors (who will continue to be engaged in clinical front line work). The Clinical Divisions report to the Chief Operating Officer, but the Clinical Directors, covering each clinical Division have a professional reporting line to the Medical Director. Each Clinical Director has a team of clinical leads for individual service areas. The Trust has Performance meetings twice a month, once to cover quality and once to cover finance and performance.

The Finance Directorate provides dedicated support to each clinical Division and to non-Clinical Directorates through nominated Business Accountants. Business planning, and information technology is provided by the Directorate of Strategy and Planning. This Directorate works to closely link strategy development across the wider health economy and the Humber Coast and Vale STP with service planning in clinical service areas.

Plans are being developed to transform and streamline the way in which services are provided ensuring patient care is provided closer to home limiting unnecessary expensive hospital attendances.

The Trust continues to adopt a project based approach to savings delivery through an established PMO-style approach. Whilst the Trust has enhanced governance and oversight arrangements in respect of savings delivery coupled with comprehensively documented plans, emerging cost pressures have begun to outweigh the level of savings being delivered. Savings are subject to a full Quality Impact Assessment sign off process undertaken jointly by the Chief Nurse and Medical Director. Delivery support has been augmented during 2018/19 through the Financial Special Measures process, with additional regulatory scrutiny, a Turnaround Director in post until the end of March 2019, and support provided by external partners, EY (Ernst & Young).

The Trust maintains focus on performance management. All Directorates and Divisions are explicitly made responsible for the delivery of financial and other performance targets through a system of performance agreements, documented as part of the annual business planning cycle and monitored through a series of regular performance review meetings. The Trust is aware that whilst the framework in place is robust the changes and gaps in operational leadership have made these difficult to manage in practice.

The Financial Plan and budget adopted annually by the Trust Board contains an overarching assessment of the strategic planning climate within which the framework has been constructed and sets out the mechanisms by which the key risks emanating from the strategic context are to be managed.

This assessment reflects both the national planning context and the local context; and recognises the financial planning context for the public sector as a whole; especially the expectation for significant efficiencies on an ongoing basis.

The Trust conducts a comprehensive review of the in-year progress of the Business and Financial Framework in the form of a Mid-Year Review report – any issues or emerging risks not previously identified within the original Framework are identified and mitigating actions recommended and actioned during this process.

In 2018/19 there was an extensive year end projection process in place though estimates had to be adjusted upwards three times during the year with the Trust ending the year with a higher deficit position.

The Trust's Finance and Performance Committee provides assurance to the Trust Board as to the achievement of the Trust's financial plan and priorities and, in addition, it acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities.

It interfaces with the other Trust Board Committees and the Trust Executive Team and also has particular regard to the work of the Business Planning Group, which sets the agenda and co-ordinates the process of business planning, specific business case development, and capital programme management.

Compliance is further assured through quarterly monitoring and annual planning processes with auditors. The Trust has developed an internal audit programme, based on key business governance themes with the internal audit providers, designed to enhance focus on business governance process and support improved compliance.

The Trust, building upon the lessons learned following the 2013 Keogh review process, understands that robust front line clinical services are the real purpose of the organisation, delivering effective quality outcomes for patients. The Trust is proactive and continuously reviews and realigns its structure where necessary, to allow it to adapt and respond to the rapidly changing business environment brought about by the changes in the economy, the NHS environment, competitive markets and patient pathway best practice.

The Trust has also enhanced its focus on workforce planning in order to secure a more consistent supply of appropriately skilled and qualified staff to carry out front line service delivery, specifically to review plans for future workforce numbers and to oversee implementation processes, working jointly with Commissioners and other local provider organisations. In support of this work the Trust has focused on the People and Organisational Effectiveness Strategy and an Employment Framework sustainability workstream commenced in 2017/18, covering both retention and recruitment, which has been endorsed by the Trust Board.

The Trust continues to be non-compliant with NHS Improvements Use of Resources performance measure under the Single Oversight Framework recognising that this is within the context of a wider sustainability gap across the local health economy. Work is ongoing to address this through the Accountability Frameworks and the STP. NHS Improvement have issued enforcement undertakings stating that the Trust had not demonstrated that it has established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively. Consequently, the Trust was placed in financial 'special measures' in March 2017.

As a result of the above factors, the position in respect of Quality Special Measures and the ongoing issues in respect of data quality (referred to on pages 15 & 18), the External Audit opinion is likely to be adverse from a perspective of economy, efficiency and effectiveness.

The processes and review work established by the Trust in response to Financial Special Measures have been designed to supply corrective actions for any failures in delivery of services in an economic, effective and efficient manner. This remains a work in progress, with further actions required to strengthen planning and management systems across the trust.

The Financial Governance Review previously undertaken within the Trust during 2017/18 established an outline assessment of the structural cost premium facing the Trust because of its configuration (i.e. three small hospitals spread out over 60 miles) and also laid the foundations for a corrective savings programme addressing those issues within the Trust's control. The premium cost was calculated by EY.

There remains a significant piece of work that needs to be completed to ensure that this programme is well understood, achievable and can be delivered year after year.

INFORMATION GOVERNANCE (IG)

The Trust continues to strengthen its arrangements for Information Governance and has the following arrangements in place:

- an active Information Governance Steering Group which meets monthly;
- an Information Governance Strategy and collection of Information Governance Policies along with a dedicated IT Security Policy;
- a dedicated Data Protection Officer in post from August 2018;
- the Trust continues to monitor Information Governance Incidents to ensure that if required they are reported to the Information Commissioners office within 72 hours;
- Completion of the new Data Security and Protection Toolkit for 2018/2019.

The Information Governance Steering Group, which is chaired by the Data Protection Officer monitors the Trusts compliance with National Data Protection Regulations and with the Data Security and Protection Toolkit, which encompasses the National Data Guardian standards. This group reports to the Audit Risk and Governance Committee which feeds directly to the Board. In Q4 of 2018/2019 an extra level of reporting and monitoring was introduced, this was the WebV, IT and Information Risk and Governance Meeting chaired by the Trust's SIRO (Senior Information Risk Owner). This group monitors compliance and progression with identified work streams and action plans.

2018/2019 saw the release of the new 'Beta' Data Security and Protection Toolkit by NHS Digital. The Trust submitted its annual final submission in line with NHS Digitals guidance on the 28th March 'Standards not Met (Action Plan Approved)'. The Improvement plan will be closely monitored by the Trust IG Steering group and NHS Digital to ensure actions are met within the first two quarters and once all actions have been completed the Trusts final Submission will change to one of 'Standards Met'.

Data Security and Protection Incidents

All incidents reported within the organisation were investigated and appropriate action taken, this could be the strengthening of policies or a change to process. Lessons learnt are disseminated through face to face Information Governance Awareness Training and through the 'Learning Lessons' Newsletter.

During 2018/2019, the Trust, using the new Incident Reporting Guide and Tool developed by NHS Digital in conjunction with the ICO reported 8 Data Security and Protection Incidents.

- 1 incident was withdrawn by the Trust due to the correspondence which was incorrectly addressed, being recovered before exposure to external parties took place.
- 4 of the incidents required 'No Further Action by the ICO is necessary' these related to the disclosure of personal information to unauthorised external 3rd parties.

- 1 incident which required 'No Further Action by the ICO is necessary' related to a system error, where the system was failing to generate clinical correspondence.
- 2 incidents are currently still open with the ICO as internal investigations continue. These incidents relate to clinical system technical failures.
- All incidents linked to clinical system failures are also directly reported via the tool to the Department of Health and Social Care and NHS England.

Data Security

The following arrangements continue to be in place:

- a security feature at login to the Trust network, giving guidance to users and requiring acceptance of 'rules of use'; this is to be further strengthened following the recent review and updating of the duty of confidence statement that all new starters complete as part of their induction process. Key points of the duty of confidence declaration, specifically those sections relating to users responsibilities will be added to the log-in screen of the Trust's network. The review and acceptance of the duty of confidence will also be an ongoing reminder, as well as at the commencement of an employee's work in the Trust.
- IT policies which take account of updated national requirements;
- a 'best practice' IT security awareness leaflet alongside a dedicated email security and best practice leaflet;
- all computer hard drives are physically destroyed on decommissioning prior to disposal;
- the encryption of all removable / portable devices including laptops, USB pens and CDs, specifically:
- laptop encryption has been completed on all laptops / clinical tablets;
- encrypted USB pens have been allocated to staff;
- no machines are purchased with floppy drives as standard and port blocking software has been implemented;
- CD/DVD writers are not issued as a standard piece of equipment. Where the use of these writers is required, the creation of data on these devices is covered by Trust policies;
- the creation of data on PACs CDs is governed by Trust policy and encryption ability is available. Tracking procedures are in place for CDs sent off site.

ANNUAL QUALITY REPORT

The Directors of Northern Lincolnshire and Goole NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual.*

The following arrangements are in place within Northern Lincolnshire & Goole Hospitals NHS Foundation Trust to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

Governance and Leadership:

- The Trust's Medical Director is the Trust Board Lead for Quality. The Medical Director advises the Trust Board on all matters relating to the preparation of the Trust's annual Quality Account.
- The Trust's Director of Strategy & Planning is responsible for providing the information and performance data which informs the Annual Quality Account. An Information Services Manager, to whom this responsibility is delegated, is also in post.
- The Trust's Director of Strategy & Planning is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate.

Policies and plans in ensuring quality of care provided:

- Policies and procedures are in place in relation to the capture and recording of patient data.
- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.

Systems and processes:

- Systems and processes are in place for the audit and validation of performance data although in respect of waiting list data plans are being developed to create a strengthened central validation team to ensure these arrangements are robust.

People and skills:

- All staff involved in collecting and reporting on quality metrics are suitably trained and experienced.
- All PAS users have to receive training before being issued a password, and individual user activity is auditable.
- Clinical Coding is regularly audited both internally and externally and audits also take place with individual clinicians. Where appropriate any changes or strengthening of these arrangements will occur arising from the recent coding review and recommendations undertaken by Grant Thornton.

Data Use and Reporting:

- A monthly Integrated Performance Report which outlines the Trust's performance against key quality and other objectives including benchmarking and comparative data is the subject of discussion and challenge at every monthly Trust Board meeting and also informs the annual Quality Account. A refresh of the Integrated Performance Report and KPIs is currently underway. As part of the Board Development Session, the Analytics Team have been invited to undertake a sessions for the Trust Board on 'Making Data Count for Trust Boards'.

In preparation for the requirement for a published audit opinion in the 2018/19 Quality Account, the purpose of which is to provide assurance on the arrangements in place to ensure Quality Accounts are fairly stated and in respect of the accuracy of the information and indicators within the report, audit review has been undertaken.

This has involved sample testing in respect of a number of mandated quality indicators.

During 2016/17, the Trust identified data quality issues in connection with the information on the Trust's waiting list which is used to manage delivery of the Referral to Treatment (RTT) Waiting Times (maximum waiting time of 18 weeks) standard. The Trust, in response to these findings, appointed an external validation company to work through specific elements of the waiting list data to identify errors and correct accordingly. Work continued during 2017/18 to address identified inaccuracies within the Trust's waiting list management process. A comprehensive training plan was rolled out across the Trust and continued into 2018/19. Areas of training included RTT, Patient Tracker List (PTL) Management and Demand and Capacity.

Further testing of data quality in relation to the Trust's waiting list was undertaken during 2017/18 as part of the Internal Audit Programme. That audit aimed to assess amongst other things:

- waiting list accuracy of RTT rules;
- data Quality;
- patient pathway management and tracking;
- adherence to the Trust's Access Policy.

On the basis of the results of this review and whilst acknowledging the significant work in this area, particularly in relation to data quality enhancement, validation, training and PTL development, an assessment of 'partial assurance with improvements required' was awarded. The audit found that core systems, processes and working practices were still not fully effective and that reported waiting list data did not provide a true picture of performance. The review raised 18 recommendations; 7 of which were rated as high priority. These recommendations were included within the Trust's patient administration improvement plan.

Whilst the improvement work has continued during 2018/19 and significant improvements have been made – including in respect of the transparency and governance and oversight of the waiting list, the Trust continues to identify issues in respect of the accuracy of waiting list data – specifically in relation to the application of the RTT rules. Whilst training is key to sustaining accurate waiting list data there is also work underway to validate the business rules applied to the data and create a central validation team to enable the Trust to validate a larger proportion of the waiting list and proactively track patients through the pathway.

REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Northern Lincolnshire and Goole NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Annual Quality Report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit, Risk & Governance Committee and the Quality & Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work (Appendix I, page 161, refers). The BAF and the monthly Integrated Performance Report provide me with evidence that the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust's BAF and Risk Register including NED review and challenge through the relevant Board sub-committees.
- Regular risk management activity reports to the Trust Board assurance sub-committees and / or the Trust Board covering incidents / SIs, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit, Risk & Governance Committee, Finance & Performance Committee, Workforce Committee and the Quality & Safety Committee.
- The ongoing development of the BAF and Risk Register tested through the Internal Audit Programme.
- Annual independent external review by the Internal Auditors of the Trust's board assurance and self-certification processes.
    - Consideration of a bi-monthly 'Improving Together' report, allowing the Trust Board to monitor improvements across the six workstreams within 'Improving Together': Leadership & Culture, Quality & Safety, Safe Staffing, Access & Flow, Finance and Strategy & Capital.
    - The provision and scrutiny of a monthly Integrated Performance to the Trust Board, which covers a combination of specific KPIs and including the identification of key risks to future performance and mitigating actions. The Trust's performance management arrangements were further strengthened during 2018/19 including the implementation of more structured Performance Review Meetings.

The validity of the Annual Governance Statement has been provided to me by the Audit, Risk and Governance Committee, which has considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of internal control.

CONCLUSION

In conclusion, the following significant internal control issues arose or continued during 2018/19:

Finance and Sustainability

The Trust remains in breach of its Licence, specifically conditions CoS3(1)(a) and (b), CoS3(2)(c), and FT4(5)(a),(d), and (f), this is due to continued financial pressures and the inability to maintain and improve financial sustainability, efficiency and compliance with sector controls. The Trust's financial year end deficit was £58.1m.

The main reasons are increased agency costs and changes to the income position mainly due to deductions that had not been taken into account. The Trust agreed a control total for 2018/19 but was unable to achieve it and therefore lost the funding that goes with achieving that total. The Trust continues to be non-compliant with NHS Improvements Use of Resources performance measure under the Single Oversight Framework recognising that this is within the context of a wider sustainability gap across the local health economy.

Given the above position, the Trust remains in 'financial special measures' (FSM) and continues to receive support from EY and the NHSI FSM Team. The development of the Trust's Financial Improvement Plan sits within the wider framework of the Trust's Improving Together programme, linking quality, performance and financial improvements together.

There is support from partners of the need to address the sustainability gap as a system and, based on that support, the Trust has agreed a revised control total for 2019/20 from £15.4 m to £25.4m. Delivery of the revised control total is a key success factor for 2019/20.

CQC

As outlined in section 4. above, as at the time of preparing this report, the Trust is not fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust remains in quality 'special measures'. The Trust's improvement plan in response to the CQC findings and recommendations (specifically the 'must dos' and 'should dos') are captured within the Improving Together Programme with monthly reporting to the Trust Board.

Testing in respect of specific actions is the subject of challenge and 'deep dives' through the Patient Safety Group (PSG) of the System Improvement Board. A Q4 stocktake of the Trust's position in respect of the 'must dos' and 'should dos' is due to take place at the June 2019 meeting of the PSG. An internal 'dry run' will be undertaken by the Improving Together Board.

The Trust will receive a further CQC inspection visit during 2019/20.

Performance:

A&E

Whilst the Trust continues to treat more patients within 4 hours than in the previous year and to perform better than the national picture and performance in March 2019 was 1% short of the target.

Performance continues to be impacted by the significant increase in demand which has also been seen nationally. This increase in demand also continues to be impacted by the position at ULHT.

Additional recovery actions have been in progress since December 2018 to drive a return to improvement trajectory; these have seen a faster recovery daily but are not improving the trajectory performance at the required pace.

The Finance and Performance Committee provide the detailed scrutiny and challenge in respect of performance – including A&E performance – with reporting to the Board through the Integrated Performance Report and highlight report from the Finance & Performance Committee.

Improvement actions are also monitored through the system-wide A&E Delivery Board with stakeholder support being seen as key to a return to improvement trajectory.

Cancer Performance

The Trust has consistently met the following cancer standards:

- 2ww GP referral (1st appointment)
- Breast Symptomatic (since October 2018 with the exception of a dip in December 2018 and February and March 2019)
- 62 day screening standard (since Q2 and throughout Q3 & Q4)
- All 31 day standards

Whilst the Trust saw an improvement in the 62 day cancer performance during March 2019, performance has been consistently below the target throughout 2018/19.

Key constraints to delivery of the 62 day standard include diagnostic/pathology – capacity & workforce, definitive diagnosis – Day 28, increased referrals (+ 38 per week in April 2019) Trust-wide, healthcare initiated delays for diagnostics/treatment, capacity delays for diagnostics (February/March 2019), increased delays in access to Oncology (HUTH – Hull University Teaching Hospitals).

The Trust continues to focus on reducing those patients who have waited the longest by building on and / or sourcing additional capacity.

However, there is a clear recognition by the Trust Board that resolution of the challenges in respect of the delivery of cancer services is not within the Trust's control and a more radical and collaborative approach to delivery is required.

Discussions are currently underway with the HCV Cancer Alliance team and HUTH on options for transformation of how cancer pathways might be delivered doing forward.

The Finance and Performance Committee provide the detailed scrutiny and challenge in respect of performance – including cancer performance – with reporting to the Board through the Integrated Performance Report and highlight report from the Finance & Performance Committee.

RTT & OPD Follow-ups

Whilst there is further work to do, the Trust's RTT position improved in month during March 2019. The Trust over-achieved the trajectory for 2018/19; with the Trust ending the year on 75% and seeing a reduction in the waiting list overalll.

Work continues to further improve the RTT position and this remains a priority for 2019/20.

The focus remains on patients who have waited the longest with 3 patients waiting in excess of 52 weeks (due to patient choice) going into April 2019 although all 3 patients have now been seen. .

The Trust continues to build on and / or source additional capacity including through increasing care within the community where more appropriate for the patient and the development of CNS and virtual clinics.

The Trust continues to experience pressures in respect of out-patient follow-ups with particular challenges in Ophthalmology, ENT and Gastroenterology. In respect of Ophthalmology in particular a system wide plan is being developed as a priority.

Work has continued to strengthen the infrastructure in place in support of the management of the Trust's waiting lists:

- The Trust PTLs have been updated to meet the user needs.
- A revised accountability and governance structure is in place which has been underpinned by the development of a training programme to support operational delivery for relevant staff.
- The Trust continues to see improvements in the booking of patients on an 18 week pathway in chronological order with the 'tail reducing'.

However, as outlined in section 7. above, the Trust continues to a review of the arrangements in place to support the management of the Trust's waiting list was undertaken during 2017/18 via the Internal Audit Programme.

Whilst the significant work undertaken to date was acknowledged, the audit found that core systems, processes and working practices are not yet fully effective.

The review raised 18 recommendations; 7 of which have been rated as high priority. These recommendations were included within the Trust's patient administration improvement plan.

Whilst the improvement work has continued during 2018/19 and significant improvements have been made – including in respect of the transparency and governance and oversight of the waiting list, the Trust continues to identify issues in respect of the accuracy of waiting list data – specifically in relation to the application of the RTT rules.

Whilst training is key to sustaining accurate waiting list data there is also work underway to validate the business rules applied to the data and create a central validation team to enable the Trust to validate a larger proportion of the waiting list and proactively track patients through the pathway.

The Finance and Performance Committee provide the detailed scrutiny and challenge in respect of performance – including in respect of performance around the waiting list and in respect of improvements to the Trust's patient administration arrangements – with reporting to the Board through the Integrated Performance Report and highlight report from the Finance and Performance Committee.

Finally, where control issues have been identified during 2018/19, action has been taken or improvement plans are in place to address the gaps in control identified.

Key to delivery of the required improvement internally includes the strengthening of the Divisional operational and governance structures – capacity and capability.

The Trust Board is satisfied that plans are adequate to ensure delivery of these targets or improvements during 2019/20 or that external support has / is being secured. Where appropriate these action / improvement plans will be tested via relevant external scrutiny and review processes. External support is in place as required through the support package in place through NHSI.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Appendix I: Head of Internal Audit opinion on the effectiveness of the system of internal control at the Northern Lincolnshire and Goole NHS Foundation Trust for the year ended 31 March 2019

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accounting Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accounting Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- the purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process;
- the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the AGS requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit Committee, which should provide a reasonable level of assurance, subject to the inherent limitations described below.
The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its AGS.

The Head of Internal Audit Opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accounting Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will in turn assist the Board in the completion of its AGS.

My opinion is set out as follows:

1. Overall opinion;
2. Basis for the opinion;
3. Commentary.

My **overall opinion** is that:

***Significant assurance* can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls, put the achievement of particular objectives at risk.**

The **basis** for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes; and
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses.

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

The design and operation of the Assurance Framework and associated processes.

My detailed review of the Northern Lincolnshire and Goole NHS Foundation Trust Board Assurance Framework (BAF) document found that its design complied with best practice as embodied in Department of Health guidance.

As regards my review of the assurance and risk management processes that underpin the BAF documents (e.g. organisation-wide risk management systems and the design and operation of the Trust's governance / assurance structure), it was found that there is a generally sound system of control in place.

Our review found that there is scope to improve the format of the BAF in order to provide clarity around the mapping of controls, assurances and gaps.

The BAF and strategic risks are reviewed by the relevant Board Sub Committee each month and by the Audit, Risk and Governance Committee and Trust Board each quarter.

The BAF is supported by a developing risk management process and a structure is in place to escalate risks from directorate to corporate level, however our review found a number of high rated risks which were not identified as a strategic risk or linked to a strategic risks.

An opinion of Significant Assurance is awarded in relation to the design and operation of Trust's Assurance Framework and underpinning risk management processes.

The range of individual opinions arising from risk-based audit assignments, contained within risk-based plans that have been reported throughout the year.

The 2018/19 Internal Audit operational plan was approved by the Trust's Audit Committee on 26th July 2018 and is based upon:

- Mandatory requirements (review of the Board Assurance Framework and its underpinning processes and the Data Security and Protection Toolkit submission)
- A 3 year strategic plan covering high risk, enduring systems and processes;
- External Audit requirements;
- Known risks at the time of production (including gaps in control and / or assurance identified in the 2018/19 Assurance Framework and suggestions from management raised and evaluated during the audit planning process).

Audit Yorkshire won the contract and started providing Internal Audit services to the Trust in July 2018. An audit plan, based on risk assessment with the Executive Team, was presented and approved at the 26 July 2018 Audit, Risk and Governance Committee. Work on the programme started in September 2018 after Executive approval of the initial audit briefs.

A number of changes to the audit programme have been requested by the Trust during the course of the year, which were agreed by the Director of Finance and approved by the Audit, Risk and Governance Committee. These include the work on Divisional Management and Accountability, Medical Workforce Planning, Incident Management, GDPR Compliance and Pressure Ulcer (Data Quality).

During 2018/19, we undertook 19 internal audit assignments resulting in 18 reports, all of which were reported to the Audit, Risk and Governance Committee and have been summarised to the Audit, Risk and Governance Committee. The assurance levels awarded were as follows:

- 56% of the individual reviews received a Significant Assurance opinion (compared to 25% in 2017/18*);
- One review (6%) received a High Assurance opinion (compared to 8.5% in 2017/18).
- No reports received a Low Assurance opinion (compared to 8.5% in 2017/18);
- 11% of the individual reviews received a Limited Assurance opinion (compared to 58% in 2017/18);
- Five advisory reports did not receive an assurance opinion.

**This is a comparison with the assurance opinions of KPMG which although are not the same as the opinions used by Audit Yorkshire they do loosely align.*

The outcome of the assurance audit reports from the 2018/2019 audit plan are summarised below.

Audit Area	Assurance Level
National Cost Collection	Significant
Risk Register benchmarking	N/A
BAF Benchmarking	N/A
Remuneration Committee (Confidential)	N/A
Data Security and Protection Toolkit (Stage 1)	N/A
Private Practice	Limited
Business Continuity and EPRR	High

Audit Area	Assurance Level
Board Assurance Framework	Significant
Staff Recruitment	Significant
Core Financial Controls	Significant
Clinical Audit	Significant
Activity Planning	Significant
Data Security and Protection Toolkit (Stage 2)	Limited
Performance Management Framework	Significant
Waiting List Management	Significant
Performance Data Quality (Sickness Reporting)	Significant
Cyber Security (Advisory – provided by Falanx)	In progress
CQC Registration	Significant
AGS Benchmarking	N/A

Taking into account all of our findings, and the Trust's actions in response to audit recommendations during 2018/19 and timing of audits, the following areas of notable control weakness remain:

- Private Practice – The audit found that whilst there is a largely well designed control framework in place, supported by Trust policy, there were weaknesses with the operation of controls, in particular not all Consultants declaring interest and evidencing indemnity insurance at appraisals, not all consultants disclosing private patient work and a lack of monitoring and reporting of compliance against the policy.
- Medical and Nursing Capacity – Internal Audit has reviewed a number of audit areas this year which have confirmed controls are in place and generally operating well for the systems we have reviewed. However, we note that underlying resourcing and capacity issues are adversely impacting the outcome of these systems, regardless of the control framework in place. Work on Waiting List Management and the Performance Management Framework are two such examples of this. The Trust is working with local partners and the wider STP footprint to develop plans and initiatives to address these workforce supply issues.
- The Trust's Standing Orders (SOs) and Standing Financial Instructions (SFIs) are currently out of date. The Board has approved the decision to defer approval of these key financial policies until after the end of the year.

The Trust has continued to respond actively to recommendations to improve its control environment by implementing internal audit recommendations promptly. The small number of control weaknesses outstanding is testament to the pro-active attitude of the Trust in relation to addressing Internal Audit findings and recommendations. All internal audit recommendations are systematically followed-up until implemented, with reporting on progress to the Audit, Risk and Governance Committee. We are pleased to report that over 53% of internal audit recommendations scheduled to be implemented during 2018/19 were fully implemented during the year. Overall, the findings from our audit work in the year provide ***Significant Assurance*** that there is a generally sound system of internal control.

Helen Kemp-Taylor
Managing Director and Head of Internal Audit, April 2019

Equality and diversity

The Northern Lincolnshire and Goole NHS FT (the Trust) aims to be an organisation that people want to access for care and treatment.

The Trust aims to be an organisation that people want to join and remain with as staff because it allows them to make their distinctive contributions and achieve their full potential.

The Trust does not tolerate any form of intimidation, humiliation, harassment, bullying or abuse and will ensure that patients, staff, visitors and the public are treated fairly, with dignity and respect.

Our aim is to break down all barriers of discrimination, prejudice, fear or misunderstanding, which can damage service effectiveness for service users and carers.

The Trust is committed to compliance with the Public Sector Equality Duty as set out in the Equality Act 2010.

The Trust will do this by eliminating discrimination, harassment and victimisation and have due regard to advancing equality for the relevant protected characteristics:

- Age
- Disability
- Gender Re-assignment
- Marriage and Civil Partnership
- Pregnancy and Maternity
- Race
- Religion & Belief
- Sex / Gender
- Sexual Orientation

The Trust aims to ensure that its services and employment opportunities are equally accessible to other groups that are ‘seldom heard’. These other groups could include the long term unemployed, sex workers, homeless groups; substance misusers; migrant workers; asylum seekers/refugees; but this list is not exhaustive.

The Trust is committed to building a workforce which is valued and whose diversity reflects the community it serves, enabling it to deliver the best possible healthcare service to those communities.

By addressing any inequalities in employment practices, the Trust seeks to deliver equitable services to all.

The Trust believes that unlawful discrimination is unacceptable and aims to ensure that all patients, applicants, employees, contractors, agency staff and visitors will receive appropriate treatment and will not be disadvantaged by conditions or requirements which cannot be shown to be justified.

This is particularly so on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and trade union activity.

To support this we have a dedicated Equality and Diversity Lead whose remit includes providing strategic and operational advice and guidance to the Trust’s Management Team, its staff and other key stakeholders on all matters around equality and diversity linked to patient care and workforce.

In the last year a new Equality and Diversity Strategy has been introduced along with a number of Equality Objectives.

These Equality Objectives are giving direction and supporting the organisation to move forward against the equality and diversity agenda.

The Equality Objective's cover the period 2018 - 2022 and focus on:

- Implementing an equalities framework (Equality Delivery System 2)
  - This framework is encouraging the organisation to identity gaps in engagement and areas of potential inequalities. The key themes identified are being addressed through Staff Equality Networks and the Pride and Respect Campaign.

- Improving the collection of patient equality data
  - To help understand the diverse communities we serve Public Health data has been collected and some early analysis has been conducted.

- Continuing to deliver a high level of equality and diversity training to our staff
  - Equality and Diversity training is mandatory for all staff using blended learning. Face to face training is delivered as part of the corporate induction course and refreshers are completed using workbooks. A half day Equality and Diversity course has been running for the last year with one or two courses taking place each month.

- During 2018 approximately 700 staff received face to face equality, diversity and inclusion training. This course covered basic legislation, exploring difference and set the behavioural standards our patients, service users and staff/colleagues expect.

- Reporting against the Workforce Standards
  - We collected, analysed, developed action plans and published information relating to the Workforce Race Equality Standard and the Gender Pay Gap.

- Develop and Grow Staff Equality Networks
  - We have two staff equality networks which represent Ethnic Minority Staff and Lesbian, Gay Bi-Sexual and Trans+ Staff.

- We have renewed our membership and satisfactorily maintained our Disability Confident status as an employer who supports and attracts people with a disability or long term condition.

Looking ahead the new Equality and Diversity Strategy and the Equality Objectives will continue to provide the organisational direction to move this challenging agenda forward.

The Health Tree Foundation

The Health Tree Foundation is the working name for Northern Lincolnshire and Goole NHS Foundation Trust's charitable funds and the official charity for the Trust.

The new name was launched in November 2015 with support from Hull and East Yorkshire Smile Foundation (Smile). The name 'The Health Tree Foundation' was inspired by an organisation with roots in the NHS that branch out into the community.

After reaching the goals set out in the first strategy early, the Health Tree Foundation (HTF) carried out an exercise to refresh its vision and mission and set out a three year plan.

The new plan for the charity was approved at the Health Tree Foundation Trustees Committee (formerly Charitable Funds Committee) in March 2018.

The vision for the charity is: 'To be recognised as a leading NHS charity in the UK.' The mission is: 'We inspire, engage and channel the charitable intent of your local community, helping to turn donations of time and money into making your NHS sparkle'.

The Health Tree Foundation introduced the 'circle of wishes'. This is a process in which any patient, member of staff, relative or public visitor to the Trust can make a wish for a change at one of the hospital sites or in the community.

The Health Tree team will then look into turning their wish into a reality. After a successful introduction the charity now receives more than one wish per day.

As a result of Circle of Wishes and supporting capital investments, in the year 2018/19 the Health Tree Foundation contributed around £1.7 million to Northern Lincolnshire and Goole NHS Foundation Trust.

A total of £1,382,000 was spent on capital equipment including a £1 million contribution at Diana Princess of Wales and £53,000 at Scunthorpe General Hospital for a Lucentis room.

THE HEALTH TREE FOUNDATION

Your hospital charity

Chapter Four: The Independent Auditor's Report and Opinion

Independent Auditors' Report to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Northern Lincolnshire and Goole NHS Foundation Trust's Group and Trust financial statements (the "financial statements"):

- give a true and fair view of the state of the Group's and Trust's affairs as at 31 March 2019 and of the Group's income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19.

We have audited the financial statements, included within the Annual Report, which comprise: the Consolidated and Trust's Statement of Financial Position as at 31 March 2019; the Consolidated Statement of Comprehensive Income for the year then ended; the Consolidated Statement of Cashflows for the year then ended; the Consolidated Statement of Changes in Taxpayer's Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 to the financial statements concerning the Group's and the Trust's ability to continue as a going concern.

In the year, the Trust delivered a deficit of £58.1m against its control total for 2018/19 of £32.4m. This has placed pressure on its cash reserves and, combined with the borrowings from the Department of Health and Social Care of £188.4m at 31 March 2019 and the content of the financial plan for 2019/20, means that further financial support will be required over the coming 12 months to support the financial sustainability of the Trust. As described in note 1 to the financial statements, the extent and nature of any financial support from NHS Improvement (NHSI) is unknown and will be agreed between the Trust and NHSI on a monthly basis. The accounts do not include any adjustments that would result if the NHS Foundation Trust was unable to continue as a going concern.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Group's and the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Group or the Trust were unable to continue as a going concern.

Our audit approach

Context

Our audit for the year ended 31 March 2019 was planned and executed having regard to the fact that the Group's and Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and key audit matters was largely unchanged.

Overview

- Overall Group materiality: £7,094,000 (2018: £6,855,000) which represents 2% of total revenue.

- The scope of the audit covered the Northern Lincolnshire and Goole NHS Foundation Trust group. The Group includes the Trust's wholly owned subsidiary and wholly owned Charitable Funds.

- Going concern/financial sustainability;
- Risk of fraud in revenue and expenditure recognition and management override of control; and
- Valuation of land and buildings.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to going concern, described in the 'Material uncertainty related to going concern' section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the key audit matter*
Risk of fraud in revenue and expenditure recognition and management override of control - Group and Trust See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes 3 to 5 for further information. We focused on this area because there is a heightened risk due to: • The Trust being under increasing financial pressure: the deficit for the year is £58.1m, and whilst the Trust is actively looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate the timing of recognition of both revenue and expenditure. • In order to receive Sustainability and Transformation Funding ("STF") of £7.2m, the Trust needed to achieve its control total for 2018/19 of £32.4m deficit, providing further incentive to manipulate timing of both revenue and expenditure. • The continued regulatory interventions and financial support required by the Trust over that period, there remains an increased incentive to misreport the Trusts position. Given these incentives, we considered the key areas of focus to be: • Recognition of revenue and expenditure; • Manipulation through journal postings; and Items of income or expenditure whose value is dependent upon estimates.	*Revenue* We evaluated and tested the accounting policy for income recognition and found it to be consistent with the requirements of the Group Accounting Manual 18/19. For income/receivable transactions close to the year-end we tested, on a sample basis that the transactions and the associated income had been posted to the correct financial year by tracing them to invoices or other documentary evidence. No differences were identified that required amendment within the financial statements. For revenue from Clinical Commissioning Groups ("CCGs"), we reconciled revenue received to signed contracts and correspondence between the Trust and the CCG. We also tested a sample of reconciling items to confirm they related to contract variations. No differences were identified that required amendment within the financial statements. We tested a sample of income from activities and other income to invoice and remittance. *Expenditure* For invoices received/balances paid for a period after the year-end we tested, on a sample basis that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded. We tested a sample of operating expenses through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements. *Intra-NHS balances* We obtained the Trust's mismatch reports received from NHS Improvement, which identified balances (debtor, creditor, income or expenditure balances) that were disputed by the counterparty. We then checked that management had investigated all disputed amounts over the investigation threshold set by NHS Improvement, and discussed with them the results of their investigation and the resolution. We also read correspondence with the counterparties, which validated these explanations. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact. *Manipulation through journal postings* We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on those with unusual characteristics. We traced these journal entries to supporting documentation (for example, invoices, good received notes and cash receipts and payments) to check that the transaction was valid and had been correctly accounted for within the financial statements. Our testing identified no issues that required further reporting. *Management estimates* We evaluated and tested management's accounting estimates, focussing on: • useful lives of PPE; • provisions; • allowance for doubtful accounts; and

	We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by: • comparing the assumptions used by management in the calculation of their estimate with independent assumptions and investigating any differences.
Valuation of Property, Plant and Equipment –Group and Trust See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 16 for further information. We have focused on this area because Property, Plant and equipment ("PPE") represents the largest balance in the Trust's statement of financial position. PPE is valued at £173m. All property, plant and equipment assets are measured initially at cost with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date. A full valuation was undertaken during 2016/17 by the Trust's valuation experts which has been updated during the current year as at 31st March 2019. This valuation has resulted in a net downwards valuation adjustment of £2.5m. The valuation of Land and Buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions therefore our work has focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.	We obtained and read the relevant sections of the desktop valuation performed by the Trust's Valuers. We have utilised our valuations experts to evaluate and challenged the assumptions and methodology applied in the valuation exercise. We found the assumptions and methodology applied to be consistent and in line with our expectations. We tested the underlying data upon which the valuation was based back to floor plans for a sample of properties. We found the valuation to have been based on appropriate and up to date floor space data. We tested a sample of new additions to land and buildings in the year to confirm they had been appropriately valued – this involved agreement back to supporting invoice. We physically verified a sample of assets to confirm existence and in doing so assessed whether there was any indication of physical obsolescence which would indicate potential impairment. We considered the disclosures in the financial statements and were satisfied that they appropriately reflected the valuation undertaken in the period We considered whether the change in valuation was appropriately disclosed in the financial statements and correctly reflected in management's corresponding accounting entries.
Going concern/financial sustainability The Trust has delivered a deficit of £58.1m against a planned control total of a £32.4m deficit, which includes Sustainability and Transformation (STF) of £7.2m (£39.6m excluding STF). This represents an adverse variance of £25.7m. The deterioration in the Trust's financial position during the year led to non compliance of the control total for all four quarters. This was driven by reduced income relating to under delivery of activity against contractual targets in planned care, and increases in pay expenditure, predominantly agency expenditure. The Trust is facing a number of underlying challenges in 2019/20 including: • Implementing transformational change and recovery of the financial plan. The original plan included Cost Improvement Savings of £15m. • The Trust's financial performance in 2018/19 continues to place pressure on cash reserves and the Trust remains reliant on working capital extensions and loans from the Department of Health and Social Care. The outstanding loan balances from the Department of Health and Social Care now total £188m, with future financial plans showing little ability to repay these on current terms.	ISA (UK) 570 requires that we obtain sufficient evidence about the appropriateness of management's use of the going concern assumption in the preparation of the financial statements and to conclude whether there is a material uncertainty about the entity's ability to continue as a going concern. We have performed the following to inform our assessment of the Trust's financial position and performance: • Reviewed material balances owing to and from other health bodies through the national agreement of balances exercise; • Assessed the Trust's budget, cash flow forecasts and levels of reserves and challenged assumptions within the Trust's financial forecasts; • Performed targeted audit procedures to gain comfort over the recognition of revenue, in particular for the recognition of complex revenue streams such as patient income and whether this is compliant with the revenue recognition principles of IFRS; and • Review of key areas of accounting judgement including deferred income and provisions; and We have also sought to understand the license condition in place and consider the work of relevant regulatory bodies on economy, efficiency and effectiveness.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group financial statements	*Trust financial statements*
Overall materiality	£7,094,000 (2018: £6,855,000)	£7,093,820 (2018: £6,907,580)
How we determined it	2% of revenue (2018: 2% of revenue)	2% of revenue (2018: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £300,000 (Group audit) (2018: £300,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance 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 an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of 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 based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2018/19 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 45, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2018/19, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they 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 directors are responsible for assessing the Group's and Trust'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 directors either intend to liquidate the Group and Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' 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 auditors' 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 these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

We are required under Schedule 10 (1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

Our audit did not consider any impact that the United Kingdom's withdrawal from the European Union may have on the Trust as the terms of withdrawal are not clear, and it is difficult to evaluate all of the potential implications on the Trust's activities, patients, suppliers and the wider economy.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.

Adverse opinion

As a result of the matters described below, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2019.

Basis for adverse opinion and Key Audit Matter

License condition

The license condition issued by Monitor on 6 August 2013 to the Board of Directors and the Council of Governors, triggered by a deterioration in the Trust's financial position, still remains in place. In addition on 8 April 2015, Monitor (now NHS Improvement) issued enforcement undertakings, which remain in place, stating that the Trust had not demonstrated that it had established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively.

Financial Performance and financial special measures

On 24 March 2017, NHS Improvement placed the Trust in Financial Special Measures, noting the following:

- It had a control total, but had a significant negative variance against the control plan and is forecasting a significant deficit; and
- There are no factors NHS Improvement considers that mitigate the need for Financial Special Measures.

In 2018/19 the Trust planned a budgeted deficit of £32.4m. The Trust experienced financial pressure during the year that resulted in it not meeting the control total for all four quarters. Recovery plans did not deliver the anticipated financial improvement and the Trust delivered a £58.1m deficit.

CQC Inspection and Quality special measures

In November 2016, the Trust had a follow up Care Quality Commission (CQC) inspection, the outcome of which was received on 6 April 2017, with an overall 'Inadequate' rating being determined. The CQC also recommended to NHS Improvement that the Trust be placed back in quality special measures. NHS Improvement placed the Trust in quality special measures on the 6 April 2017, a status which remains in place.

The above issues are evidence of weaknesses in proper arrangements for:

- planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- for planning and developing a workforce to deliver strategic priorities effectively.

Other matters on which we report by exception

We are required to report to you if:

the statement given by the directors on page 52, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for patients, regulators, and other stakeholders to assess the Group's and Trust's performance, business model, and strategy is materially inconsistent with our knowledge of the Group and Trust acquired in the course of performing our audit.

the section of the Annual report on page 50, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.

the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.

we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.

Ian Looker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds
29 May 2019

Chapter Five: The Annual Accounts for the year ended 31 March 2019

Foreword to the Accounts

Northern Lincolnshire and Goole NHS Foundation Trust

These accounts, for the year ended 31 March 2019, have been prepared by Northern Lincolnshire and Goole NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 29 May 2019

Consolidated Statement of Comprehensive Income for the year ended 31 March 2019

		Group		
		2018/19		2017/18
	Note	£000		£000
Operating income from patient care activities	3	316,522		307,771
Other operating income	4	38,227		38,727
Operating expenses	5	(408,493)		(380,119)
Operating deficit from continuing operations		**(53,744)**		**(33,621)**
Finance income	10	219		121
Finance expenses	11	(5,663)		(2,898)
PDC dividends payable		-		(571)
Net finance costs		**(5,444)**		**(3,348)**
Other gains / (losses)	11.2	52		(116)
Share of profit of associates / joint arrangements		-		79
Corporation tax expense	13	(4)		(30)
Deficit for the year from continuing operations		**(59,140)**		**(37,036)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	**-**		**-**
Deficit for the year		**(59,140)**		**(37,036)**
Other comprehensive (expense)/income				
Will not be reclassified to income and expenditure:				
Impairments	6, 12	(2,197)		(763)
Revaluations	12	1,131		5,973
Other reserve movements		10		-
Total comprehensive expense for the period		**(60,196)**		**(31,826)**
Deficit for the period attributable to:				
Northern Lincolnshire and Goole NHS Foundation Trust		(59,140)		(37,984)
TOTAL		**(59,140)**		**(37,984)**
Total comprehensive expense for the period attributable to:				
Northern Lincolnshire and Goole NHS Foundation Trust		(60,196)		(31,826)
TOTAL		**(60,196)**		**(31,826)**
Adjusted financial performance (control total basis):				
Deficit for the period		(59,140)		(37,036)
Remove impact of consolidating NHS charitable fund		1,028		(826)
Remove net impairments		1,392		(2,851)
Remove I&E impact of capital grants and donations		(1,015)		(62)
CQUIN risk reserve adjustment (2017/18 only)		-		(1,421)
Adjusted financial performance deficit		**(57,735)**		**(42,196)**

Statements of Financial Position as at 31 March 2019

		Group				Trust			
		31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	Note	£000		£000		£000		£000	
Non-current assets									
Intangible assets	15	785		849		785		849	
Property, plant and equipment	16	173,066		159,279		173,066		159,279	
Other investments / financial assets	20	1,757		1,978		-		-	
Total non-current assets		**175,608**		**162,106**		**173,851**		**160,128**	
Current assets									
Inventories	23	2,981		2,773		2,981		2,773	
Receivables	24	23,292		22,649		23,082		22,501	
Cash and cash equivalents	29.1	14,963		12,555		14,677		11,370	
Total current assets		**41,236**		**37,977**		**40,740**		**36,644**	
Current liabilities									
Trade and other payables	30	(51,052)		(48,867)		(50,905)		(48,665)	
Borrowings	32	(17,370)		(2,146)		(17,370)		(2,146)	
Provisions	35	(1,001)		(1,008)		(1,001)		(1,008)	
Other liabilities	31	(384)		(177)		(384)		(177)	
Total current liabilities		**(69,807)**		**(52,198)**		**(69,660)**		**(51,996)**	
Total assets less current liabilities		**147,037**		**147,885**		**144,931**		**144,776**	
Non-current liabilities									
Borrowings	32	(172,504)		(115,282)		(172,504)		(115,282)	
Provisions	35	(4,466)		(4,696)		(4,466)		(4,696)	
Total non-current liabilities		**(176,970)**		**(119,978)**		**(176,970)**		**(119,978)**	
Total (liabilities)/assets employed		**(29,933)**		**27,907**		**(32,039)**		**24,798**	
Financed by									
Public dividend capital		129,295		126,939		129,295		126,939	
Revaluation reserve		17,795		18,861		17,795		18,861	
Other reserves		10		-		-		-	
Income and expenditure reserve		(178,992)		(120,880)		(179,129)		(121,002)	
Charitable fund reserves	21	1,959		2,987		-		-	
Total taxpayers' equity		**(29,933)**		**27,907**		**(32,039)**		**24,798**	

The notes in the rest of this Chapter form part of these accounts.

Name Dr Peter Reading
Position Chief Executive
Date 29 May 2019

Consolidated Statement of Changes in Taxpayers' and other Equity for the year ended 31 March 2019

Group	Public dividend capital	Revaluation reserve	Other reserves	Income and expenditure reserve	WebV Solutions Ltd Income and Expenditure reserve	Charitable fund reserves	Total taxpayers' and others' equity
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018 - brought forward	**126,939**	**18,861**	**-**	**(121,003)**	**123**	**2,987**	**27,907**
Surplus/(deficit) for the year	-	-	-	(58,770)	14	(384)	**(59,140)**
Impairments	-	(2,197)	-	-	-	-	**(2,197)**
Revaluations	-	1,131	-	-	-	-	**1,131**
Public dividend capital received	2,356	-	-	-	-	-	**2,356**
Other reserve movements	-	-	10	644	-	(644)	**10**
Taxpayers' and others' equity at 31 March 2019	**129,295**	**17,795**	**10**	**(179,129)**	**137**	**1,959**	**(29,933)**
Group	**Public dividend capital**	**Revaluation reserve**	**Other reserves**	**Income and expenditure reserve**	**WebV Solutions Ltd Income and Expenditure reserve**	**Charitable fund reserves**	**Total**
	£000	£000	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017 - brought forward	**126,039**	**13,651**	**-**	**(83,019)**	**1**	**2,161**	**58,833**
Surplus/(deficit) for the year	-	-	-	(38,668)	122	1,510	**(37,036)**
Impairments	-	(763)	-	-	-	-	**(763)**
Revaluations	-	5,973	-	-	-	-	**5,973**
Public dividend capital received	900	-	-	-	-	-	**900**
Other reserve movements	-	-	-	684	-	(684)	**-**
Taxpayers' and others' equity at 31 March 2018	**126,939**	**18,861**	**-**	**(121,003)**	**123**	**2,987**	**27,907**

Information on Reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the trust, is payable to the DHSC as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Other reserves

This represents the share capital of the NHS Foundation Trust's subsidiary company, WebV Solutions Limited.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

NHS Charitable funds reserve

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted.

Consolidated Statement of Cash Flows for the year ended 31 March 2019

		Group		
		2018/19		2017/18
	Note	£000		£000
Cash flows from operating activities				
Operating deficit		(53,744)		(33,621)
Non-cash income and expense:				
Depreciation and amortisation	5	7,225		7,077
Net impairments	6	1,392		(2,851)
Income recognised in respect of capital donations	4	(1,238)		(281)
Increase in receivables and other assets		(795)		(1,989)
Increase in inventories		(208)		(115)
Increase in payables and other liabilities		2,972		5,153
Decrease in provisions		(251)		(2,331)
Movements in charitable fund working capital		(88)		97
Tax paid		(30)		-
Other movements in operating cash flows		25		-
Net cash flows used in operating activities		**(44,740)**		**(28,861)**
Cash flows from investing activities				
Interest received	10	140		46
Purchase of intangible assets		(317)		(379)
Purchase of PPE and investment property		(22,742)		(9,846)
Sales of PPE and investment property		10		183
Receipt of cash donations to purchase assets		1,238		281
Net cash flows from charitable fund investing activities		391		75
Cash from acquisitions / disposals of subsidiaries		-		128
Net cash flows used in investing activities		**(21,280)**		**(9,512)**
Cash flows from financing activities				
Public dividend capital received		2,356		900
Movement on loans from DHSC		70,996		45,194
Capital element of finance lease rental payments		(55)		(22)
Interest on loans	11	(5,062)		(2,128)
Other interest	11	(5)		-
Interest paid on finance lease liabilities	11	(1)		(7)
PDC dividend refunded/(paid)		199		(681)
Net cash flows generated from financing activities		**68,428**		**43,256**
Increase in cash and cash equivalents		**2,408**		**4,883**
Cash and cash equivalents at 1 April - brought forward		**12,555**		**7,672**
Cash and cash equivalents at 31 March	29.1	**14,963**		**12,555**

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting Convention

These accounts have been prepared on a going concern basis, under the historical cost convention modified to account for the revaluation of land and buildings. Plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities have been reviewed to represent fair value as at 31 March 2019.

Note 1.1.2 Going Concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust's Annual Reporting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the NHS Foundation Trust to continue as a going concern and these are disclosed below.

The Trust's performance in year showed a deficit of £58.13m (excluding WebV Solutions Ltd) inclusive of all non cash balance sheet review adjustments and impairments. The Trust received £2.33m of Provider Sustainability Funding (PSF). The Trust had year end cash balances of £14.68m. During the year the Trust had to utilise revenue support funding of £64.11m (net of repayments).

The Trust has a total outstanding loans balance of £188.37m, and aside from £20.57m relating to specific capital projects, these are emergency revenue support loans from the DHSC. No plans are in place which can support ultimate repayment of these support loans through normal business operations.

In March 2017 NHSI formally placed the Trust in Financial Special Measures. Financial Special Measures presents no risk of the Trust having to cease trading within the next twelve months, or face regulator action to cease or modify its trading status in that period.

The Trust has agreed an amended control total for 2019/20 of £25.4m, and is forecasting a further deficit of £25.6m. This includes a savings programme of £20m, approximately 5% of expenditure.

The Trust remains dependent upon central loan support to maintain cashflow.

There obviously continues to be some uncertainty around the extent and nature of any financial support from NHSI, however, given there is no indication from regulators that the Trust will cease any part of its' trading activities, (the Trust will continue its' ability as a going concern). The directors have determined that the circumstances outlined above amount to a material uncertainity which may cast significant doubt over the ability of the Trust to continue as a going concern. However given the commitment to funding from both NHSI and the Department of Health, it remains appropriate to prepare these accounts on a going concern basis.

Note 1.2 Consolidation

1.2.1 Subsidiaries - Charitable Funds

The NHS Foundation Trust is the corporate trustee to Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because it is exposed to variable returns from its involvement with the charitable fund to obtain benefits for itself, its patients or its staff.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- Eliminate intra-group transactions, balanced, gains and losses.

Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds Accounting Policies:

a) Funds Structure

Perpetuity funds are funds which are to be used in accordance with specific restriction imposed by the donor. Where the restriction requires the gift to be invested to produce income but the capital cannot be spent, it is classed as a perpetuity fund.
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 perpetuity funds or expendable endowments:

b) Incoming Resources

All incoming resources are recognised once the charity has entitlement to the resources. Provided it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

1.2.1 Subsidiaries - Charitable Funds

c) Incoming Resources from Legacies
Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain; 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.

d) 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.

e) 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.

f) Allocation of Overhead and Support Costs
Overhead and support costs have been apportioned on an appropriate basis between all funds. The apportionment is in proportion to the quarterly aggregate balance on each of the funds and is distributed on a quarterly basis.

g) Non Current Investments
Investments are stated at market value as at the balance sheet date. The Statement of Comprehensive Income includes the net gains and losses arising on revaluation and disposals throughout the year.
The Common Investment Fund Units and Brewin Dolphin Ltd portfolio are included in the balance sheet at the closing dealing price at 31 March 2019

h) Realised Gains and Losses
All gains and losses are taken to the Statement of Comprehensive Income 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). Gains or losses arising on revaluation are credited or charged in the 'Movement in the fair value of other investments' in the income and expenditure account.
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).

1.2.2 Subsidiaries - WebV Solutions Limited

The NHS Foundation Trust owns 99% of the share capital in WebV Solutions Limited, the remaining 1% is owned by Harrogate & District NHS Foundation Trust. The statutory accounts are prepared to 31 March in accordance with UK Financial Reporting Standards (FRS) 102. On consolidation, necessary adjustments are made to the companies' assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- Eliminate intra-group transactions, balances, gains and losses.

1.3 Joint Venture

The Foundation Trust entered into a cooperation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operated from Ward 4 at Goole District Hospital. The joint venture provided both NHS Care and care independent to the NHS but within an NHS location.
The joint venture ceased on 31st August 2017. The Trust includes within its 2017/18 financial statements its share of the activities, assets, liabilities and any transactions relating to the termination of this agreement.

1.4 Critical Accounting Judgements and Key Sources of Estimation and Accuracy

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

a) Going Concern
The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. Please refer to Accounting Policy 1.1.

b) Property Valuations and Asset Lives
Valuations are undertaken by an independent external valuer. These values will therefore be subject to changes in market conditions and market values. The asset lives are also estimated by the independent external valuer and are subject to professional judgement.

c) Accruals
Accruals included within the accounts are based on the best available information. This is applied in conjunction with historical experience and based on individual circumstances.

d) Annual Leave Accruals
The NHS Foundation Trust has written to all members of staff requesting details of their outstanding annual leave at the end of March 2019. The value of the outstanding amount has been calculated based on the returns received back from staff and their average salary. The NHS Foundation Trust is carrying £0.327m.

e) Provisions
The estimates of outcome and financial effect of provisions are determined by the judgement of the management of the Trust, supplemented by experience of similar transactions and, in some cases, reports of independent experts.
Uncertainties surrounding the amount to be recognised as a provision are dealt with by various means according to the circumstance. Where the provision being measured involves more than one outcome, the obligation is estimated by weighing all possible outcomes by their associated probabilities; the expected value of the outcome. Where there is a range of possible outcomes, and each point in the range is likely as the other, the mid-point of the range is used. Where a single outcome is being measured, the individual most likely outcome may be the best estimate of the liability. However, even in such a case, the Trust considers other possible outcomes.
The NHS Foundation Trust is carrying a restructuring provision of £0.18m to support payments in line with the NHS Foundation Trust pay protection policy.

1.5 Income
The transition to IFRS 15 has been completed in accordance with paragraph C3 (b) of the Standard, applying the Standard retrospectively recognising the cumulative effects at the date of initial application.

In the adoption of IFRS 15 a number of practical expedients offered in the Standard have been employed. These are as follows:
- As per paragraph 121 of the Standard the Trust will not disclose information regarding performance obligations part of a contract that has an original expected duration of one year or less,

- The Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with value of the performance completed to date.
- The FReM has mandated the exercise of the practical expedient offered in C7 (a) of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

The main source of revenue for the Trust is contracts with commissioners in respect of healthcare services. Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer, and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue.

Where income is received for a specific performance obligation that is to be satisfied in the following year, that income is deferred.

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20, Accounting for Government Grants. Where these funds are paid directly to an accredited training provider, non cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

1.6 Expenditure

1.6.1 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

1.6.3 Apprentice Levy

The Apprentice levy was introduced by the UK Government on 6 April 2017.

There are two aspects to the treatment of the levy in local accounts:

- Recognition of the initial payment in social security cost;
- Recognition of the receipt of the associated training grant.

1.6.4 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition

"Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes;
• it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust;
• it is expected to be used for more than one financial year;
• the cost of the item can be measured reliably;
• the item has cost of at least £5,000, or
• collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control."

Items form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.
Borrowing costs associated with the construction of new assets are not capitalised.

Measurement

"Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation. "

Land and buildings used for the Foundation Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed by professional valuers every five years and in the intervening years by the use of appropriate indices or by interim valuation as necessary to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

· Freehold Properties – Existing Use Value (EUV);
· Specialised buildings – Depreciated Replacement Cost (DRC) – Modern Equivalent Asset (MEA);
· Others – DRC – EUV;
· Land – Modern Equivalent Asset (MEA).

For any new acquisition of property, plant and equipment, the following table details the useful economic lives for the main classes of assets and where applicable, sub categories within each:

Main Assets	Sub Category	Life in Years
Buildings	Structural Engineering	Up to 70 years
Fixtures	Plant, machinery and equipment	5 to 15 years
	Furniture and fittings	5 to 10 years
Vehicles/transport equipment		Up to 7 years
Intangible		Up to 10 years

Valuations are carried out in accordance with the current Valuation Standards and UK Valuation Standards contained within the Royal Institute of Chartered Surveyors (RICS) Valuation Standards – The Red Book, which are consistent with the agreed requirements of the DHSC and HM Treasury.

Property assets have been valued primarily by using the Depreciated Replacement Cost (DRC) approach. In accordance with VS6.6, the DRC will be subject to the prospect and viability of the continued occupation and use by the Foundation Trust.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The ultimate objective of the valuation is to place a value upon the asset. In this the value of the land in providing a modern equivalent facility was also considered. The modern equivalent may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at present, which has given rise to reduction in the land values.

The results of these valuations have been incorporated into these financial statements.

Equipment assets are valued using appropriate indices (for 2018/19 no change) and predominantly the Depreciated Replacement Cost is assumed to be the fair value. Annually, an equipment review is also conducted by the department/directorate/equipment specialist and the life of the equipment assets is reviewed in conjunction with the experts in the field (medical electronics/suppliers/market intelligence). Assets in the course of construction are valued at current cost and they are revalued by professional valuers when they are brought into use or as part of the five or intervening years valuation whichever occurs first. These assets include any existing land or buildings under the control of a contractor.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Revaluation and Impairments

At each reporting period end, the Foundation Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the DHSC GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item under “Other Comprehensive Income”.

De-Recognition

Assets intended for disposal, are reclassified as 'Held for Sale' once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms;

- Which are usual and customary for such sales;
- The sale must be highly probable i.e.:
  Management are committed to a plan to sell the asset;
  An active programme has begun to find a buyer and complete the sale;
  The asset is being actively marketed at a reasonable price;
  The sale is expected to be completed within 12 months of the date of classification as "held for Sale"; and
  The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significantly changed.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8 Donated Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.
The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.
Within these financial statements, the Foundation trust does not have any donations with conditions attached at this present moment in time.

1.9 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally Generated Intangible Assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.
Expenditure on research is not capitalised.
Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Foundation Trust intends to complete the asset and sell or use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate financial, technical and other resources to complete the intangible asset and sell or use it, and
- The ability to measure reliably the expenses attributable to the intangible asset during its development.

Software

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.
Measurement
Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.
Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.
Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.
Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.
Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Intangible assets – internally generated	**Min. Life – Years**	**Max. Life – Years**
Information Technology	5	5
Intangible assets – purchased		
Software	5	10
Licences & Trademarks	5	10

1.10 Government Grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups (CCG's) or NHS Trusts for the provision of services. Where a Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.12 Private Finance Initiative (PFI) Transactions

At the 31 March 2019, the Foundation Trust did not have any PFI transactions.

1.13 Leases

The Trust as Lessee

"Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires."

"Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease."

"Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. "

"The Foundation Trust as a Lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs, Disability Trust, etc. renewable on an annual basis. These are operating leases and the rental from these leases is recognised on a straight line basis within these financial statements."

1.14 Cash and Cash Equivalent

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Clinical Negligence Costs

"NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 35.1 but is not recognised in the NHS Foundation Trust's accounts. "

1.16 Non-Clinical Risk Pooling

"The NHS Foundation Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises. "

1.17 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.29% in real terms for early retirement and injury benefit provisions only. When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.
A restructuring provision is recognised when the Foundation Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity. The NHS Foundation Trust is carrying a provision of £0.18m to support payments in line with the NHS Foundation Trust pay protection policy.

1.18 Sustainability and Carbon Reduction Commitment (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Foundation Trust has registered with the CRC scheme, and therefore, is required to surrender to the Government an allowance for every tonne of CO2 emitted during the financial year. Accordingly, the Foundation Trust has recognised a liability (and related expense) in respect of this obligation for CO2 emissions.

The carrying amount of the liability at 31 March 2019 reflects the CO2 emissions that have been made during this financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.
The liability will be measured at the amount expected to be paid out at the rate of £18.30 per tonne allowance.

1.19 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 36 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 36, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.20 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.21 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Corporation Tax

The NHS Foundation Trust has carried out a review of corporation tax liability of its non-healthcare activities. At present, all activities are either ancillary to the Trust's patient care activity or are below the de minimus level at which corporation tax is due. Therefore, the Trust has determined that it has no liability for corporation tax. Further guidance is awaited from NHS Improvement, the HM Treasury and the Inland Revenue.

The Trust will incur corporation tax through its wholly owned subsidiary WebV Solutions Limited and this has been estimated at £4k.

1.23 Foreign Exchange

The functional and presentational currencies of the Foundation Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.
The Foundation Trust does not have any assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

1.24 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 45) to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 42 is compiled directly from the losses and compensations register which is prepared on an accrual basis with the exception of provisions for any future losses.

1.26 Financial Instruments – Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets are classified into the following categories: financial assets at amortised cost, financial assets at fair value through other income and expenditure. The classification is determined by the cash flow and business model characteristics of the financial assets, as set out in IFRS 9, and is determined at the time of initial recognition.
Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.

De-Recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are classified into the following categories:

- Financial assets at fair value through income and expenditure;
- Loans and receivables;
- Available for sale financial assets.

Financial liabilities are classified as:

- Fair value through income and expenditure, or as
- Other financial liabilities.

Financial Assets at Amortised Cost

Financial assets measured at amortised cost are those held within a business model whose objective is to hold financial assets in order to collect contractual cash flow and where the cash flows are solely payments of principal and interest. This includes most trade receivables, loans receivable, and other simple debt instruments.
After initial recognition, these financial assets are measured at amortised cost using the effective interest method, less any impairment. The effective interest rate is the rate that exactly discounts estimated future cash receipts through the life of the financial asset to the gross carrying amount of the financial asset.

Financial Assets and Financial Liabilities at Fair Value through Income and Expenditure

Financial assets and financial liabilities at "fair value through income and expenditure" are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related" to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities. These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains and losses in the Statement of Comprehensive Income.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.
The Foundation Trust's loans and receivables comprise of, cash and cash equivalents, NHS debtors, accrued income and "other receivables".
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments/ receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.
Interest on loans and receivables is calculated using the effective interest method and charged/credited to the Statement of Comprehensive Income.
The carrying value of the loan presented in the financial statements includes both the loan principal and any interest accrual at the reporting date.

Available for Sale Financial Assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Foundation Trust intends to dispose of them within 12 months of the date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "Finance Costs" in the Statement of Comprehensive Income.

Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred and measured subsequently at amortised cost using the effective interest method, except for loans from DHSC, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

The Foundation Trust has reviewed all its main contracts and any derivatives the contracts many have with other contracts are 'closely-related' and therefore, does not warrant separate accounting or disclosure.

Determination of Fair Value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from using a number of appropriate techniques including quoted market prices, independent professional appraisals, discounted cash flow analysis, and previous trends and experiences.

Impairment of Financial Assets

The Trust adopts the simplified approach to impairment, in accordance with IFRS 9, and measures the loss allowance for trade receivables, contract assets and lease receivables at an amount equal to lifetime expected credit losses. For other financial assets, the loss allowance is measured at an amount equal to lifetime expected credit losses if the credit risk on the financial instrument has increased significantly since initial recognition and otherwise at an amount equal to 12 month expected credit losses.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

The Foundation Trust has reviewed its income receivable from the injury recovery unit on an annual basis taking into account local trends of recovery and appropriate top up provision has been made for irrecoverable debtors (25%), this is over and above the proposed bad debt provision of 21.89% recommended by the DHSC.

In line with policy, the Foundation Trust has undertaken a review of all outstanding debts and suitable provisions are recognised within these statements for bad and doubtful debts.

1.27 Transfers of Functions to / from Other NHS Bodies / Local Government Bodies

For functions that have been transferred to the Foundation Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.28 Accounting Standards, Amendments and Interpretations that have been Adopted Early

No new accounting standards or revisions to existing standards have been adopted early in 2018/19.

1.29 Accounting Standards that have been Issued but have not yet been Adopted

The HM Treasury FReM / DHSC GAM does not require the following Standards and Interpretations to be applied in 2018/19. The application of the Standards below as revised is not expected to have a material impact on the accounts for 2018/19 were they applied in that year.

IFRS 14

Regulatory Deferral Accounts
Not applicable to DHSC group bodies

IFRS 16

Leases
Expected to be effective from 2020/21.

IFRS 17

Insurance Contracts
Expected to be effective from 2021/22.

IFRS 23

Uncertainty over Income tax Treatments
Effective from 2019/20

Note 2 Operating Segments

The NHS Foundation Trust's major activity is healthcare and therefore is treated as a single segment. The operating results of the Foundation Trust are reviewed monthly by the Foundation Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes non-executive directors. For 2018/19, the Board of Directors reviewed the financial position of the Foundation Trust as a whole in their decision making process. The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		**Total**	
	2018/19	2017/18	**2018/19**	2017/18
	£000	£000	**£000**	£000
Income	**352,418**	346,498	**352,418**	346,498
Deficit before impairments and Restructuring	**58,764**	33,097	**58,764**	33,097
Restructuring costs	**(302)**	1,088	**(302)**	1,088
Impairment reversals relating to market value changes included in expenses	**569**	3,136	**569**	3,136
Impairments relating to market value changes charged to expenses	**(1,961)**	(285)	**(1,961)**	(285)
Retained Deficit	**57,070**	37,036	**57,070**	37,036
Segment net assets	**(32,264)**	27,907	**(32,264)**	27,907

2.1 Income Generation Activities

The Foundation Trust undertakes certain activities with an aim of break even or achieving a small profit, which is then used to support patient care. Some of these activities are essential for providing the right level of service to patients and visitors and the profit element, if any, is incidental to the service provision. The following table provides details of activities for which gross income exceeded £1m.

i) Car Parking Services

	2018/19	2017/18
	£000	£000
Income	**2,179**	2,058
Direct costs	**(881)**	(874)
Surplus before indirect costs	**1,298**	1,184
Indirect Costs	**(855)**	(837)
Surplus	**443**	347

Car parking services is a managed service operated by ISS Mediclean. The income is received by the Foundation Trust and is accounted for gross within the financial statements.

ii) Staff Accommodation

Staff accommodation amounted to £1.39m (£1.10m 2017/18) during the year. However, the costs associated with the income generation form part of the costs of the total provision of accommodation and property rental.

Note 3 Operating Income from Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.1.1

Note 3.1 Income from Patient Care Activities (by nature)

	Group		
	2018/19		**2017/18**
	£000		**£000**
Elective income	43,719		41,056
Non elective income	86,418		72,858
First outpatient income	18,237		18,168
Follow up outpatient income	20,676		20,755
A & E income	18,593		16,455
High cost drugs income from commissioners (excluding pass-through costs)	25,414		26,653
Other NHS clinical income *	97,132		108,420
Income from other sources (e.g. local authorities)	-		665
Private patient income	1,088		1,008
Agenda for Change pay award central funding	4,121		-
Other clinical income	1,124		1,733
Total income from activities	**316,522**		**307,771**

* Other NHS clinical income includes income from non-tariff services relating to activity such as Pathology, Radiology, Imaging, Therapy, Community,etc.

Note 3.2 Income from Patient Care Activities (by source)

	Group		
	2018/19		2017/18
Income from patient care activities received from:	**£000**		**£000**
NHS England	24,673		23,786
Clinical Commissioning Groups	283,263		264,013
Department of Health and Social Care	4,121		-
Other NHS providers	688		15,761
NHS other	-		23
Local Authorities	-		1,447
Non-NHS: private patients	882		1,008
Non-NHS: overseas patients (chargeable to patient)	206		154
Injury cost recovery scheme *	1,124		912
Non NHS: other	1,565		667
Total income from activities	**316,522**		**307,771**
Of which:			
Related to continuing operations	316,522		307,771

* Injury cost recovery income is subject to a provision for impairment of receivables of 25%, which is 3.11% (2.16% 2017/18) more than the recommended DHSC rate, to reflect expected rates of collection based on historical trend

Note 3.3 Overseas Visitors (relating to patients charged directly by the provider)

	Group		
	2018/19		2017/18
	£000		£000
Income recognised this year	206		154
Cash payments received in-year	145		46
Amounts written off in-year	7		6

The remaining balance in each year is accounted for across accounts receivable and allowance for doubtful debt.

Note 4 Other Operating Income

Research and development (contract)	645		660
Education and training (excluding notional apprenticeship levy income)	10,822		9,455
Non-patient care services to other bodies *	17,253		20,285
Provider sustainability / sustainability and transformation fund income (PSF / STF)	2,331		2,286
Other contract income **	4,495		3,758
Education and training - notional income from apprenticeship fund	741		199
Receipt of capital grants and donations	1,238		281
Charitable fund incoming resources	702		1,803
Of which:			
Related to continuing operations	38,227		38,727

* Non Patient Care Services to other bodies *includes* £10.34m (£10.4m 2017/18) income from United Lincolnshire Hospitals NHS Trust for Pathology services, £1.8m (£2.0m 2017/18) from other providers for Pathology Services, and £4.10m (£5.0m 2017/18) relates to other provider to provider agreements.
** Other income includes £2.18m (£2.06m 2017/18) for car parking, £0.03m (£0.02m 2017/18) for catering and £1.39m (£1.10m 2017/18) for staff accommodation.

Note 4.1 Additional Information on Contract Revenue (IFRS 15) Recognised in the Period

		2018/19
		£000
Revenue recognised in the reporting period that was included within contract liabilities at the previous period end.		177

Note 4.2 Income from Activities arising from Commissioner Requested Services

Under the terms of its provider licence, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group		
	2018/19		2017/18
	£000		£000
Income from services designated as commissioner requested services	306,045		297,570
Income from services not designated as commissioner requested services	10,477		10,201
Total	**316,522**		**307,771**

Note 4.3 Profits and Losses on Disposal of Property, Plant and Equipment

	Group		
	2018/19		2017/18
	£000		£000
Gains on disposal of land and buildings	-		7
Gains on disposal of other property plant and equipment	10		57
Losses on disposal of land and buildings	-		(108)
Losses on disposal of other property plant and equipment	(49)		(18)
Total losses on disposal of assets	**(39)**		**(62)**

Note 5 Operating Expenses

	Group		
	2018/19		2017/18
	£000		£000
Purchase of healthcare from NHS and DHSC bodies	4,982		5,486
Purchase of healthcare from non-NHS and non-DHSC bodies	7,101		5,577
Staff and executive directors costs	269,822		256,120
Remuneration of non-executive directors	132		134
Supplies and services - clinical (excluding drugs costs)	33,508		31,465
Supplies and services - general	4,675		4,504
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	33,154		32,287
Consultancy costs	2,640		3,231
Establishment	3,175		2,888
Premises	17,253		15,038
Transport (including patient travel)	2,876		2,850
Depreciation on property, plant and equipment	6,844		6,682
Amortisation on intangible assets	381		395
Net impairments	1,392		(2,851)
Movement in credit loss allowance: contract receivables / contract assets	61		-
Movement in credit loss allowance: all other receivables and investments	-		(26)
Decrease in other provisions	-		(1,361)
Audit fees payable to the external auditor			
audit services- statutory audit	72		54
other auditors' remuneration (external auditor only)	30		9
Internal audit costs	71		119
Clinical negligence	14,084		13,038
Legal fees	500		502
Insurance	365		370
Research and development	538		481
Education and training	2,046		1,408
Rentals under operating leases	362		331
Early retirements	126		95
Redundancy	302		-
Hospitality	66		48
Losses, ex gratia & special payments	22		29
Other NHS charitable fund resources expended	1,256		314
Other	657		902
Total	**408,493**		**380,119**
Of which:			
Related to continuing operations	408,493		380,119
Related to discontinued operations	-		-

Note 5.1 Other Auditors' Remuneration

	Group		
	2018/19		2017/18
	£000		£000
Other auditors' remuneration paid to the external auditor:			
1. Audit of accounts of any associate of the trust	-		-
2. Audit-related assurance services *	10		9
3. Taxation compliance services	-		-
4. All taxation advisory services not falling within item 3 above	-		-
5. Internal audit services	-		-
6. All assurance services not falling within items 1 to 5	-		-
7. Corporate finance transaction services not falling within items 1 to 6 above	-		-
8. Other non-audit services not falling within items 2 to 7 above	20		-
Total	**30**		**9**

* Audit-related assurance services is the audit of the Trust Quality Accounts.

Note 5.2 Limitation on Auditors' Liability

The limitation on auditors' liability for external audit work is £1m (2017/18: £1m).

Note 6 Impairment of Assets

	Group		
	2018/19		2017/18
	£000		£000
Net impairments charged to operating surplus / deficit resulting from:			
Changes in market price	(569)		(3,136)
Other	1,961		285
Total net impairments charged to operating surplus / deficit	**1,392**		**(2,851)**
Impairments charged to the revaluation reserve	2,197		763
Total net impairments	**3,589**		**(2,088)**

Note 7 Employee Benefits

	Group		
	2018/19		2017/18
	Total £000		Total £000
Salaries and wages	203,543		188,996
Social security costs	20,346		19,435
Apprenticeship levy	1,057		999
Employer's contributions to NHS pensions	22,622		21,458
Temporary staff (including agency)	23,366		26,247
Total gross staff costs	**270,934**		**257,135**

Note 7.1 Retirements due to Ill-Health

During 2018/19 there were 3 early retirements from the trust agreed on the grounds of ill-health (6 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £233k (£206k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' Remuneration

The aggregate amounts payable to Directors were:

	Group		
	2018/19		2017/18
	Total		Total
	£000		£000
Salary	1,627		1,466
Employer's National Insurance	206		183
Employer's pension contributions	167		139
Total	**2,000**		**1,788**

Note 7.3 Management Costs

	Group		
	2018/19		2017/18
	Total		Total
	£000		£000
Management Costs	**18,047**		16,769
Income	**352,496**		345,504
Management Costs as a % of income	**5.12%**		4.85%

The above is excluding Charitable income and costs.

Note 8 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it was a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”.

An outline of these follows:

a) Accounting Valuation
A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2017, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full Actuarial (funding) Valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating Leases

Note 9.1 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs renewable on an annual basis. These are operating leases and the rental from these leases is recognised on a straight line basis within these financial statements

Note 9.2 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessee

This note discloses costs and commitments incurred in operating lease arrangements where Northern Lincolnshire and Goole NHS Foundation Trust is the lessee.

	Group		
	2018/19		2017/18
	£000		£000
Operating lease expense			
Minimum lease payments	362		331
Total	**362**		**331**
	31 March 2019		**31 March 2018**
	£000		**£000**
Future minimum lease payments due:			
- not later than one year;	1,346		1,403
- later than one year and not later than five years;	1,137		1,158
- later than five years.	-		-
Total	**2,483**		**2,561**
Future minimum sublease payments to be received	-		-

The balance of the lease payments is expended through expenditure with the remaining balance through an employee salary sacrifice and deduction scheme.

Note 10 Finance Income

Finance income represents interest received on assets and investments in the period.

	Group		
	2018/19		2017/18
	£000		£000
Interest on bank accounts	140		46
NHS charitable fund investment income	79		75
Total finance income	**219**		**121**

Note 11 Finance Expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group		
	2018/19		2017/18
	£000		£000
Interest expense:			
Loans from the Department of Health and Social Care	5,633		2,886
Finance leases	1		7
Other interest payable (including interest on late payment of commercial debt)	5		-
Total interest expense	**5,639**		**2,893**
Unwinding of discount on provisions	14		5
Other finance costs	10		-
Total finance costs	**5,663**		**2,898**

Note 11.1 The Late Payment of Commercial Debts (interest) Act 1998 / Public Contract Regulations 2015

	Group		
	2018/19		2017/18
	£000		£000
Amounts included within interest payable arising from claims made under this legislation	(5)		-

Note 11.2 Gains / (Losses) on Disposal of Non Current Assets

	Group		
	2018/19		2017/18
	£000		£000
Gains on disposal of assets	10		64
Losses on disposal of assets	(49)		(126)
Total losses on disposal of assets	**(39)**		**(62)**
Fair value gains / (losses) on charitable fund investments & investment properties	91		(54)
Total other gains / (losses)	**52**		**(116)**

Note 12 Revaluation of Assets (property, plant and equipment) Cushman & Wakefield Valuations Summary

	Group		
	2018/19		2017/18
	£000		£000
Impairments			
Impairments charged to Revaluation Reserve	(2,197)		(763)
Impairments charged to Statement of Comprehensive Income	(1,961)		(285)
Total Impairments due to Market Changes	**(4,158)**		**(1,048)**
	Group		
	2018/19		2017/18
Revaluation gains	**£000**		**£000**
Revaluation gains credited to Revaluation Reserve	1,131		5,973
Revaluation gains relating to previous impairments credited to Statement of Comprehensive income	569		3,136
Total Revaluation gains due to Market Changes	**1,700**		**9,109**

Note 13 Corporation Tax expense

	2018/19		2017/18
	£000		£000
UK corporation tax expense	4		30
Adjustments in respect of prior years	-		-
Current tax expense	**4**		**30**
Origination and reversal of temporary differences	-		-
Adjustments in respect of prior years	-		-
Change in tax rate	-		-
Deferred tax expense	**-**		**-**
Total income tax expense in Statement of Comprehensive Income	**4**		**30**
Reconciliation of effective tax charge			
Effective tax charge percentage	19%		20%
Effect of:			
Surpluses not subject to tax	-		-
Non-deductible expenses	-		-
Adjustments in respect of prior years	-		-
Share of results of joint ventures and associates	-		-
Change in tax rate	-		-
Other	4		30
Total income tax charge for the year	**4**		**30**

Note 14 Surplus/(deficit) on discontinued operations and the gain/(loss) on disposal of discontinued operations

	2018/19		2017/18
	£000		£000
Operating income of discontinued operations	-		-
Operating expenses of discontinued operations	-		-
Gain on disposal of discontinued operations	-		-
(Loss) on disposal of discontinued operations	-		-
Corporation tax expense attributable to discontinued operations	-		-
Total	**-**		**-**

Note 15 Intangible Assets

Note 15.1 Intangible Assets - 2018/19

Group	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**6,533**	**6,533**
Additions	317	**317**
Valuation / gross cost at 31 March 2019	**6,850**	**6,850**
Amortisation at 1 April 2018 - brought forward	**5,684**	**5,684**
Provided during the year	381	**381**
Amortisation at 31 March 2019	**6,065**	**6,065**
Net book value at 31 March 2019	**785**	**785**
Net book value at 31 March 2018	**849**	**849**

Note 15.2 Intangible Assets - 2017/18

Group	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**6,245**	**6,245**
Additions	379	**379**
Disposals / derecognition	(91)	**(91)**
Valuation / gross cost at 31 March 2018	**6,533**	**6,533**
Amortisation at 1 April 2017 - as previously stated	**5,380**	**5,380**
Provided during the year	395	**395**
Disposals / derecognition	(91)	**(91)**
Amortisation at 31 March 2018	**5,684**	**5,684**
Net book value at 31 March 2018	**849**	**849**
Net book value at 31 March 2017	**865**	**865**

Note 16 Property, Plant and Equipment

Note 16.1 Property, Plant and Equipment - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**9,994**	**145,073**	**3,468**	**7,636**	**40,757**	**138**	**10,505**	**794**	**218,365**
Additions	-	6,027	9,716	2,117	2,480	31	2,535	231	**23,137**
Impairments	(503)	(1,686)	(8)	-	-	-	-	-	**(2,197)**
Revaluations	830	264	37	-	-	-	-	-	**1,131**
Reclassifications	-	1,034	6,322	(7,508)	152	-	-	-	**-**
Disposals / derecognition	-	(79)	(889)	-	(2,970)	(27)	(112)	(28)	**(4,105)**
Valuation/gross cost at 31 March 2019	**10,321**	**150,633**	**18,646**	**2,245**	**40,419**	**142**	**12,928**	**997**	**236,331**
Accumulated depreciation at 1 April 2018 - brought forward	**688**	**14,561**	**1,019**	**-**	**34,384**	**116**	**7,630**	**688**	**59,086**
Provided during the year	-	3,048	314	-	2,328	13	1,094	47	**6,844**
Impairments	-	1,477	484	-	-	-	-	-	**1,961**
Reversals of impairments	-	(558)	(11)	-	-	-	-	-	**(569)**
Disposals / derecognition	-	(79)	(889)	-	(2,922)	(27)	(112)	(28)	**(4,057)**
Accumulated depreciation at 31 March 2019	**688**	**18,449**	**917**	**-**	**33,790**	**102**	**8,612**	**707**	**63,265**
Net book value at 31 March 2019	**9,633**	**132,184**	**17,729**	**2,245**	**6,629**	**40**	**4,316**	**290**	**173,066**
Net book value at 31 March 2018	**9,306**	**130,512**	**2,449**	**7,636**	**6,373**	**22**	**2,875**	**106**	**159,279**

Note 16.2 Property, Plant and Equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**9,934**	**136,876**	**3,523**	**1,162**	**41,872**	**138**	**10,520**	**803**	**204,828**
Additions	-	2,671	376	6,668	1,922	-	527	5	**12,169**
Impairments	(501)	-	(262)	-	-	-	-	-	**(763)**
Revaluations	630	5,337	6	-	-	-	-	-	**5,973**
Reclassifications	-	189	5	(194)	-	-	-	-	**-**
Disposals / derecognition	(69)	-	(180)	-	(3,037)	-	(542)	(14)	**(3,842)**
Valuation/gross cost at 31 March 2018	**9,994**	**145,073**	**3,468**	**7,636**	**40,757**	**138**	**10,505**	**794**	**218,365**
Accumulated depreciation at 1 April 2017 - as previously stated	**598**	**14,901**	**676**	**-**	**34,834**	**103**	**7,092**	**649**	**58,853**
Provided during the year	-	2,714	253	-	2,569	13	1,080	53	**6,682**
Impairments	91	81	113	-	-	-	-	-	**285**
Reversals of impairments	(1)	(3,135)	-	-	-	-	-	-	**(3,136)**
Disposals / derecognition	-	-	(23)	-	(3,019)	-	(542)	(14)	**(3,598)**
Accumulated depreciation at 31 March 2018	**688**	**14,561**	**1,019**	**-**	**34,384**	**116**	**7,630**	**688**	**59,086**
Net book value at 31 March 2018	**9,306**	**130,512**	**2,449**	**7,636**	**6,373**	**22**	**2,875**	**106**	**159,279**
Net book value at 31 March 2017	**9,336**	**121,975**	**2,847**	**1,162**	**7,038**	**35**	**3,428**	**154**	**145,975**

Note 16.3 Property, Plant and Equipment Financing - 2018/19

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019									
Owned - purchased	9,633	129,340	17,729	2,212	6,128	40	4,309	290	**169,681**
Finance leased	-	-	-	-	31	-	-	-	**31**
Owned - donated	-	2,844	-	33	470	-	7	-	**3,354**
NBV total at 31 March 2019	**9,633**	**132,184**	**17,729**	**2,245**	**6,629**	**40**	**4,316**	**290**	**173,066**

Note 16.4 Property, Plant and Equipment Financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	9,306	127,687	2,449	7,636	5,821	22	2,861	106	**155,888**
Finance leased	-	-	-	-	54	-	-	-	**54**
Owned - donated	-	2,825	-	-	498	-	14	-	**3,337**
NBV total at 31 March 2018	**9,306**	**130,512**	**2,449**	**7,636**	**6,373**	**22**	**2,875**	**106**	**159,279**

Note 17 Donations of Property, Plant and Equipment

The Foundation Trust received Charitable contributions to support capital purchases as follows;

		2018/19		2017/18
		£000		£000
Buildings ex Dwellings		1,086		10
Plant and machinery		152		271
		1,238		**281**

Note 18 Revaluations of Property, Plant and Equipment

The NHS Foundation Trust's property have been revalued on a Modern Equivalent Asset basis. At the 31 March 2019, the Foundation Trust's Valuers, Cushmann & Wakefield completed a revaluation of the estate which resulted in a net valuation increase. The results of this valuation have been included in these financial statements.

The property asset lives are as stated in the revaluation by the Trust's Valuers.

Basis of Valuation

The valuations have been carried out primarily on the basis of Market Value Existing Use using the depreciated replacement cost (DRC) methodology on a modern substitute basis. Non-operational property, including surplus land, has been valued to Market Value Alternate Use.
Unless otherwise stated, the assumption has been made that the properties valued will continue to be in the occupation of the Foundation Trust for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

Method of Valuation

Depreciated Replacement Cost (DRC) is the method of valuation adopted for arriving at the value of specialised operational property for financial accounting purposes as recommended by UK GAAP, the Royal Institution of Chartered Surveyors and HM Treasury.

DRC is based on an estimate of the market value for the existing use of the land, plus the current gross replacement (reproduction) costs of the improvements, less allowances for physical deterioration and all relevant forms of obsolescence and optimisation.

Where the actual use of the property is so special that it proves impossible to categorise it in general market terms, land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site. In these circumstances, the Market Value for the Existing Use (MVEU) of the land has been arrived at having regard to the cost of purchasing a notional replacement site in the same locality that would be equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use.

Note 19 - Property Valuations Summary by Cushman & Wakefield

The NHS Foundation Trust Valuers (Cushman & Wakefield) completed a valuation of the Property Assets at 31 March 2019 and concluded that there were changes to the Value of Property Assets. The Foundation Trust identified that these changes are material and therefore, the results have been incorporated into these financial statements. The outcome from the valuation was that, on all three sites, some of the assets suffered revaluation gains whilst other assets had an impairment. The approximate net impact of the Foundation Trust's valuations are given below.

Site	Description	Net Change in Valuation (increase) Decrease	Charged to Expenses	Impairment Reversals Credited to Expenses	Changes to Revaluation Reserves
		£000	£000	£000	£000
Diana, Princess of Wales Hospital, Grimsby	Land and Buildings	1,588	1,802	(544)	330
Scunthorpe General Hospital	Land and Buildings	892	159	(11)	744
Goole District Hospital	Land and Buildings	(22)	-	(14)	(8)
	Total	**2,458**	**1,961**	**(569)**	**1,066**

All the above changes relate to properties in the Trust's main healthcare segment.

Note 20 Other Investments / financial assets

	Group		
	2018/19		2017/18
	£000		£000
Carrying value at 1 April - brought forward	**1,978**		**2,032**
Acquisitions in year	700		-
Movement in fair value through income and expenditure	91		(54)
Disposals	(1,012)		-
Carrying value at 31 March	**1,757**		**1,978**
	Group		
	31 March 2019		31 March 2018
	£000		£000
Carrying value at 1 April 2018	-		-
At start of year for new FTs	-		-
Share of profit	-		-
Carrying value at 31 March 2019	**-**		**-**

Note 21 Charitable Fund Reserves

The Northern Lincolnshire and Goole NHS Foundation Trust Board is the Corporate Trustee of the NHS Charitable Funds and therefore, the charitable funds represents a subsidiary of the Foundation Trust on the basis that it:

- has control over the NHS charitable fund (as determined by IRFS 10) and
- benefits from the NHS charitable fund.

From 2013/14 Northern Lincolnshire and Goole NHS Foundation Trust has consolidated the NHS charitable funds into its accounts.

For 2018/19, the NHS Charitable Funds balances are as follows:

	31 March 2019		31 March 2018
	£000		£000
Unrestricted funds:			
Unrestricted income funds	1,940		2,958
Restricted funds:			
Other restricted income funds	19		29
	1,959		**2,987**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Disclosure of Interests in Other Entities

The NHS Foundation Trust had entered into a cooperation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operated from Ward 4 at Goole District Hospital. The joint venture provided both NHS Care and care independent to the NHS but within an NHS location.

The joint venture ceased on 31st August 2017. The Trust included within its 2017/18 financial statements its share of the activities, assets, liabilities and any transactions relating to the termination of this agreement.

The NHS Foundation Trust owns 99% of a subsidiary company called WebV Solutions Limited, the remaining 1% is owned by Harrogate & District NHS Foundation Trust. The accounting year end for WebV Solutions Limited is 31 March. The registered office is, Diana, Princess of Wales Hospital, Scartho Road, Grimsby. This was established to provide innovative software solutions.

Note 23 Inventories

	Group			Trust		
	31 March 2019		31 March 2018	31 March 2019		31 March 2018
	£000		£000	£000		£000
Drugs	930		952	930		952
Consumables	1,693		1,482	1,693		1,482
Energy	12		15	12		15
Other	346		324	346		324
Total inventories	**2,981**		**2,773**	**2,981**		**2,773**

Inventories recognised in expenses for the year were £32,193k (2017/18: £30,817k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 24 Receivables

	Group			Trust		
	31 March 2019		31 March 2018	31 March 2019		31 March 2018
	£000		£000	£000		£000
Current						
Contract receivables*	20,134		-	20,008		-
Trade receivables*	-		11,219	-		11,132
Allowance for impaired contract receivables / assets*	(515)		-	(515)		-
Allowance for other impaired receivables	-		(610)	-		(610)
Prepayments (non-PFI)	2,932		2,744	2,926		2,742
PDC dividend receivable	-		199	-		199
VAT receivable	637		482	645		462
Other receivables	18		8,576	18		8,576
NHS charitable funds: trade and other receivables	86		39	-		-
Total current receivables	**23,292**		**22,649**	**23,082**		**22,501**

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 24.1 Allowances for Credit Losses - 2018/19

	Group				Trust			
	2018/19		2017/18		2018/19		2017/18	
	Contract receivables and contract assets		Contract receivables and contract assets		Contract receivables and contract assets		Contract receivables and contract assets	
	£000		£000		£000		£000	
Allowances as at 1 Apr 2018 - brought forward	**610**		**699**		**610**		**699**	
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	-		-		-		-	
New allowances arising	288		140		288		140	
Reversals of allowances	(227)		(63)		(227)		(63)	
Utilisation of allowances (write offs)	(156)		(166)		(156)		(166)	
Allowances as at 31 Mar 2019	**515**		**610**		**515**		**610**	

Note 25 Other Assets

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Current								
EU emissions trading scheme allowance	-		-		-		-	
Other assets	-		-		-		-	
Total other current assets	**-**		**-**		**-**		**-**	
Non-current								
Net defined benefit pension scheme asset	-		-		-		-	
Other assets	-		-		-		-	
Total other non-current assets	**-**		**-**		**-**		**-**	

Note 26 Other Financial Assets

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Non-current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	**-**	**-**	**-**	**-**
Current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 27 Non-current Assets for Sale and Assets in Disposal

At the Statement of Financial Position date the NHS Foundation Trust does not have any assets held for sale.

Note 28 Liabilities in Disposal Groups

	Group		Trust	
	31 March 2019	31 March 2018	31 March 2019	31 March 2018
	£000	£000	£000	£000
Categorised as:				
Provisions	-	-	-	-
Trade and other payables	-	-	-	-
Other	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 29 Cash and cash equivalents

Note 29.1 Cash and cash equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group				Trust			
	2018/19		2017/18		2018/19		2017/18	
	£000		£000		£000		£000	
At 1 April	**12,555**		**7,672**		**11,370**		**7,469**	
Net change in year	2,408		4,883		3,307		3,901	
At 31 March	**14,963**		**12,555**		**14,677**		**11,370**	
Broken down into:								
Cash at commercial banks and in hand	634		1,430		348		245	
Cash with the Government Banking Service	14,329		11,125		14,329		11,125	
Total cash and cash equivalents as in SoFP	**14,963**		**12,555**		**14,677**		**11,370**	
Total cash and cash equivalents as in SoCF	**14,963**		**12,555**		**14,677**		**11,370**	

Note 29.2 Third Party Assets Held by the Trust

Northern Lincolnshire and Goole NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust		
	31 March 2019		31 March 2018
	£000		£000
Bank balances	-		-
Monies on deposit	-		-
Total third party assets	**-**		**-**

Note 30 Trade and Other Payables

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Current								
Trade payables	23,208		20,689		23,161		19,350	
Capital payables	5,381		5,012		5,381		5,012	
Accruals	12,757		13,797		12,721		13,735	
Other taxes payable	6,137		5,692		6,137		5,692	
Accrued interest on loans*	-		908		-		908	
Other payables	3,505		2,664		3,505		3,968	
NHS charitable funds: trade and other payables	64		105		-		-	
Total current trade and other payables	**51,052**		**48,867**		**50,905**		**48,665**	
Non-current								
Total non-current trade and other payables	**-**		**-**		**-**		**-**	
Of which payables from NHS and DHSC group bodies:								
Current	5,804		6,203		5,714		6,203	
Non-current	-		-		-		-	

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note 8. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 30 Early Retirements in NHS Payables Above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2019		31 March 2019		31 March 2018		31 March 2018	
	£000		Number		£000		Number	
- number of cases involved	-		3		-		6	
- outstanding pension contributions	233		-		206		-	

Note 31 Other Liabilities

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Current								
Deferred income: contract liabilities	384		177		384		177	
Total other current liabilities	**384**		**177**		**384**		**177**	
Non-current								
Total other non-current liabilities	**-**		**-**		**-**		**-**	

Note 32 Borrowings

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Current								
Loans from DHSC	17,359		2,091		17,359		2,091	
Obligations under finance leases	11		55		11		55	
Total current borrowings	**17,370**		**2,146**		**17,370**		**2,146**	
Non-current								
Loans from DHSC	172,489		115,282		172,489		115,282	
Obligations under finance leases	15		-		15		-	
Total non-current borrowings	**172,504**		**115,282**		**172,504**		**115,282**	

Note 32.1 Reconciliation of Liabilities Arising from Financing Activities

	Loans from DHSC		Finance leases		Total
	£000		£000		£000
Carrying value at 1 April 2018	**117,373**		**55**		**117,428**
Cash movements:					
Financing cash flows - payments and receipts of principal	70,996		(55)		**70,941**
Financing cash flows - payments of interest	(5,062)		(1)		**(5,063)**
Non-cash movements:					
Impact of implementing IFRS 9 on 1 April 2018	908		-		**908**
Additions	-		26		**26**
Application of effective interest rate	5,633		1		**5,634**
Carrying value at 31 March 2019	**189,848**		**26**		**189,874**

Note 33 Other Financial Liabilities

			Group		Trust
			31 March 2019		31 March 2019
			£000		£000
Current					
Total current other financial liabilities			**-**		**-**
Non-current					
Total non-current other financial liabilities			**-**		**-**

Note 34 Finance Leases

Note 34.1 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessor

The Foundation Trust has arrangements with other NHS and non NHS bodies whereby the Foundation Trust receives income for the premises rented to these bodies. These arrangements are covered by annual service level agreements and are normally for a term of one year, renewable at the end of each year by mutual agreement. This income is included within this year's operating income shown in these financial statements. These arrangements are not classed as leases.

Note 34.2 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessee

Obligations under finance leases where Northern Lincolnshire and Goole NHS Foundation Trust is the lessee. The leases relate to medical equipment.There are no sub lease or contingent rents.

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Gross lease liabilities	**26**		**56**		**26**		**56**	
of which liabilities are due:								
- not later than one year;	11		56		11		56	
- later than one year and not later than five years;	15		-		15		-	
- later than five years.	-		-		-		-	
Finance charges allocated to future periods	-		(1)		-		(1)	
Net lease liabilities	**26**		**55**		**26**		**55**	
of which payable:								
- not later than one year;	11		55		11		55	
- later than one year and not later than five years;	15		-		15		-	
- later than five years.	-		-		-		-	
Total of future minimum sublease payments to be received at the reporting date	-		-		**-**		**-**	

Note 35 Provisions

Group	Pensions: early departure costs	Pensions: injury benefits*	Legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000	£000
At 1 April 2018	**2,199**	**2,899**	**133**	**168**	**305**	**5,704**
Arising during the year	126	38	118	191	300	**773**
Utilised during the year	(270)	(136)	(70)	(179)	(286)	**(941)**
Reversed unused	-	-	(64)	-	(19)	**(83)**
Unwinding of discount	6	8	-	-	-	**14**
At 31 March 2019	**2,061**	**2,809**	**117**	**180**	**300**	**5,467**
Expected timing of cash flows:						
- not later than one year;	269	135	117	180	300	**1,001**
- later than one year and not later than five years;	1,047	537	-	-	-	**1,584**
- later than five years.	745	2,137	-	-	-	**2,882**
Total	**2,061**	**2,809**	**117**	**180**	**300**	**5,467**

* In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions. The other provision is Carbon Reduction Commitment.

Note 35.1 Clinical Negligence Liabilities

At 31 March 2019, £139,763k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northern Lincolnshire and Goole NHS Foundation Trust (31 March 2018: £137,367k).

Note 36 Contingent Assets and Liabilities

	Group			Trust		
	31 March 2019		31 March 2018	31 March 2019		31 March 2018
	£000		£000	£000		£000
Value of contingent liabilities						
NHS Resolution legal claims	(65)		(98)	(65)		(98)
Gross value of contingent liabilities	**(65)**		**(98)**	**(65)**		**(98)**
Amounts recoverable against liabilities	-		-	-		-
Net value of contingent liabilities	**(65)**		**(98)**	**(65)**		**(98)**
Net value of contingent assets	**-**		**-**	**-**		**-**

Note 37 Contractual Capital Commitments

	Group				Trust			
	31 March 2019		31 March 2018		31 March 2019		31 March 2018	
	£000		£000		£000		£000	
Property, plant and equipment	1,945		10,069		1,945		10,069	
Total	**1,945**		**10,069**		**1,945**		**10,069**	

Note 38 Defined Benefit Pension Schemes

The Trust has no defined benefit pension schemes.

Note 39 On-SoFP PFI, LIFT or Other Service Concession Arrangements

The Foundation Trust does not have any PFI or LIFT schemes at 31 March 2019.

Note 40 Off-SoFP PFI, LIFT and Other Service Concession Arrangements

The NHS Foundation Trust does not have any Off-SOFP PFI or LIFT schemes at 31 March 2019.

Note 41 Financial Instruments

Note 41.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.
The Foundation Trust's treasury management operations are carried out by the Finance Directorate, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to regular review by the Finance and Performance Committee and the Trust's internal auditors.

Currency Risk
The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust currently has borrowings of £188.368m (£117.373m 2017/18), (excluding interest), the following table provides details of the interest rates, purpose of the loan and outstanding balance.

	Interest Rate		Balance at 31 March 2019
Loan - Purpose	**%**		**£000**
DoH Land	0.00%		-
Residential Accommodation DPoW	2.06%		6,489
Residential Accommodation DPoW Phase 2 *	1.19%		6,749
Energy Performance Contract	2.39%		7,040
Diagnostics Scanners	1.68%		300
Diagnostics Scanners *	1.68%		2,000
Water Tanks DPoW *	0.90%		231
Interim Revenue Support	1.50%		15,000
Interim Working Capital Support	3.50%		26,054
Uncommitted Interim Revenue Support	1.50%		13,646
Uncommitted Interim Revenue Support	6.00%		44,387
Uncommitted Interim Revenue Support *	3.50%		66,472
Total			**188,368**

* These facilities were drawn down in 2018/19.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers and investments held by the charitable fund as shown note 20, as disclosed in the Trade and other receivables note 24.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from internally generated funds and funds obtained from Department of Health or Independent Financing Facility loans. The Trust has in place Liquidity Support Funding agreed with the Department of Health and the Independent Financing Facility for short term working capital support. This gives the Trust liquidity assurance to cover the period prior to regulator approval of future plans and to manage normal variations in cashflow.

Note 41.2 Carrying Values of Financial Assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses

Group	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	19,547	-	-	**19,547**
Cash and cash equivalents	14,768	-	-	**14,768**
Consolidated NHS Charitable fund financial assets	2,038	-	-	**2,038**
Total at 31 March 2019	**36,353**	**-**	**-**	**36,353**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available -for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	18,507	-	-	-	**18,507**
Cash and cash equivalents	11,480	-	-	-	**11,480**
Consolidated NHS Charitable fund financial assets	39	3,053	-	-	**3,092**
Total at 31 March 2018	**30,026**	**3,053**	**-**	**-**	**33,079**

Trust	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
Carrying values of financial assets as at 31 March 2019 under IFRS 9	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	17,216	-	-	**17,216**
Cash and cash equivalents	14,677	-	-	**14,677**
Total at 31 March 2019	**31,893**	**-**	**-**	**31,893**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available -for-sale	Total book value
Carrying values of financial assets as at 31 March 2018 under IAS 39	**£000**	**£000**	**£000**	**£000**	**£000**
Trade and other receivables excluding non financial assets	18,507	-	-	-	**18,507**
Cash and cash equivalents	11,370	-	-	-	**11,370**
Total at 31 March 2018	**29,877**	**-**	**-**	**-**	**29,877**

Note 41.3 Carrying Values of Financial Liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Group Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	189,848	-	**189,848**
Obligations under finance leases	26	-	**26**
Trade and other payables excluding non financial liabilities	44,670	-	**44,670**
Provisions under contract	5,467	-	**5,467**
Total at 31 March 2019	**240,011**	**-**	**240,011**

Group Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	**£000**	**£000**
Loans from the Department of Health and Social Care	117,373	-	**117,373**
Obligations under finance leases	55	-	**55**
Trade and other payables excluding non financial liabilities	43,247	-	**43,247**
Provisions under contract	3,505	-	**3,505**
Consolidated NHS charitable fund financial liabilities	105	-	**105**
Total at 31 March 2018	**164,285**	**-**	**164,285**

Trust Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	189,848	-	**189,848**
Obligations under finance leases	26	-	**26**
Trade and other payables excluding non financial liabilities	44,691	-	**44,691**
Provisions under contract	5,467	-	**5,467**
Total at 31 March 2019	**240,032**	**-**	**240,032**

Trust Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	117,373	-	**117,373**
Obligations under finance leases	55	-	**55**
Trade and other payables excluding non financial liabilities	43,070	-	**43,070**
Other financial liabilities	177	-	**177**
Provisions under contract	3,505	-	**3,505**
Total at 31 March 2018	**164,180**	**-**	**164,180**

Note 41.4 Maturity of Financial Liabilities

	Group		Trust	
	31 March 2019 £000	31 March 2018 £000	31 March 2019 £000	31 March 2018 £000
In one year or less	63,040	46,237	63,061	46,132
In more than one year but not more than two years	88,097	15,156	88,097	15,156
In more than two years but not more than five years	74,353	92,337	74,353	92,337
In more than five years	14,521	10,555	14,521	10,555
Total	**240,011**	**164,285**	**240,032**	**164,180**

Note 42 Losses and Special Payments

	2018/19		2017/18	
Group and Trust	**Total number of cases**	**Total value of cases**	**Total number of cases**	**Total value of cases**
	Number	**£000**	**Number**	**£000**
Losses				
Cash losses	20	10	-	-
Bad debts and claims abandoned	546	153	542	69
Stores losses and damage to property	12	2	17	50
Total losses	**578**	**165**	**559**	**119**
Special payments				
Ex-gratia payments	38	22	25	25
Total special payments	**38**	**22**	**25**	**25**
Total losses and special payments	**616**	**187**	**584**	**144**
Compensation payments received		-		-

There were no cases exceeding £0.30m in the year and prior years.

Note 43 Events after the Reporting Date

There are no post balance sheet events in the reporting year.

Note 44 Related Parties

During the year none of the DHSC Ministers, NHS Foundation Trust Board Members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Lincolnshire and Goole NHS Foundation Trust. The DHSC is regarded as a related party. During the year, this NHS Foundation Trust has had a significant number of material transactions with other entities for which the DHSC is regarded as the parent department. These entities are: NHS England, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts and NHS Resolution. In addition, the NHS Foundation Trust has had a number of material transactions with other Government departments and other central and Local Government bodies. The NHS Foundation Trust has also received revenue and capital payments from a number of charitable funds. The trustees of the charitable funds are also members of the NHS Foundation Trust Board.

	2018/19	2018/19	31 March 2019	31 March 2019
	Income	**Expenditure**	**Receivables**	**Payables**
	£000	**£000**	**£000**	**£000**
Calderdale & Huddersfield NHS Foundation Trust	-	100	-	10
Care Quality Commission	-	242	-	-
Department of Health and Social Care	4,121	-	-	-

	2018/19	2018/19	31 March 2019	31 March 2019
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	116	271	94	115
East Riding of Yorkshire Council	-	265	-	-
Health Education England	10,687	-	43	-
Harrogate & District NHS Foundation Trust	147	18	101	-
Hull University Teaching Hospitals NHS Trust	2,091	2,183	1,653	1,544
Humber NHS Foundation Trust	58	(82)	49	1
Leeds Teaching Hospitals NHS Trust	7	472	2	254
Lincolnshire Community Health Services NHS Trust	958	1	262	-
Lincolnshire Partnership NHS Foundation Trust	120	-	-	2
NHS Bassetlaw CCG	151	-	32	-
NHS Blood & Transplant	-	1,671	-	149
NHS Bradford City CCG	45	-	1	-
NHS Bradford Districts CCG	184	-	51	-
NHS Doncaster CCG	885	1	29	1
NHS East Riding of Yorkshire CCG	16,217	1	181	95
NHS England	25,371	66	2,894	170
NHS Hull CCG	295	41	171	109
NHS Improvement	378	-	203	-
NHS Lincolnshire East CCG	30,843	-	902	207
NHS Lincolnshire West CCG	9,252	-	388	16
NHS North East Lincolnshire CCG	107,442	224	2,161	640
NHS North Lincolnshire CCG	112,576	15	3,589	592
NHS Pension Scheme	-	22,622	-	3,241
NHS Pension Scheme	-	22,622	-	3,241
NHS Property Services	-	661	-	594
NHS Resolution	-	14,352	-	-
NHS Scarborough & Ryedale CCG	52	-	-	-
NHS Sheffield CCG	142	-	-	-
NHS South Lincolnshire CCG	1,186	-	-	-
NHS South West Lincolnshire CCG	2,812	-	-	45

	2018/19	2018/19	31 March 2019	31 March 2019
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
NHS Vale of York CCG	991	-	-	-
NHS Wakefield CCG	126	-	-	-
North East Lincolnshire Council	710	1,040	37	-
North Lincolnshire Council	284	731	81	-
North Tees and Hartlepool NHS Foundation Trust	-	136	-	28
North West Anglia NHS Foundation Trust	24	218	5	53
Northumbria Healthcare NHS Foundation Trust	-	50	-	80
Nottingham University Hospitals NHS Foundation Trust	83	197	41	77
Portsmouth Hospitals NHS Trust	-	87	-	7
Public Health England	5	334	-	205
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	115	204	131	40
Sheffield Children's NHS Foundation Trust	52	255	5	110
Sheffield Teaching Hospitals NHS Foundation Trust	544	575	14	265
The Rotherham NHS Foundation Trust	2	136	-	75
United Lincolnshire Hospitals NHS Trust	10,503	1,002	62	91
University Hospitals Birmingham NHS Foundation Trust	-	169	-	54
University Hospitals of Leicester NHS Trust	113	53	48	11
York Hospitals NHS Foundation Trust	5	47	11	31
Other (Total)	1,835	309	703	145
Total Related Parties	**341,528**	**48,667**	**13,944**	**9,057**
HM Revenue and Customs (Taxes and Duties)	-	21,407	637	6,138
Other Government Departments	**-**	**21,407**	**637**	**6,138**
Comparatives 2017/18				
Total Related Parties	**331,998**	**45,699**	**11,219**	**8,268**
Other Government Departments	**-**	**20,464**	**482**	**5,692**

Note 45 Third Party Assets

The Trust held £791 (2017/18 £420) cash and cash equivalents which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

Chapter Six: The Quality Account

Part 1 - Statement on quality from the chief executive of the Northern Lincolnshire and Goole NHS Foundation Trust

In May 2018 Northern Lincolnshire & Goole NHS Foundation Trust (referred to as the Trust throughout this document) received a comprehensive inspection from the Care Quality Commission (CQC). The outcomes of this inspection resulted in our overall rating improving. Importantly for me, as Chief Executive, this demonstrated that the Trust is making progress on its improvement journey. I am pleased to say that the Trust has made clear improvements in its performance and delivery of high quality services. The Trust's Accident and Emergency teams have demonstrated real resilience despite incredible pressures from an increasing demand on emergency services. Community colleagues within the Trust have supported this with provision of different care models (outside hospital), like the 'virtual ward'. This is where more care is provided in patient's own homes and can support earlier discharge of patients from acute services and work to prevent admission to hospital.

Recognising the particular challenge faced in connection with patients on waiting lists, improved arrangements are now in place and are resulting in reduced numbers, with continuing effort to prioritise those who have waited the longest to make further improvements. Aligned to this is the significant work undertaken during the year to ensure that those patients waiting are assessed for evidence of clinical harm. This has now been built into the established waiting list management arrangements in place, whilst we resolutely continue to focus on reducing the numbers of those patients still further. Pressure ulcer incidence has decreased, infection prevention and control indicators demonstrate that hospital acquired infections remain low and the Trust's performance as measured by the Summary-Hospital Level Mortality Indicator (SHMI) has also improved throughout the year. The Trust has continued to focus on quality improvement through the ongoing delivery of its 'Improving Together' programme which is demonstrating further improvements with key projects that underpin clinically effective, safe care resulting in positive experiences.

This annual quality account is designed to outline the Trust's progress against a wide variety of indicators and to the best of my knowledge the information contained within this report is accurate. Whilst the Trust has made significant progress, there is still much to do. The work to maintain this progress and ambitiously pursue further improvements is underway. One particular area of focus is staff engagement. The most recent staff survey results from 2018 demonstrate some improvements, but demonstrate this is still a key area. During 2017 and 2018 significant investment into initiatives designed to listen to staff feedback and act on this have been made, with some good results. I am particularly proud of the Trust's Pride and Respect campaign, which has grown in strength during 2018, driven by the organisations workforce to provide our teams of staff with access to additional support where necessary. The Trust Board and I, continue to focus on effective communication and providing increased visibility to our teams. This has highlighted to us the incredible work achieved on a day to day basis. We remain determined to recognise these efforts and support our teams to get what they need to provide great care, supporting the Trust's ambition to get to good by consistently providing high quality care, with respect and in line with our common values.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading **Date:**25 March 2019

Executive summary of key points

Five Quality Priority Themes for 2018/19

The Trust set out five key quality priority themes for focus on within 2018/19, which were:

1. Safety – specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators.

2. Safe emergency care – specific focus on access to non-elective care and flow through our hospitals.

3. Safe planned care – specific focus on cancer care, 52 week waits and clinical harm reviews.

4. Safe maternity care.

5. Safe staffing and improved staff engagement.

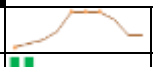
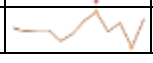
Understanding Trust performance against these themes has been based on a number of indicators that are reported on within the integrated performance report (or other internal reporting mechanisms) to the Trust's Board. Whilst the quality priority themes have remained the same, some of the indicators used to support understanding of performance against these themes may have changed or been refined during the 2018/19 year.

The executive summary outlines key performance against these quality priority themes. For a more detailed narrative and explanation of performance, see part 2.1 of this report. The Trust's quality priority themes for 2019/20 are also described within this executive summary, which demonstrate the continued focus on some of the work streams commenced during 2018/19 into next year. More detail is available in part 2.1

****HELP NOTES: How to interpret the summary of performance during 18/19:****
The reported performance that follows uses a summary table, which is designed to demonstrate, at a glance, performance during 18/19. To help the reader understand this, the following is designed to guide understanding of key points.

Performance against 2018/19 Quality Priority Themes

THEME 1: SAFETY – Specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators:

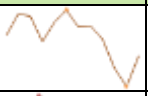
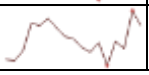
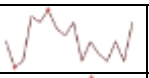
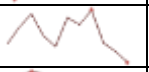
THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Jan-19				
1.1	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30	Work underway to assess Trust benchmarked position with NHSi support	Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local
		Oct 17 - Sep 18	Jul 17 - Jun 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	113	113		100	WORSE (117/131) Oct 17-Sep 18	National
	Position vs peers	Higher than expected R	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National
		Mar-19	Feb-19				
1.4	Falls per 1,000 bed days	Not yet available	3.89		TBD	No benchmark	TBC
	Falls: No harm	79 G	74		80	No benchmark	Local
	Falls: Minior harm	37 G	48		40	SAME (65/132) Q2, ST Falls with harm	Local
	Falls: Moderate harm	0 G	2		0		Local
	Falls: Major or catastrophic harm	1 R	0		0		Local
1.5	MRSA (Hospital acquired) (Year to date: 0)	0 G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0 G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3 R	6		52	No benchmark	National
1.6	Venous Thromboembolism (VTE) Screening rate (%)	93.70% R	91.40%		95%	AMBER (Safety Thermometer)	National

Key points

- Overall, during the latter half of 2018/19, improvement has been seen against the quality indicators used to measure this quality priority theme.
- **Pressure ulcer** incidence, within the Trust's acute hospitals has shown significant reductions during the 18/19 period. Work is underway with NHS Improvement to provide greater understanding of the Trust's performance against a benchmark. Whilst this is underway, the Trust has confirmed that it is not an outlier in terms of the number of pressure ulcers reported.
- **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording. Performance at present is static and further work is underway with wards to improve this area further. The Trust is aware that there are sometimes delays in entering patient observations onto the electronic system on wards, any delays from recording observations and entering these into the electronic system will adversely affect this indicators reported performance.

- **Mortality** performance has been measured during 18/19 using the national Summary-Hospital Level Mortality Indicator (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge, and the Hospital Standardised Mortality Ratio (HSMR). Both indicators are ratios that compare the actual number of deaths to a statistically calculated construct as to what would be expected. This construct is based on the quality of recorded and coded information. The Trust's performance against these indicators during 18/19 has shown improvement, with the 'official' SHMI indicator reducing and the HSMR reducing to demonstrate 'as expected' performance against the national average. The Trust has a strategy on reducing mortality that focusses on 3 specific areas: (1) medical model and improved access and flow around the Trust's hospitals, (2) recognition of the deteriorating patient (linked to the previous indicator assessing early warning scores recorded on time) and (3) learning lessons following retrospective review of deaths in our hospitals. The Trust's strategy closely aligns both Trust and community partners, recognising that these indicators are a reflection on healthcare systems performance, not just hospital provided care. For more information see part 2.1 of this report and later sections detailing mortality performance.
- **Falls** within the Trust have been decreasing as demonstrated by the trending over time.
- **Infection prevention and control indicators,** specifically the number of hospital acquired MRSA and *Clostridium Difficile* infections resulting from a lapse in clinical care, have demonstrated that systems in place are effective. The Trust has not had a Trust apportioned case of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 18/19 and demonstrated a higher than target number of infections. The Trust is working with community partners to reduce the number of patients being admitted to hospital from the community with GNBI aiming for a 50% reduction during 2019/20 in line with national aspirations.
- **Venous Thromboembolism (VTE)** is an indicator demonstrating the percentage of patients admitted who have documented evidence that their risks of acquiring VTE have been assessed, leading to preventative treatment. The Trust's performance during 18/19 has demonstrated improvement towards the 95% target, but performance during December and February has slipped. Work to ensure timely completion of the risk assessment document to evidence this is ongoing.

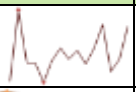
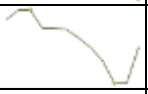
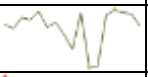
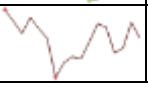
THEME 2: SAFE EMERGENCY CARE – Specific focus on access to non-elective care and flow through our hospitals

	THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals	Most recent data	Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19	Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - All (inc. Goole) (%)	83.8% A	79.8%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81 R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86 R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19	Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5 R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3% R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0% R	64.64%		>90%	No benchmark		Local

Key points

- The Trust's performance against the **A&E 4 hour target** has not yet achieved the 90% goal, performance should be considered in the context of a growing demand on the Trust's urgent and emergency care services. When comparing November 2018 to November 2017, the Trust saw, on average, 18 more patients per day. Trust performance has been ahead that of local peer Trusts and has been consistent with the England average. Work continues to improve access and flow processes throughout the Trust's acute hospitals to support the emergency department meeting increasing demands. The Trust's community services have been working closely with colleagues in the acute sector and local authority to support patient flow from hospital and to develop alternatives to admission, supporting patients in their own homes as an alternative to admission where it is safe to do so. They have successfully piloted a new working model, where the patient's own home is used for care delivery, resulting in a 'virtual ward'.
- Patients who have been in hospital for long lengths of stay are referred to as **super stranded**, if in a hospital bed for more than 21 days. NHS Improvement set a target for the trust to achieve 61 days length of stay working as part of its local system. Such long lengths of stay reduce the number of available beds, resulting in increased pressure to urgent and emergency services, which can lead to increased waiting times in A&E. These long lengths of stay also result in poor patient experience and deconditioning of the patient resulting in further support required to enable discharge. Trending data demonstrates reductions during 2018/19. Whilst not yet achieving the target, there have been reductions which support the wider hospitals ability to cope with increased demands.
- Following a switch in the systems used to record and track patient's **early warning score (NEWS)** being recorded on time, performance has seen significant improvement across the Trust. In urgent and emergency care, performance with this indicator has remained static. The Trust is reviewing this data at individual ward and department level and are developing location specific improvement plans. This will continue to feature as a quality priority during 2019/20.

THEME 3: SAFE PLANNED CARE – Specific focus on cancer care, 52 week waits and clinical harm reviews

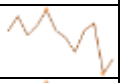
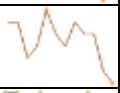
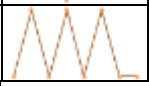
	THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9% R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6 A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551 G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0% G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7% G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6% R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

Key points

- The Trust has been focussed on delivering significant improvements against the **62 day GP referral to treatment for cancer** during 2018/19. Progress has been made and performance during the year has been improving as measured by this target. In recent months performance against the target has dropped below the trajectory set as there has been prioritisation of those waiting the longest amount of time. This work has reduced the number of patients waiting 62 days or more by 50% with a similar reduction for those waiting between 42-62 days. The Trust's main challenge for cancer pathways is access to diagnostics (endoscopy and CT scan). Both diagnostic areas have received significant funding to increase and renew medical equipment. This has resulted already in a new CT scanner on the DPoW site and the ongoing work to install an additional CT scanner at SGH which has also just become operational during early 2019. In endoscopy new equipment has been purchased which is enabling 7 day working with minimal operational downtime. These efforts will support further improvements against this target. See part 2.1 for more information.
- The **Maximum 6-week wait for diagnostic procedures** is not yet meeting the target set (>99%). This reflects the wider diagnostic challenges the Trust is facing, for which some investment has been successful in CT scanners and in endoscopy. There are still remaining challenges in meeting the demand for diagnostic investigations.
- **Patients on an incomplete referral to treatment (RTT) pathway waiting more than 52 weeks** has seen significant improvement during 2018/19 towards the Trust's quality aim of having zero patients waiting in excess of 52 weeks by the 31 March 2019. At the end of March, the Trust declared just 24 patients waiting more than 52 weeks, due to patient choice. See part 2.1 for further details.
- **Patients on an incomplete referral to treatment (RTT) to be less than the Trust's March 2018 reported figure** is a national target aiming to focus on reducing waiting lists across the NHS. The Trust's has demonstrated a reducing waiting list during the latter half of the 2018/19 financial year, which is ahead of the Trust's improvement trajectory set and is moving towards the performance of other local providers.

- At the end of 2017/18 it was a key priority for the Trust to establish and embed an effective process to integrate **clinical harm reviews** into the Trust's focus on waiting list improvement. This was initiated and overseen by an external clinical harm review group, chaired by the NHS England Medical Director for the North of England. The principle focus of this groups work was to establish a clinical harm review process for a snapshot of patients who at the 8 August 2017 had waited in excess of 40 weeks for treatment or who were more than 6 months after their due follow-up date, or who had waited more than 104 days on a cancer tracking pathway. The Trust has now assessed and seen all of these patients. Part 2.1 of this report outlines in greater detail the work undertaken to date and that ongoing around clinical harm reviews in conjunction with the aforementioned waiting list improvement initiatives.

THEME 4: SAFE MATERNITY CARE

THEME 4: SAFE MATERNITY CARE		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

Key points

- The **Ratio of midwives to births** data is currently unavailable as this is being validated against standard definitions to ensure accuracy of reporting.
- The Trust chose a priority indicator linked to the commencement of **cardiotocography (CTG)** to ensure that women who needed such investigations had no delays in accessing. This is a key form of monitoring used during pregnancy to monitor fetal well-being and to determine any indications where there is a need for more investigations. Performance has remained above 89% during 2018/19. Linked to this, **fresh eye reviews** are designed to reduce the risk of misinterpretation of a CTG trace. This was found to be effective in reducing the incidence of errors. The Trust has been focussed on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring, to reduce to the risk of errors and harm to women in the Trust's care. The Trust has maintained consistently high performance, exceeding 93% during 2018/19.

- The proportion of **still births** in the Trust is low and in line with the England average. Whilst public health and social factors affect the risk of still births, the Trust has been focussed on identifying the risk of still birth due to small for gestational age (SGA) and fetal growth restriction (FGR) in the use of **individualised growth charts.** The Trust uses the Perinatal Institute tool for this purpose and is performing above the UK average. Comparing this data with that of other UK centres shows that the Trust is proactively taking action to identify and act on the risk factors for still birth. See part 2.1 for more detailed information on this and the Trust's performance versus the UK average.

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE

	THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5% G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00% G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available	7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6% A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5% G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50% G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%	8.70%		TBD	No benchmark	
5.8	Mixed Sex Accomodation breaches	0 G	36		0	No benchmark	National
		Mar-19	Feb-19				
5.9	Friends and Family Test Results - A&E	75.2% R	73.00%		≥ 95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0% G	99.10%		≥ 95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0% G	100.00%		≥ 95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2% G	98.20%		≥ 95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative					
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative					
5.15	Staff engagement: Listening to Improve	See narrative					
		2018	2017				
5.16	NHS national staff survey - overall engagement	6.5 G	6.4		> 6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3% G	43.0%		> 43.0%	WORSE 62.6% (Average)	Local

Key points

- **Safer staffing fill rates** is a measure of the extent to which rota hours on ward areas are being filled by registered nurses and midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust and to provide reassurance to local people that wards are safely staffed. The trending data demonstrates an increased fill rate by registered nurses and midwives. Un-registered carer staff shows have also exceeded the target set following a targeted recruitment programme during the latter part of 2018 which has led to a decrease in carer vacancies across the Trust.

- During 2018/19 the Trust set a vacancy target of <6% for registered nurses and <2% for unregistered carer staff. **Registered nursing staff vacancy rates** during the year had been increasing, largely as a result of the Trust rebasing its establishment needs for ward areas (i.e. reviewing the demands on each ward and resetting the number of trained nurses needed on that location) so in effect deciding that more staff were needed, rather than this being solely in relation to nursing staff retention rates. During November 2018 the vacancy rates reduced significantly towards the target. This remains a key priority for the Trust and part 2.1 of this report provides further details as to the work underway to reduce nurse vacancy rates.
- **Medical staff vacancy rate** is another challenge for many Trusts in the NHS. At the beginning of 2018, the Trust set an improvement target to reduce the medical staff vacancy rate to less than 15%. This has been a significant priority for the Trust and a variety of improvements have been undertaken to maximise the Trust's appeal to doctors from other areas to successfully recruit more medical staff, as well as ongoing clinical engagement work to listen to the medical workforce and aid and improve retention rates. The Trust has also invested significantly in improving the experience of rotating junior medical staff, with the opening of a new £16.4 million accommodation complex, called The Roost, on the DPoW site.
- In February 2019 the Trust reduced its Medical vacancy rate to fewer than 14% and has maintained this trajectory to close the 2018/19 financial year and thus achieve the target set. This was supported by an above average junior doctor fill rate of 87% in August 2018 which was an improvement of 20% when compared with the previous year. A continued approach to reducing the Trust medical vacancy rate via innovative recruitment methods and meaningful engagement to aid retention, will be an ongoing priority for the Trust to ensure safe staffing. These local efforts have also been supported by the UK Government's lifting of the cap on staff from outside of the EU being able to apply to work in the UK on medical visas earlier during 2018. Included in part 2.1 of this report is an annual update on the work to manage medical staffing rota gaps.
- **Staff engagement, satisfaction and feedback** have been supported during 2018/19 as the Trust continued to focus on a number of work streams designed to improve engagement and support to staff within the organisation. Two specific pieces of work have been used, firstly Listening to Improve which has become a part of the much larger Pride and Respect – the Trust's anti-bullying campaign. Both of these work streams have focussed on listening to staff feedback and initiating actions in response to this feedback. These have resulted in a number of very positive outcomes, however, the Trust recognises that more time is needed to evaluate the outcomes from these programmes and is committed to focus on this as a long-term priority using the latest national staff survey results as a further catalyst for change and improvement. Part 2.1 of this report outlines in greater detail some of the staff engagement work being undertaken and more detail relating to the latest national staff survey findings and also an annual update on the Trust's Speaking Up arrangements.
- The Trust recognises too the importance of the **patient voice and listening to the feedback of patients and service users**. Whilst detailed in the at a glance is key performance against the Friends and Family Test, part 2.1 of this report also outlines greater detail about the work undertaken during 2018 to listen more acutely to patient feedback and some of the improvements made, as well as providing a summary of key feedback received. This section also includes an exciting update on improvements planned during 2019/20 to understand and act on this feedback even more comprehensively.

QUALITY PRIORITY THEMES 2019/20

The Trust has agreed 5 priority areas for the following year:

1) **Clinical Effectiveness: Mortality reduction:**
   a. Mortality case note review work by clinical staff, key performance indicators;
   b. Patients able to die in their preferred place of death (end of life quality indicator);
   c. Reduction in the Trust's Summary Hospital-Level Mortality Indicator (SHMI).

2) **Patient Safety: Improved management of the deteriorating patient:**
   a. Monitoring and action taken in response to National Early Warning Scores (NEWS);
   b. Compliance with the Sepsis Six care bundle;

3) **Patient Safety: Medication safety**
   a. Reduction in omitted doses;
   b. Reduction in incidents relating to insulin;

4) **Patient Experience: Improved patient flow:**
   a. Embedding the use of the SAFER bundle to improve flow;
   b. Seven day services – improved performance against the priority 4 standards;

5) **Patient Experience: Cancer pathways:**
   a. Increased availability of straight to test diagnostics for suspected cancers;
   b. Improved cancer pathways.

Setting quality priority themes for 2019/20

Reflecting on the Trust's performance against its quality priority themes set during 2018/19, the Trust's Acting Medical Director commenced a consultation exercise within the Trust that started during November 2018 to determine what the quality priorities for 2019/20 should be to continue the Trust's improvement journey.

As a result of this collaborative approach, the first draft contained a wide variety of priority topics. Following subsequent discussion with public and staff governors, who represent the public at the Quality Review Group, following discussion within the Trust with divisions at the Quality Governance Group and also the Non-executive Director chaired Quality and Safety Committee, with CCG representatives present, the Acting Medical Director has facilitated a gradually focussing lens, to ensure the Trust and the Board have clarity on the organisations priorities for quality improvement during 2019/20.

How progress will be monitored and measured

Performance against these quality priority themes will be monitored through the Trust's Integrated Performance Report by the Quality and Safety Committee for executive understanding of issues and oversight of actions necessary, the Performance Improvement Meetings, the Quality Governance Group and in terms of assurance, the Governors Quality Governance Group with reporting also directly to the Trust Board.

Part 2 - Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Priorities for improvement: overview of the quality of care against 2018/19 quality priorities & quality priorities planning for 2019/20

2.1a Theme 1: Safety – Specific Focus on Pressure Ulcers, Recognising the Deteriorating Patient and Mortality Indicators

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's safety indicators (including pressure ulcers, recognising the deteriorating patient and mortality indicators) have demonstrated positive progress against the quality indicators used to measure.

Specific focus on: Pressure Ulcers

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
1.1	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30	Work underway to assess Trust benchmarked position with NHSi support	Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local

- **Pressure ulcer** incidence within the Trust's acute hospitals has shown reductions during the 18/19 period, as demonstrated in the chart following (figure 1).

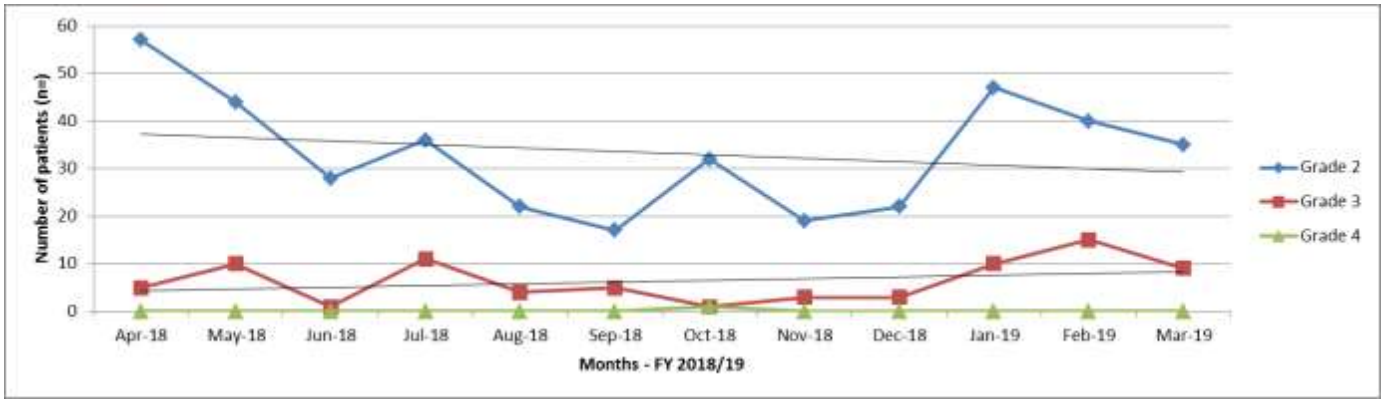
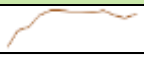


Figure 1: In hospital pressure ulcers during 2018/19

- Figure 1 details all reported acute pressure ulcers, recorded as incidents on the Trust's incident reporting system. The Trust has been working with NHS Improvement (NHSI) to determine comparator data relating to reported pressure ulcers to determine how the Trust compares. This work is still underway at the time of writing this report, but the Trust understands from NHSI that pressure ulcer reporting is not an outlier compared to other Trusts.
- Work to support further improvements in pressure ulcer prevention and management continues including more proactive support from Tissue Viability Nurses working alongside ward staff.

Specific focus on: Recognising the deteriorating patient

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local

- **Early Warning Scores recorded on time** has shown progress during the year, following the change in systems used to record this, from paper based to electronic recording. The benefits of electronic recording are that performance against this indicator measures all admitted patients, not a sample. This information is reported at ward level within a deteriorating patient scorecard, to support wards assess their performance against this indicator in order to support localised improvement plans. The Trust is aware that there are still some data quality issues including some delays in entering details of patient observations onto the electronic system and inconsistent recording of criteria that mean NEWS observations are not appropriate (i.e. end of life care). Any such delays or inconsistencies in entering these into the electronic system will adversely affect this indicators reported performance.

- Using this data, the Trust has identified there are some differences between performance across the Trust's hospital sites. With this data being reported at ward level and provided to individual ward managers and matrons in the deteriorating patient scorecard, this provides localised development and tracking of improvement initiatives. The Deteriorating Patient Group oversees this data and the improvement plan, so that ward specific support is more targeted to areas where performance is below certain thresholds. This group is also looking at data quality issues, IT and equipment problems as well as training needs for clinical staff.

- Focus on this indicator will continue during 2019/20 as this will remain as one of the Trust's 5 quality priorities and will expand to include a focus on the action taken as a result of NEWS observations and monitoring.

- Included in the 19/20 quality priorities is also sepsis pathway adherence. During 18/19 the Trust monitored performance with sepsis by sampling patients admitted or already in hospital with sepsis on a regular basis, using the national CQUIN (Commissioning for Quality and Innovation) indicator. During November 2018, the Trust incorporated within its electronic ward based system, alongside NEWS, an electronic screening tool for sepsis. From this, the Trust is working towards further ward level reporting of performance for all patients. To embed this, during 19/20, this is listed as a distinct quality priority alongside taking appropriate action in response to both NEWS and sepsis.

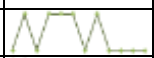
- The Trust recognises the impact of sepsis on patient outcomes, and this focus is aimed at improving outcomes for our patients.

Specific focus on: Mortality Indicators

	THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Oct 17 - Sep 18	Jul 17 - Jun 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	113	113		100	WORSE (117/131) Oct 17-Sep 18	National
	Position vs peers	Higher than expected R	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National

- **Mortality** performance has been measured during 18/19 using the Summary-Hospital Level Mortality Indicator (SHMI), which includes deaths within the hospital and those within 30 days following hospital discharge, and the Hospital Standardised Mortality Ratio (HSMR). These are both commonly referred to as Standardised Mortality Ratios (SMR).
- Both indicators are ratios that compare the actual number of deaths to a statistically calculated construct as to what would be expected. This construct is based on the quality of recorded and coded information. (It is important to note that national guidance makes clear that these indicators are not to be confused with measures of service quality). The Trust's performance against these indicators during 18/19 has shown some improvement with the 'official' SHMI indicator reducing and the HSMR also showing positive signs of reduction. The Trust's most recent data demonstrates the SHMI as being 'as expected'.
- The Trust also monitors crude mortality (the simple arithmetic ratio comparing number of deaths to the number of admissions) and has seen an improvement on last year. The crude number of deaths for January – December 2018 reduce to 1.43%, from 1.58% (January – December 2017) which is lower than the local peer group (1.52%) the Trust benchmarks performance against.
- For more detailed information regarding the Trust's work on reducing mortality, please refer to part 2.2i.
- Other aspects of the Trust's focus on mortality has been by assessing cardiac arrest rates which are reported at ward level as part of the ward owned deteriorating patient scorecards. This will feature more within the work of the Trust's Mortality Improvement Group.

Specific focus on: Gram Negative Blood Stream Infections (GNBI)

	THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Jan-19				
1.5	MRSA (Hospital acquired) (Year to date: 0)	0 G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0 G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3 R	6		52	No benchmark	National

- **Infection prevention and control indicators,** specifically the number of hospital acquired MRSA, *Clostridium Difficile* infections resulting from a lapse in clinical care have demonstrated during 18/19 effective procedures in place to prevent and control hospital infections. The Trust has met its target of having no more than 20 *C. Difficile* cases resulting from a lapse in care. There has been zero Trust apportioned cases of MRSA in the last 18 months. Gram Negative Blood Stream Infections (GNBI) is a newly measured indicator during 18/19 and has demonstrated a higher than target number of infections.
- Gram Negative Blood Stream Infections (GNBI) are primarily made up of E. coli bacteraemia blood stream infections. The Secretary of State for Health has launched an ambition for healthcare associated blood stream infections to be reduced by 50% by 2021. The majority of such infections occur in the community, prior to a patient being admitted, therefore for any targeted reduction work to be successful; a whole health system approach is needed. During 2018/19 the Trust, along-with local Clinical Commissioning Groups (CCGs), local system partners and specialist teams including those providing continence and care for the elderly, worked together to develop a GNBI reduction plan. This plan has focussed on specific high prevalence areas such as diagnosis and treatment of urinary tract infections, the use of urinary catheters and options for reducing their use in practice when appropriate. This reduction plan is overseen by a Northern Lincolnshire Infection Prevention and Control Group which has been established by the CCG. This multi-agency group will continue work together on a joint approach to achieve a targeted reduction of GNBI in line with the 50% reduction target by 2021.

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 1 – Safety:

- The Trust has improved safety by reducing the number of hospital acquired pressure ulcers;
- The Trust has made safety improvements with the tracking and recording of early warning scores using an electronic system, and plan further improvements during 2019/20, as this will continue to feature as a quality priority;
- The Trust has maintained safety by having had zero MRSA infections, and only a small number of C Diff infections, caused by omissions in clinical practice;
- GNBI infections reported have been above the safety target being aimed for, however, a plan is in place with local health partners to target on patients with this infection in the community, prior to any hospital attendance;
- Screening for VTE has not yet achieved the safety target being aimed for, with an average of 93% of admitted patients having evidence of screening being completed. The Trust are working to improve safety further in this area, ensuring this is reported internally to the Trust Board for assurance that action is being taken.

Progress monitored, measured and reported: Progress with these indicators is monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality and Safety committee and the Trust Board. Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 2018/19 to aid understanding of Trust performance have either not been measured or changed, these include:

- Cardiac arrest indicators – as referred to within the focus on mortality section, these have been reported at ward level and will be used more as part of the Mortality Improvement Group's focus on mortality indices and learning from mortality reviews
- Appropriate clinical response taken in response to NEWS – as referred to within the focus on deteriorating patient section, during 2018/19 the focus has been to embed the use of electronic recording and monitoring of NEWS observations, now these systems are in place, the next phase of the Trust's improvement plan (and therefore a quality priority for 2019/20) will be appropriate action taken following NEWS observations
- Sepsis bundle compliance – as referred to within the focus on mortality section, the Trust has monitored performance against the Commissioning for Quality and Innovation (CQUIN) sepsis scheme, however, this does not provide full assurance as it does not assess all patients admitted neither does it focus on all elements of the sepsis pathway, therefore, this will feature as part of the 2019/20 quality priorities to be measured and reported on.

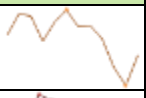
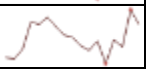
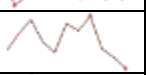
Relationship to 2019/20 Quality Improvement Priorities: The following 2018/19 indicators are to remain as quality priorities during 2019/20:

- NEWS – appropriate action taken in response,
- Mortality improvement,
- Sepsis six bundle compliance.

2.1b Theme 2: Safe Emergency Care – Specific focus on access to non-elective care and flow through our hospitals

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's safety indicators for emergency care have not yet met the performance being aimed for, however, on the whole, these demonstrate improvement over time.

Specific focus on access to non-elective care and flow through our hospitals

THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals		Most recent data		Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19		Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - All (inc. Goole) (%)	83.8%	A	79.8%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81	R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86	R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19		Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5	R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3%	R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0%	R	64.64%		>90%	No benchmark		Local

- The Trust's performance against the **A&E 4 hour target** has not yet achieved the 90% target aimed for. However, this performance should be considered in the context of growing demand on the Trust's urgent and emergency care services. When comparing November 2018 to November 2017, the Trust saw on average, 18 more patients per day. Urgent and emergency services in the Trust also came under increased pressure. Despite these challenges, the Trust's performance over time shows an improving trend. When compared nationally, the Trust's performance has been better than the national average, as demonstrated by the following chart, for the period up until January 2019:

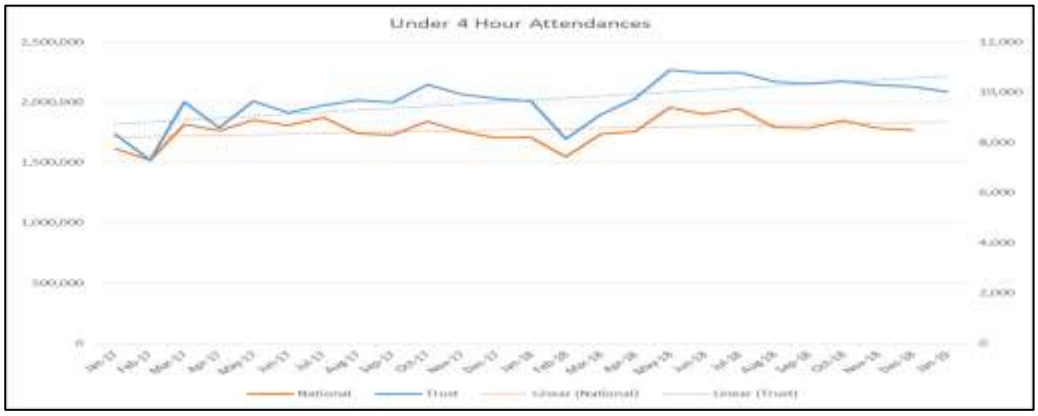


Figure 2: Trust A&E 4 hour target performance (blue line) contrasted against national performance (orange line) up until January 2019 (more recent national data not yet available at time of writing)

- Mitigation of these demands on the service have been planned through increased use of rapid assessments and triage, increased A&E consultant availability until midnight and increased senior nursing cover all shifts until 1am, as well as collaborative work to agree on and trial new multi-disciplinary assessment pathways aimed at improving flow.

- The Trust's community services have been working closely with colleagues in the acute sector and local authority to support patient flow from hospital and to develop alternatives to admission, supporting patients in their own homes as an alternative to admission where it is safe to do so. They have successfully piloted a new working model, where the patient's own home is used for care delivery, resulting in a 'virtual ward'.

- Another related quality indicator linked to flow through the Trust's hospitals is one focused on those patients who have been in hospital for long lengths of stay. This group of patients is referred to as **super stranded**, if in a hospital bed for more than 21 days. Such long lengths of stay reduce the number of available beds which results on increased pressure in urgent and emergency services, leading to increased waiting times in A&E. The Trust is actively working to reduce the numbers of super stranded patients. At present the target has not yet been met, but the trending chart below demonstrates significant reductions during 2018.

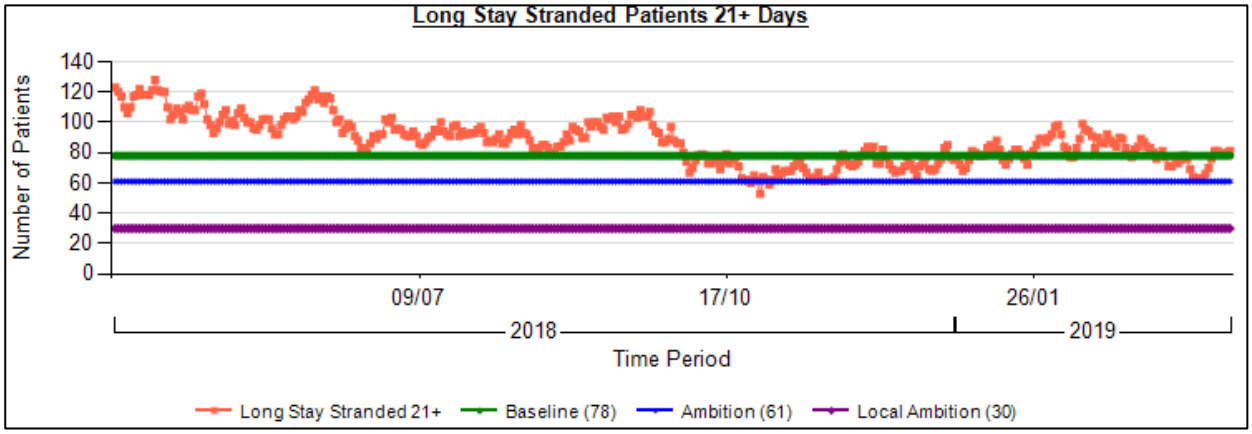


Figure 3: Statistically significant reduction during 2018/19 of the number of patients staying 21 or more days within the Trust's hospitals

- **Non-elective length of stay** is another indicator related to flow. These are not yet meeting the target set, but the trend in Medicine is reducing. A focus on improvements in these areas will mean that patients admitted, as a result of a range of interventions, are staying in hospital for less time, minimising the risk of a loss of independence through immobility for longer than necessary and associated risks of infection.

- These three quality indicators have provided the basis for a focus on access and flow through the Trust's hospital services. These are all elements that support the Trust's improvement journey and are elements of the **SAFER[1] care bundle**. This bundle contains other elements that are designed to support effective throughput, including accessing senior decision making sooner during the admission process, more senior clinician led ward and board rounds and implementation of related seven day service standards. During 2018, the Trust has engaged with an NHS Improvement collaborative project where two of the Trust's wards have worked to implement the SAFER care bundle, with another hospital in Leeds acting as a 'buddy' site for the two hospitals teams to share and learn best practice. The Trust is committed to spread and share this work to many more ward areas. This will be the focus of the 2019/20 quality priority around patient flow.

- **Other emergency department quality indicators** used by the Trust include the Emergency Department safety checklist which is a tool that acts as a reminder for staff to ensure the patients requiring clinical assessment via a 'majors' pathway, receive standardised treatment and care planning. This provides operational benefits, particularly for any staff new to the department, encourages flow through the department, and includes reminders for nutrition and hydration to be assessed. This document is filed within the patient's records to form part of their permanent medical record.

[1] SAFER Care Bundle consist of the following principles: **S**enior Review before midday, **A**ll patients have an expected date of discharge, **F**low of patients from assessment and admission units as early as possible, **E**arly Discharge before midday and **R**eview by MDT for patients with extended lengths of stay (>7 days).

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 1 – Safe Emergency Care:

- The Trust has performed better than the UK average during the bulk of the year in providing timely emergency treatment through its Emergency Departments, but aims to further improve;
- The number of patients who are in Trust hospital beds for long periods of time has shown positive reductions; this will continue to be a quality priority for 2019/20 and further improvements will be tracked.
- These indicators demonstrate the Trust is making positive progress with ensuring local patients, in a time of emergency, can access appropriate services to receive care and treatment in a timely manner.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality and Safety Committee and the Trust Board. Data from the use of the Emergency Department safety checklist is unable to be reported, as this supports operational care at the point of treatment. Outcome measures from implementation of elements of the SAFER bundle/Red to Green is reported, but further work during 2019/20 will provide further quality reporting with other elements of this bundle.

Relationship to 2019/20 Quality Improvement Priorities: The following 2018/19 indicators are to remain quality priorities during 2019/20 to continue the improvement trajectory:

- Compliance with NEWS and the Sepsis Six bundle,
- Access and Flow, linking to the SAFER care bundle.

2.1c Theme 3: Safe Planned Care – Specific focus on cancer care, 52 week waits and clinical harm reviews

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's performance with these indicators demonstrated positive progress. The Trust recognises there is more to do still, but recognises the improvement journey is underway. The 2019/20 quality priorities demonstrate the Trust's focus on improving key metrics still further.

Specific focus on cancer care, 52 week waits and clinical harm reviews

	THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9% R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6 A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551 G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0% G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7% G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6% R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

Specific focus on: Cancer care:

- The Trust has been focussed on delivering significant improvements against the **62 day GP referral to treatment for cancer** during 2018/19. Progress has been made and performance during the year has been improving, however, in recent months performance against the target has dropped below the trajectory set, as demonstrated by the chart below. This deterioration in overall performance is linked to the specific prioritisation of those patients on the waiting list for the longest time and this prioritised approach has led to sustained reductions of patients waiting the longest.

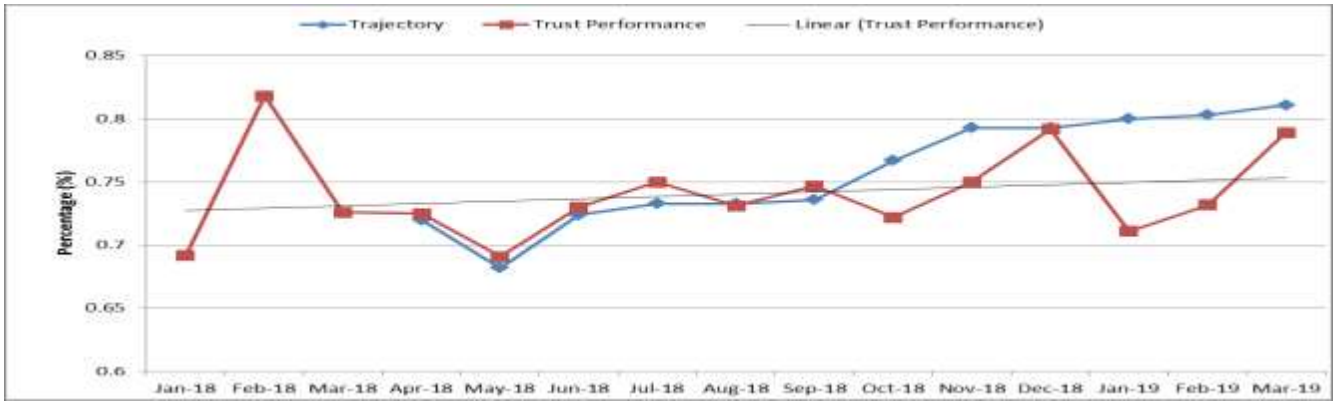


Figure 4: A chart demonstrating Trust performance against the Trust's improvement trajectory

- One of the key challenges for delivery of cancer pathways is access to diagnostics (endoscopy and CT scan). Both diagnostic areas have received significant funding to increase and renew medical equipment. This has resulted already in a new CT scanner on the DPoW site and the ongoing work to install an additional CT scanner at SGH recently becoming operational during April 2019. In endoscopy new endoscopes and equipment have been purchased enabling 7 day working with minimal operational downtime. These efforts will support further improvements against this target. Cancer pathways will remain an area during 2019/20 of focus for the Trust as a quality priority.

Specific focus on: 52 week waits

- **Patients on an incomplete referral to treatment (RTT) pathway waiting more than 52 weeks** have seen significant improvement during 2018/19 towards the Trust's quality aim of having no patients waiting in excess of 52 weeks by the 31 March 2019. This is demonstrated by the following chart which shows that the number of patients on an incomplete pathway has reduced significantly, ahead of the planned improvement trajectory. The Trust, at the end of March 2019, had only 24 patients waiting more than 52 weeks, work will continue to ensure there are zero patients waiting in excess of 52 weeks during 2019 and beyond.

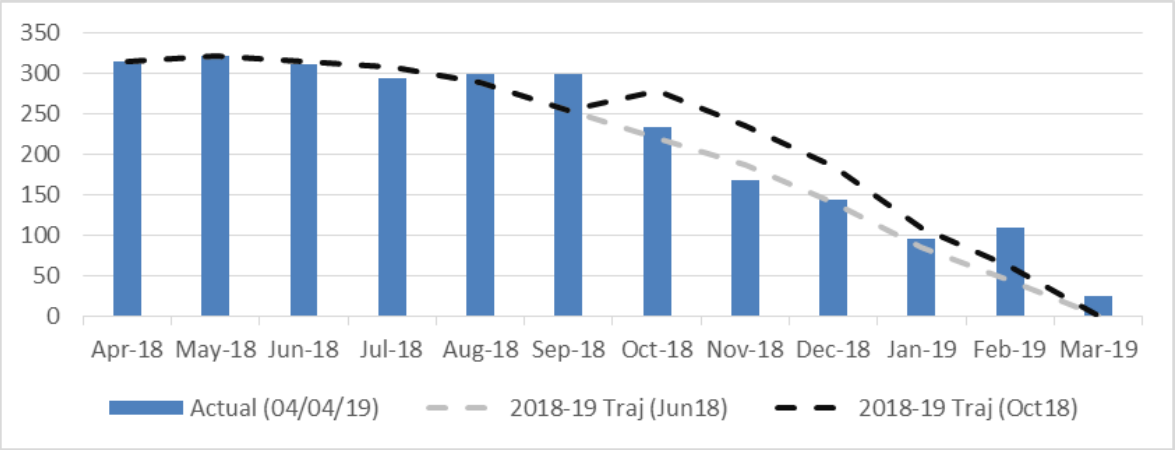


Figure 5: The number of patients on an incomplete pathway waiting more than 52 weeks has been reducing ahead of the planned improvement trajectory during 2018/19.

Specific focus on: Clinical Harm Reviews

- At the end of 2017/18 it was a key priority for the Trust to establish and embed an effective process to integrate **clinical harm reviews** into the Trust's focus on waiting list improvement to determine if any harm has arisen as a result of a delay in waiting for appointments and/or treatment and to take appropriate action for individuals if harm was deemed to have occurred.
- This was initiated and overseen by an external clinical harm review group, chaired by the NHS England Medical Director for the North of England. The principle focus of this groups work was to establish a clinical harm review process for a snapshot of patients who at the 8 August 2017 had waited in excess of 40 weeks for treatment or who were more than 6 months after their due follow-up date or who had waited more than 104 days on a cancer tracking pathway.
- The Trust established a bespoke system to track those patients that met the aforementioned criteria who required clinical review of their records by either a hospital or primary care clinician. If it was not possible to ascertain if any harm had resulted from the retrospective review of case records, a face to face appointment or telephone appointment was made to review the patient to determine if any harm had resulted.
- During 2018/19 all patients identified within these cohorts have now been reviewed. In some cases, unfortunately, the reviews concluded that harm had occurred and the Trust have been open with these patients and are investigating their care pathways in greater detail as part of a Serious Incident Investigation. As part of this process, duty of candour will be completed, or in other words, the Trust will be open and transparent and apologise to those patients.
- This priority focus on retrospective clinical harm reviews has enabled the Trust to develop ongoing systems to ensure patient safety is a foremost consideration whilst looking at the performance of waiting lists and includes criteria and policy designed to ensure that clinical harm reviews are triggered by certain criteria.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 1 – Safe Planned Care:

- The Trust has started to reduce the time taken for patients on a cancer pathway to receive treatment during the year. Specific prioritised attention has been given to those patients waiting the longest on pathways to good effect. Further improvements in waiting times are forecast. Cancer care will remain a quality priority for 2019/20;
- The Trust has reduced the number of patients waiting for more than 52 weeks for treatment following concerted focus to reduce patient waiting. The Trust finished the 2018/19 year with only 24 patients waiting on incomplete pathways for more than 52 weeks, due to patient choice, the Trust aims to have zero during 2019 and beyond;
- Recognising the Trust's challenge around waiting lists and the risk associated, the Trust have completed a large number of clinical harm reviews to provide assurance that waiting lists have not led to patient harm in the main, and where this has been identified, has enabled the Trust to be open with those affected and review individual pathways in greater detail to support a focus on learning. The Trust are working to ensure patient safety by a continued focus on reducing the waiting list first and foremost, as well as establishing clinical harm reviews as standard to assess the risk for harm resulting from waiting.

Progress monitored, measured and reported: Progress with these indicators is monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality & Safety committee and the Trust Board.

Relationship to 2019/20 Quality Improvement Priorities: The following 18/19 indicators are to remain as quality priorities during 2019/20:

- Further focus on improving cancer pathways.

2.1d Theme 4: Safe Maternity Care

Progress Made: (April 2018 – March 2019): During 2018/19, the Trust has demonstrated improved safety in maternity services.

At a glance performance during 2018/19:

	THEME 4: SAFE MATERNITY CARE	Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

Key points:

- **Ratio of midwives to births** data is currently being validated to ensure accuracy of reporting, against agreed standard deviations. This will feature when available.
- **Cardiotocography (CTG)** is a key form of monitoring used during pregnancy to monitor fetal well-being and to determine any indications where there is a need for more investigations. The Trust therefore chose this as a priority indicator to ensure that women who needed such investigations had no delays in accessing. The target of 100% of women receiving this within 30 minutes of arrival has not yet been met; however, performance has remained above 89% during 2018/19.
- **Fresh eye reviews** are designed to reduce the risk of misinterpreting a CTG tracing. This was found to be effective in reducing the incidence of errors. The Trust has been focussed on ensuring that CTGs are reviewed by more than one person during the period of CTG monitoring to reduce to the risk of errors and harm to women in the Trust's care. The Trust are not yet achieving the 100% target set, but have maintained consistently high performance exceeding 93% during 2018/19.
- The **still birth** rate in the Trust is low, with a year to date figure of 16. This is in line with the England average. A review of all still births takes place with the intention to identify any improvements possible. Other factors influencing still births are public health differences which play a role. The Trust committed to reducing the risk of still births; embedding individualised growth charts to support the identification of risks associated with still births.

- Individualised growth charts are an important part in identifying the risk of still births related to babies small for gestational age (SGA) or in danger of fetal growth restriction (FGR). As part of this, all pregnant women using the Trust's maternity services have an individualised growth chart generated. The Trust subscribes to, and uses systems supplied by, the Perinatal Institute which is a national not-for-profit organisation set up to enhance the safety and quality of maternity care. Whilst this is a non-mandatory system, the Trust are amongst 86 others in the UK to make use of this (alongside other centres across the world) to support standardising maternity records and fetal growth assessments. This features as part of the Better Birth Scheme and Saving Lives Care Bundle.
- As the growth chart is individualised to the woman, this enables tracking of the woman's pregnancy and supports continuity of care. Further the growth chart helps to identify any deviation from what is considered normal growth trajectory. Any such deviations can then be acted upon using agreed pathways of care referencing the Royal College of Obstetricians and Gynaecologist (RCOG) pathways and Perinatal Institute, including prompt scanning and induction of labour with the intention of preventing still births.
- The use of the Perinatal Institute growth charts also enables the Trust to compare itself with other participating units in the UK. This is available on a quarterly basis and assists understanding how the Trust compares with other units. This is summarised in the table below.

(b) SGA/FGR referral and detection rates[2]

- NB, Quarterly averages are displayed from the end of each quarter

	Q1 Apr-Jun 2018/19						Q2 Jul-Sep 2018/19						Q3 Oct-Dec 2018/19					
	SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]		SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]		SGA at birth[3]		Antenatal referral for suspected SGA/FGR		SGA detected antenatally[3]	
Hospital / Trust	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Diana, Princess of Wales Hospital	73	13.6	36	49.3	32	43.8	77	13.8	40	51.9	31	40.3	72	12.9	48	66.7	41	56.9
Goole & District Hospital	0	0.0	0	0.0	0	0.0	0	0.0	0	-	0	-	0	0.0	0	0.0	0	0.0
Scunthorpe General Hospital	57	14.1	32	56.1	25	43.9	51	12.8	26	51.0	16	31.4	45	11.3	25	55.6	21	46.7
Northern Lincolnshire & Goole Hospitals NHS Foundation Trust	130	13.8	68	52.3	57	43.8	128	13.4	66	51.6	47	36.7	117	12.2	73	62.4	62	53.0
GUA*		12.1		46.6		41.6		11.8		46.7		41.6		12.1		47.6		42.6

* GUA – GAP User Average – the average rate for all participating Units across the UK

Figure 6: Table summarising the Trust's performance with referral and detection of small for gestational age deviations against normal growth trajectory

- This table demonstrates:

  - **SGA at birth:** The number and percentage in each quarter of small for gestational age babies born compared to the UK average. In each quarter the Trust has a higher number of smaller babies than the UK average, which is linked to public health and social factors.

  - Antenatal referral for suspected SGA/FGR: This demonstrates that the number and percentage of referrals – in other words the number of cases where the Trust took proactive action based on the individualised growth chart – for suspected SGA/FGR is higher in the Trust compared to the UK average.
  - SGA detected antenatally: This demonstrates that the detection of babies who are small for gestational age using further imaging and scanning is higher than the UK average during quarter 3, in other words more babies were at risk of SGA than would have been expected, and in these cases further action would be taken including to induce labour to mitigate the risk of a stillbirth.

- Whilst the Trust is performing above the UK average, the Trust is always seeking to improve practice and learn lessons. A benefit of using the National Perinatal Institute methodology is that it enables the Trust to consider, from this data, if more action should have been taken, as part of retrospective reflection and if so, feedback learning from this review to staff involved in care delivery.
- The number of **Serious Incidents relating to maternity services** was also selected as an indicator to help focus on the incidence and learning from these.
- During 2018/19 the Trust had a Care Quality Commission (CQC) inspection of its services (for more details see section 2.2e of this report). The CQC review of the Trust's maternity services reflected the improvements made since their last visit in 2017/18 resulting in Trust maternity services improving to be rated as 'Good', overall. Linked to this, the Trust also received the results from the national Maternity survey which demonstrated high reported levels of patient experience.
- In March 2019 the Trust also received a MARS (Safeguarding Children's Board) Section 11 assurance visit to assess the Trust against its statutory duties outlined in Section 11 of the Children's Act. This visit covered maternity and paediatrics and the results of this assessment were positive demonstrating the Trust are promoting quality and safe care.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 4 – Safe Maternity Care:

- The Trust has consistently provided CTG within 30 minutes of arrival to more than 89% of women, where this is required, and has ensured that the results from CTG have been reviewed by a second person. This ensures 'fresh eyes' on cases involving more than 93% of women to reduce the risk of CTG misinterpretation;
- More than 97% of women receive 1:1 care in labour;
- The Trust has a low proportion of still births and has embedded the use of the Perinatal Institute individualised growth charts to proactively identify babies at risk of small for gestational age (SGA) and act accordingly, demonstrating higher than average performance compared to the rest of the UK and at the same time reflecting on a case by case basis to determine what improvements are possible to do more to prevent still births.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report, the maternity scorecards and women's and children's audit programme.

Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 2018/19 to aid understanding of Trust performance have either not been measured or changed, these include:

- Average fill rate midwives – this data is superseded by the Trust's focus on ratio of births to midwives, therefore this data has not been used to support an understanding of performance against this quality priority theme,
- Local Safety Standards in Invasive Procedures (LocSSIPs) – these will feature as part of the Trust's ongoing focus, overseen by the Quality and Safety Committee and the Performance Improvement Meetings during 2019/20.

Relationship to 2019/20 Quality Improvement Priorities: Maternity services do not feature within the 2019/20 quality improvement priorities for the Trust. The women's and children's division, however, will continue to focus on these and other quality metrics as part of their business as usual processes, overseen by their clinical governance group, which reports to the Trust's executive led Quality Governance Group. The Trust are proactively planning a suite of indicators to support the Board understand the work needed and progress against the reshaped CNST indicators, these will form the basis of the Women's and Children's Divisional reporting arrangements and will be focussed on patient safety.

2.1e Theme 5: Safe Staffing, Improved Staff Engagement and the Patient Voice

Progress Made: (April 2018 – March 2019): During the 2018/19 period, the Trust's focus on safe staffing has demonstrated considerable progress. Whilst not yet meeting the quality targets set, performance has improved throughout the year.

At a glance performance during 2018/19: Safer Staffing

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5% G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00% G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available	7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6% A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5% G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50% G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%	8.70%		TBD	No benchmark	TBC
5.8	Mixed Sex Accomodation breaches	0 G	36		0	No benchmark	National

Key points:

- Persons being admitted to the Trust for acute medical care have a right to ensure their care is provided in a way that protects their rights to privacy and dignity. **Mixed sex accommodation breaches** is an indicator to help the Trust understand how well it is balancing the access and flow pressures in order to provide urgent and emergency care against the rights of patients privacy and dignity. Mixed sex accommodation is particularly challenging to achieve in some of the Trust's small and specialist areas providing high levels of acute care. During 2018/19 the Trust and its commissioners were applying stringent rules to measure and report mixed sex accommodation breaches. Following guidance from NHS England in August, the Trust has agreed with its commissioners that its prior reporting was not in line with other NHS Trusts reporting, resulting in significantly inflated reported data. From September, using the new definitions and agreement for measuring this area has resulted in a significantly lower level of breaches being reported, in line with how this is measured nationally. Monitoring of mixed sex breaches will continue comparing against the agreed target of zero.
- Staffing is a critical component of providing safe, quality care; as such the Trust has focussed on this area throughout 2018/19 with regular updates to the Board. During the year, some significant improvements have been made with a lower turnover rate than reported in the previous 12 months, bringing the Trust in line with other Acute Trusts in the region. Improvements in the retention of medical staff in particular have supported this position. Retention of nursing staff remains a challenge, mainly due to relocation of nurses and retirement.
- Recognising the challenges with nurse staffing, the Board receives a regular report that outlines, in detail, the assurances available to demonstrate the Trust is ensuring the right staff, with the right skills, are in the right place at the right time. **Safer staffing fill rates** is a measure of the extent to which rota hours on ward areas are being filled by registered nurses and midwives and unregistered care staff to enable ongoing monitoring of safe staffing for the Trust. The Trust is presently reporting performance that exceeds 90%. This demonstrates that the Trust is robustly able to record and manage nursing and midwifery staffing levels on a shift by shift basis.
- Another indicator that enables the Trust to benchmark the provision of registered nursing and midwifery staff alongside care staff is the **Care Hours per Patient Day data or CHPPD.** This is the total hours per day of registered nurses and midwives and care staff divided by the number of patients in the ward or department at 23.59 hours each night, therefore providing an average number of care hours per patient, per day. The overall Trust's Care Hours per Patient Day data is lower than the national average. The Trust, on an ongoing basis, reviews the establishments of staff on each ward (i.e. reviewing the demands on each ward and resetting the number of trained nurses needed on that location). This data will be one of the nursing metrics used to inform these regular establishment reviews. To ensure that staffing establishments on wards are accurate and correct further work is planned to roll out and embed the Safer Nursing Care Tool (SNCT). Whilst the Trust has used this data in the past, it has not been used to support establishment planning. One of the Trust's senior nurses is working on a collaborative programme with NHS Improvement to roll out and embed the use of this data as part of routine establishment review work with the aim of improving still further the focus on safer staffing at individual ward and department level.

- Across the NHS there is a well-publicised shortfall of registered nurses leading to most Trusts having nurse vacancy rates. To support this focus during 2018/19 the Trust set an ambitious vacancy target of <6% for registered nurses and <2% for unregistered carer staff. **Registered nursing staff vacancy rates** are currently above the target set, but have improved from the nursing vacancy rates reported during the early part of 2018. **Unregistered nursing vacancy rates** have reduced significantly from 9.18% in January 2018 to 1.5% in March 2019, therefore this reduction is positive. For both areas, The Trust continue to make use of innovative approaches during 2018/19 to recruit and fill vacancies as well as working hard to retain its existing nursing workforce and build up its internal staff bank to fill any vacancies with other Trust nursing staff who are able to work temporarily to support covering of rotas. Additional work has been completed to recruit to other posts in support of safer care for example additional clinical nurse specialists and preparing to interview newly qualified nurses for additional nursing staff to be appointed and allocated.
- The **Medical staff vacancy rate** has reduced significantly from a vacancy rate of 24% in January 2018 to meeting the Trust's target with a vacancy rate of 14.5% in March 2019. This is demonstrated in the chart that follows.

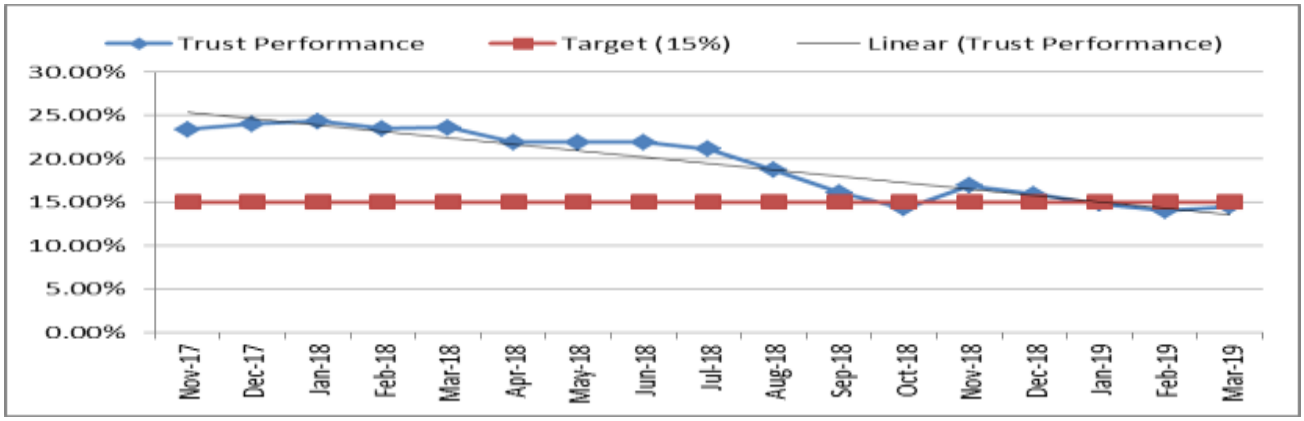


Figure 7: The reduction over 2018/19 of the medical staff vacancy rate

- This has been a significant priority for the Trust and a variety of improvements have been undertaken to maximise the Trust's appeal to doctors from other areas to successfully recruit more medical staff, as well as ongoing clinical engagement work to listen to the medical workforce and aid and improve retention rates.
- In March 2019 the Trust reduced its Medical vacancy rate to 14.5%. This has been supported by an above average junior doctor fill rate of 87% in August 2018 which was an improvement of 20% when compared with the previous year. A continued approach to reducing the Trust medical vacancy rate via innovative recruitment methods and meaningful engagement to aid retention, will be an ongoing priority for the Trust to ensure safe staffing.
- The Trust has ongoing plans to address medical and dental vacancies with 44 doctors waiting to start in the Trust between February and June 2019. Work continues to attract other doctors to the Trust to further recruit and commence them in post to support further reductions of the vacancy rate.
- The Trust has also invested significantly in improving the experience of rotating junior medical staff, with the opening of a new £16.4 million accommodation complex, called the Roost, on the DPoW site.

Annual Update on Rota Gaps:

- The Trust, compared with other Trusts in the Yorkshire and Humber region struggle to attract trainee grade doctors. Geographically the Trust is not well positioned which could contribute to these challenges. Rota gaps are therefore filled by the recruitment of permanent doctors, the use of agency locum and internal locum staff.
- Workforce and Recruitment meetings take place regularly with Medical Staffing and the groups to identify and plan for vacancies. Vacancies are advertised and active steps taken to follow up any interest in the area. Whilst the medical vacancy rate has reduced during 2018/19 staffing levels continue to give cause for concern and more is needed to be done to develop alternatives such as Physician's Associates (PA) and Advanced Clinical Practitioners (ACP). The Trust has developed a robust Workforce Strategy that incorporates these roles and is currently developing ACPs in the Trust with support from Health Education England Yorkshire and the Humber. Rota Co-ordination has improved in 2018 but there is still work to be done. The Trust is continuing its efforts to diversify the clinical workforce and thereby reduce sole reliance on medical staff.

At a glance performance during 18/19: Improved staff and patient engagement

THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
5.9	Friends and Family Test Results - A&E	75.2%	R	73.00%		≥95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0%	G	99.10%		≥95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0%	G	100.00%		≥95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2%	G	98.20%		≥95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative						
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative						
5.15	Staff engagement: Listening to Improve	See narrative						
		2018		2017				
5.16	NHS national staff survey - overall engagement	6.5	G	6.4		>6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3%	G	43.0%		>43.0%	WORSE 62.6% (Average)	Local

- The Trust is working to ensure it has effective systems and processes in place to listen to the voice of the patient. During 2018/19 the Trust listened to patient's feedback from two primary sources: (1) Friends and Family Test results and (2) the feedback to the Trust via complaints, Patient Advice and Liaison Service (PALS) and compliments collated by the Trust's Patient Experience lead nurse. The following provides an update from these and includes exciting developments that will support he Trust hear the patients' voice to a greater degree during 2019/20.
- **Friends and family test and thematic analysis of other forms of patient feedback including complaints** are a way that the Trust understands the experience and voice of the patient. Whilst the friends and family test results demonstrates very high levels of satisfaction in most areas surveyed, the Trust is aware that the response rate is low, meaning that current satisfaction rates may not give the Trust an accurate or reliable indication. To ensure completeness of understanding going forward, the Trust has approved a business case for a new IT system and a dedicated patient experience team.

This will enable easier ways for service users to provide feedback and enable greater levels of understanding of the results with interactive dashboards and the ability to design bespoke patient surveys to gain further understanding of the patient voice. This additional resource is being complimented by a review and refocus of the Friends and Family group with increased representation by divisions to work through the themes and understand the actions needed at divisional level to ensure action is taken in response to patient's feedback.

- **Complaints, PALS and compliments** are another source of feedback the Trust monitors and seeks to learn from. During 2018 the management of the central complaints team was moved to sit under the Trust's Patient Experience lead. This has enabled a greater triangulation of patient experience themes and has led to the development of a new patient feedback report which enables key points and feedback to be more widely shared for lessons learning. This increased triangulation of the patient voice and their experience has led to specific themes being identified. Key points identified from the quarter 3 report are summarised in the following infographic.

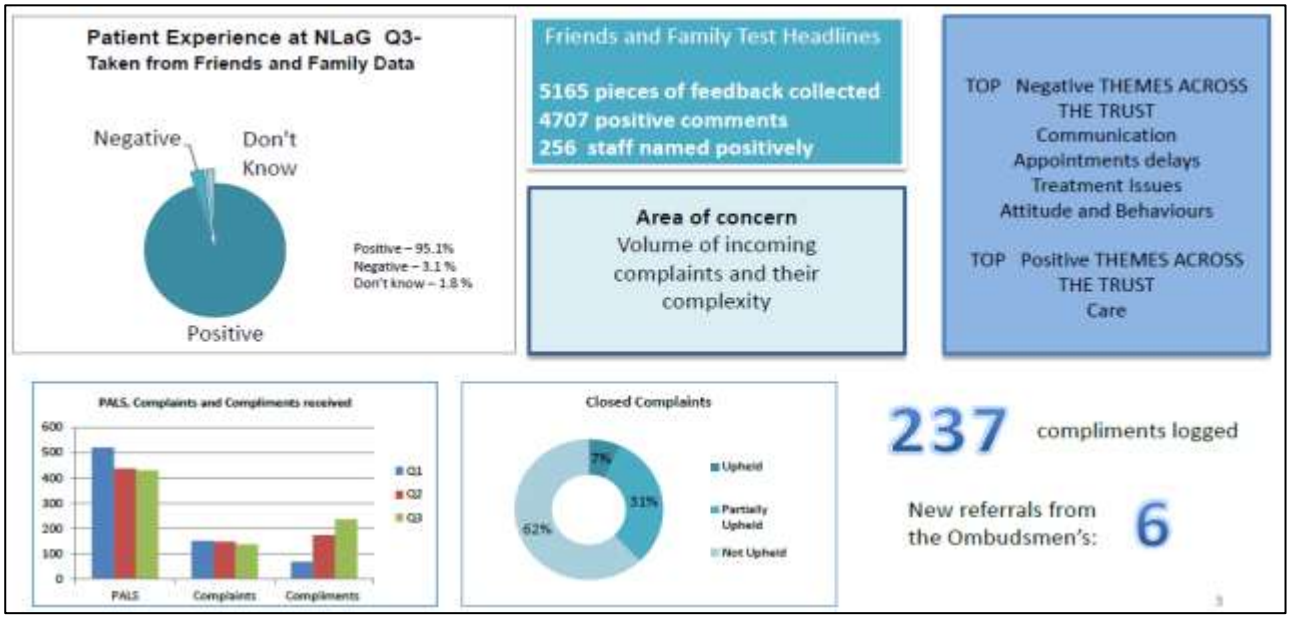


Figure 8: An infographic outlining key points from the quarter 3 patient experience report

- One of the themes identified by the quarter 3 report was in connection with staff communication with patients. This led to a workshop held to understand potential root causes for this theme linking with human factors awareness which will support planning next steps and additional training needs for staff interacting regularly with service users. Other key learning points from the quarter 3 report that have been shared for learning with operational divisions are:
  - More focus required on managing patient expectations and communication of delays/waiting times;
  - Further triangulation on communication, as this overlaps many different services and professionals;
- Actions taken in response to this patient feedback, to date, around these key findings include:
  - Feedback for A&E at Scunthorpe General Hospital related largely to waiting times within the department. This feedback has resulted in the Trust rolling out real time waiting information being displayed in the department to help manage patient expectations better. The greater focus going forward on themes emerging from patient feedback will further support the Trust closing the feedback loop.

- Revised processes in outpatients where patients are now seen in the examination room to prevent the need for the patient to move to a new location for the procedure.
- Ophthalmology consultants are kept updated and aware of up to date waiting times to enable them to brief patients to keep them updated and better manage their expectations to prevent anxiety or uncertainty.
- As referred to already in this report, proactive work in train to reduce radiology delays.

- The Trust is also proactively working to collate compliments and share these in the same way as themes from complaints. Compliments received and shared include:

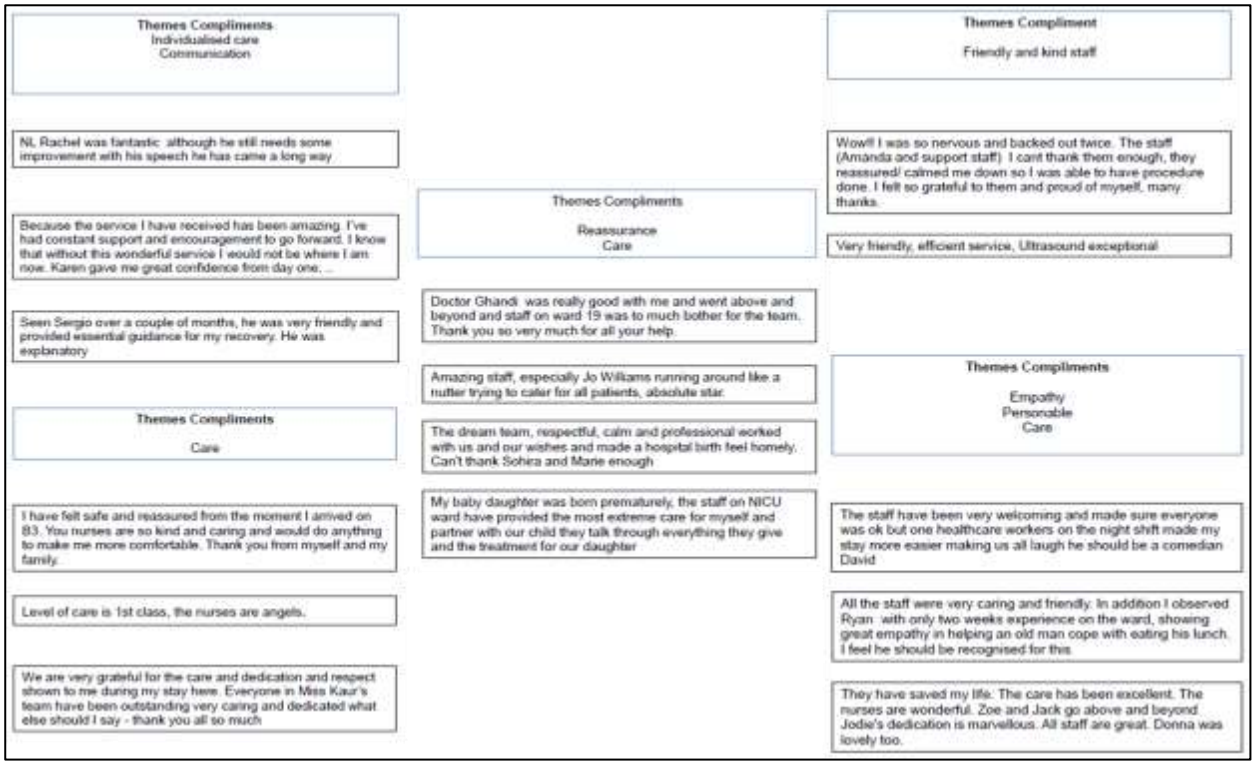
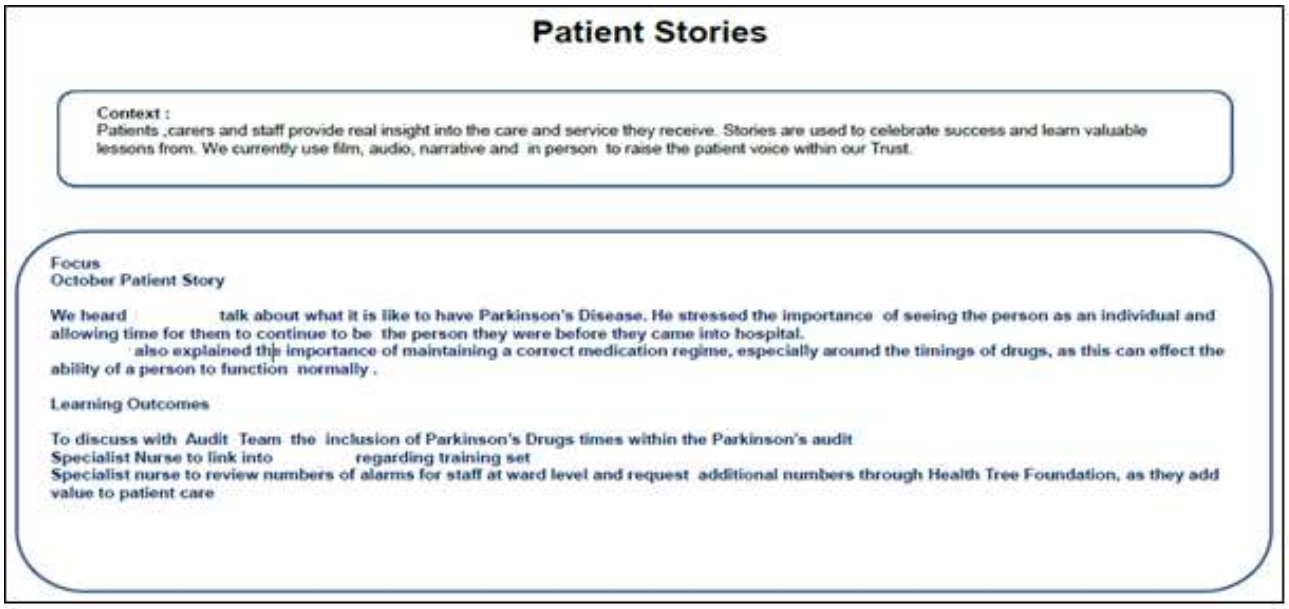


Figure 9 some of the compliment themes and comments received which feature in the patient experience report for quarter 3 and are shared, alongside other feedback, with operational divisions for sharing and learning

- Whilst this feedback is shared with operational divisions, it is also shared with the Trust Board. Another approach taken to listen to the voice of the patient is through the use of patient stories, like this example.



Patient Stories

Context :
Patients ,carers and staff provide real insight into the care and service they receive. Stories are used to celebrate success and learn valuable lessons from. We currently use film, audio, narrative and in person to raise the patient voice within our Trust.

Focus
October Patient Story

We heard talk about what it is like to have Parkinson's Disease. He stressed the importance of seeing the person as an individual and allowing time for them to continue to be the person they were before they came into hospital.
also explained the importance of maintaining a correct medication regime, especially around the timings of drugs, as this can effect the ability of a person to function normally .

Learning Outcomes

To discuss with Audit Team the inclusion of Parkinson's Drugs times within the Parkinson's audit
Specialist Nurse to link into regarding training set
Specialist nurse to review numbers of alarms for staff at ward level and request additional numbers through Health Tree Foundation, as they add value to patient care

Figure 10 an example of one of the Trust's presented patient stories for understanding of the key issues to the patient and sharing of key learning and summary of actions taken in response

- We recognise that the Team has made some significant changes to the complaints process over this last year, including moving to a co-located model. However there is added focus on the number of complaints outside of our expected timescales, and the senior team are currently working with divisions to understand issues within the current process and work towards addressing these as a priority.
- Timeliness is also an important aspect of acting and responding to patient feedback to support and improve timely resolution of patient feedback via the Patient Advice and Liaison Service (PALS), the central team now work more within divisions, linking in with clinical staff on behalf of the patient to obtain quicker resolution.
- Good progress has been made with the triangulation, understanding and reporting of the patient's voice. The further investment and development of a patient experience team is therefore an exciting step forward and will enable the Trust to develop even further a more rigorous and targeted listening opportunities to understand further patient experience. This will also fundamentally strengthen the ability of the key themes from this feedback to be fed back to operational staff and divisions to support an approach to shared learning for improvement.
- **Staff engagement, satisfaction and feedback** are other important elements that the Trust needs to listen to and act in response. During 2017/18 the National NHS Staff Survey results for the Trust demonstrated a significant challenge for the organisation in terms of doing more to listen and act on feedback from its staff.
- During 2018/19 the Trust used Listening to Improve to help support staff with improvements to in their areas. The Trust has also developed Pride and Respect, the Trust's anti-bullying campaign. Both of these work streams were initiated on the back of staff feedback.

- **Listening to Improve** is about improving the quality and safety of patient care through listening to the Trust's workforce. During 2017/18 the Trust ran a 'pulse check survey' which resulted in 1,114 submissions of feedback. This helped understand the issues that lead to staff feeling less engaged in the Trust. Key issues identified were as follows:
  - 17% day to day frustrations;
  - 19% communications between senior management and staff;
  - 20% communicating goals and priorities.

- Following this listening event, five ‘crowdfixing’ events were organised and attended by 315 staff to come together and talk through these issues and seek to identify remedies for some of the frustrations experienced.
- Following these events, a series of clinically prioritised projects were initiated to support improved quality in these areas led on by clinical staff with the aim of improving quality of patient care and responding to themes voiced at the listening or crowdfixing events. The outcomes of these projects were collated and shared widely, examples are shown below.

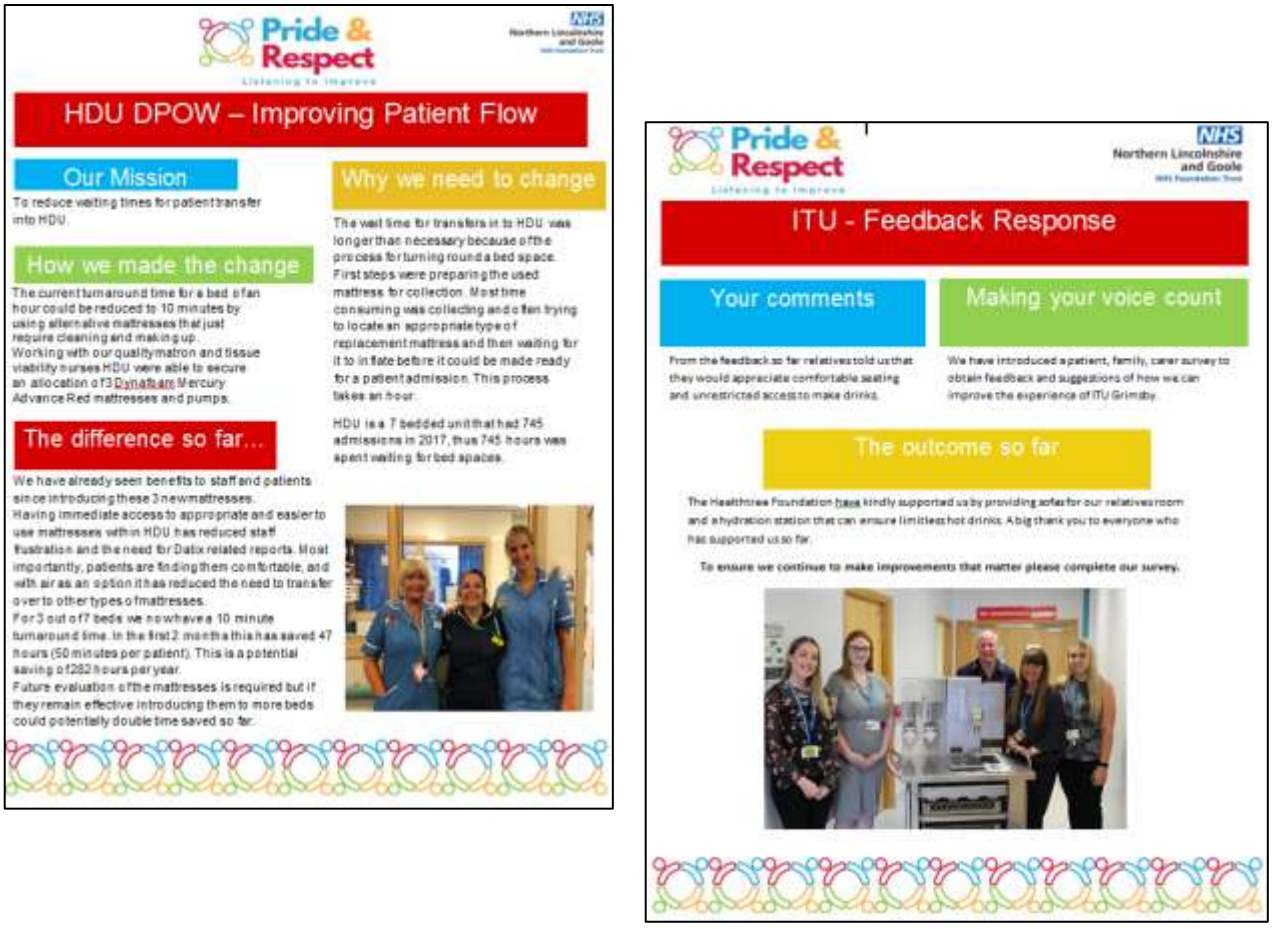


Figure 11: Examples of the Trust's Listening to Improve projects undertaken on the back of listening to staff feedback and supporting them to act to improve

- Other examples of positive outcomes from this initiative include:
  - **A data analyst forum** has now been established to support increased networking of colleagues doing similar roles and to support personal development as well as improved outcomes at work,
  - Following feedback regarding the **Medical Engineering service** there is now a 24/7 voicemail facility for staff to report faulty equipment,
  - From feedback regarding **wheelchairs**, charitable funds purchased 40 new wheelchairs that are now in use,
  - **Switchboard team’s** ability to respond to internal phone calls in a timely manner was improved by now having two dedicated consoles during Monday to Friday 09:00-17:00 hours that enable a focus on internal calls.

- Another example of listening to feedback from staff is the work undertaken by the Trust's Undergraduate team who hold feedback focus groups with the HYMS medical students. Listening to experiences is also obtained following receipt of formal feedback from HYMS and Sheffield Medical Schools via university systems which are communicated back to tutors. These mechanisms allow the Trust to react swiftly to feedback received and act to improve the experience on our placements. Reports are sent to HYMS regularly throughout the year to report how the Trust is responding to feedback and the actions taken in response.
- **Pride and Respect**, the Trust's anti-bullying campaign has seen the recruitment of more than 100 Pride and Respect Champions from a variety of different backgrounds, some of whom have further volunteered to help deliver a programme of proactive training comprising of a two hour session including training videos designed by the Trust based on specific needs, delivered by actors to support delivery of targeted messages across the organisations staff.
- To date more than 1,000 staff have attended Pride and Respect training sessions, which is a significant achievement as this remains a voluntary (non-mandatory) training session. Training sessions run weekly are trust wide and planned until December 2019. The course has received very positive feedback from participant's evaluation.
- Pride and Respect champions have attended development days and workshops covering issues such as managing conflict. In October 2018 Pride and Respect launched 'Let's talk' service which aims to help staff resolve their relationship problems. This service has helped 44 staff and this includes in-house mediation that is facilitated by champions who have received mediation training. This service is now widely advertised within the Trust for others to benefit from.
- As part of Pride and Respect, 3 leadership conferences have been held, entitled: 'Rebuilding our Organisation through Cultural Change' which have targeted the organisations senior leaders, starting in October 2018 running through to January 2019. Feedback on this 1 day session has been positive.
- The work of the network is overseen by the Pride and Respect Steering Group chaired by one of the Trust's consultants, with vice chair a Nurse educator. Related initiatives include the development of Minority Networks.
- As part of the Pride and Respect Initiatives, the Trust has also made good use of Insights Discovery Training to support staff understand their personal preferred styles, strengths and value they bring to the team. These sessions have been used to support individual sessions, team development sessions through to larger scale department wide initiatives.
- Whilst these initiatives have resulted in a number of very positive outcomes, the Trust recognises that more time is needed to evaluate the outcomes from these programmes and is committed to focus on this as a long-term priority. During this same time, between September and December 2018, the latest National Staff Survey was undertaken; these have been published on the 26 February 2019.
- More than 2,000 staff took part in the survey, equating to a 35% response rate which is an improvement. The results do show improvement across the majority of questions compared to the 2017 survey, but it's clear we still have a lot more work to do. Key points included:
  - 72% of staff surveyed said they were enthusiastic about their job and more of you would recommend the Trust as a place to work and receive treatment.
  - Reading the comments we are starting to see the signs of positive culture change. More staff feel confident about raising concerns and reporting incidents and feel more confident the Trust would act on feedback from staff and patients. Fewer staff are suffering from work related stress compared to the 2017 survey.
  - However the results also highlight that staff morale remains low with concerns around adequate staffing levels, the quality of appraisals and a lack of opportunity for progression.

- The results have been shared widely and each division will be formally looking at their own results. With support from staff from the Trust's Organisational Effectiveness team, each division is developing improvement plans for the specific feedback received broken down to divisional level.
- Since the survey was undertaken, in addition to the Listening into Action and Pride and Respect initiatives, the Trust have taken the following actions:
  - Involved staff in the creation of new Trust values (respect, kindness and courage) and behaviours. We'll be doing much more work to communicate these throughout the year.
  - Launched 'Ask Peter' to give another route for staff to ask questions and to raise concerns, which is proving very popular.
  - Created new ways to celebrate staff achievements e.g. 'Thumbs Up Friday' and 'Team of the Week'.
  - Secured £29million in capital funding to invest in urgent and emergency care and our diagnostic equipment over the next few years.
  - Secured funding to help with the rollout of ePMA (electronic prescribing and medicines administration).
  - Made substantial improvements in mortality rates.
  - Increased the amount of apprenticeships on offer for staff at all levels including trainee nurse associates.
  - Opened a new £16.4 million staff accommodation building, The Roost at Grimsby hospital.
  - Seen big improvements in our vacancy rates for doctors.
- Changing the culture of an organisation is something that takes time, but it's clear from these results that the Trust is starting to head in the right direction.

Further support to patient's mental health alongside their physical health

One in four people in the UK experience a mental health problem each year. Some patients being cared for within the Trust will therefore have both a physical and mental health issue. To care for these patient's needs, the Trust works closely with Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) a mental health provider for North Lincolnshire which provides access, crisis and hospital liaison, including child and adolescent mental health services. These services are complimented by the Local Authority who provide an approved mental health practitioner service. Within North East Lincolnshire, mental health services are provided from NAVIGO, an integrated health and social care provider, providing hospital liaison service, crisis and access services. Lincolnshire Partnership Foundation Trust provides the child and adolescent's mental health services within North East Lincolnshire.

To further support the Trust's focus on mental health care, an interim specialist practitioner for mental health has been appointed, initially on a three month pilot, which started during March 2019. The first month has been used to scope out where there are mental health needs, looking at current pathways, policies and patient flow of a typical patient journey. This has been undertaken working closely with mental health provider colleagues. Current training and education on mental health has also been reviewed as part of this initial review. Following this initial scoping work, the specialist practitioner will be working closely with colleagues to support and develop plans to improve further service provision and ultimately the patient experience.

In addition, the Trust also employs a specialist perinatal mental health midwife who works closely with midwifery and primary care colleagues. This role is also working alongside both mental health providers to develop emerging perinatal services that cater better for mental health needs during this time.

Support to patients with dementia

We are committed to providing an excellent standard of care for all patients but we know that we need to particularly ensure that those who are vulnerable and frail are getting the best possible care. There are 850,000 people with dementia in the UK, with numbers set to rise to over 1 million by 2025. This will soar to 2 million by 2051. 225,000 will develop dementia this year, that's one person every three minutes (Alzheimer's Society).

The Department of Health (2015) estimated that 25% of hospital beds are occupied with people with dementia. However, informal reports suggest this is a gross underestimate, with some hospitals stating that 40-50% of their patients have dementia (Alzheimer's Society). It is recognised that admission to hospital can have a significant negative impact on the person's physical and mental health and have an emotional impact on carers, therefore, it is important to ensure patients in hospital receive appropriate care and provide support to carers.

Within the Trust, each ward has a link champion as a resource for further information and support. Dementia link sessions continue quarterly being run by the Trust's Dementia Clinical Nurse Specialist team who visit the wards on a daily basis to ensure patients with dementia are receiving the most appropriate care for their individual needs and to support their carers.

Recognition of the need to enhance our healing environment has led to dementia friendly improvements as the Trust refurbishes wards and departments, with consideration to dementia friendly signage and clocks, colour coding in bays to support way finding, plain flooring and furnishings, such as curtains and decorative artwork.

Dementia training is mandatory for all patient-facing staff and the Trust remains consistently high with compliance for both tier one dementia awareness and tier two dementia skills training.

The Trust have successfully introduced a dementia friendly finger food menu this year across all three sites to encourage the maintenance of independence but also to ensure patients with dementia are receiving adequate nutrition whilst they are in hospital. The Trust has taken part in round 4 of the National Audit of Dementia and improvement plans are in place to ensure we are meeting the standards. The Trust continues to work with our external partners, including the Alzheimer's Society and the Carers Association who attend our quarterly Dementia Steering Group.

Clinical Leadership development to support improvements in culture and improving quality

During 2018/19, the Trust has reviewed and made changes to strengthen its clinical leadership arrangements to support improvements in both culture and quality and safety. This has been a key priority recognising the importance of these roles. In June 2018 the Trust appointed Divisional Clinical Directors to increase the focus on divisional clinical leadership structures. To support these posts, a consultation has recently concluded that reviewed the role of specialty Clinical Lead across the organisation to ensure these posts had a clearly defined and consistent job description to further support divisional clinical leadership. Now that the consultation has ended, recruitment to these posts will be the next step.

Running in conjunction with this has been work to strengthen nursing leadership with the appointment of two Deputy Chief Nurse Posts. A reorganisation of the matron role has also now been completed, following consultation, resulting in clearly defined and consistent matron and senior nurse roles now in place and being recruited to.

To support this investment in these roles to support improvements in culture, quality and safety, will be comprehensive training and development. Ward leaders have already commenced this training and support, with work underway to develop a leadership programme for the Clinical Lead roles.

Annual Update on Speaking Up

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust are committed to ensure that employees working for the Trust are not only encouraged to do this, but are actively supported and guided as to how they can do this, should they feel the need to, whether they are concerned about quality of care, patient safety or bullying and harassment within their workplace.

The Trust have encouraged and supported staff to speak up by instituting a number of mechanisms for staff to raise concerns, these include:

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
  - Through the Trust's nominated Freedom to Speak Up Guardian;
  - Via the Human Resources Department, a part of the Trust's People and Organisational Effectiveness Directorate;
  - Or by logging an incident on the Trust's incident reporting tool hosted on DATIX.

The Trust's Freedom to Speak Up Guardian presence is communicated to all new starters within the Trust as part of the corporate induction programme, is featured as part of the already referenced Pride and Respect training sessions and the Chief Executive led Senior Leadership Community. This is further promoted through printed and digital materials including the Trust staff newsletter, posters around the Trust premises and screensavers on desktop computers.

The Trust was visited by the NHS Improvement regional Freedom to Speak Up lead during January 2019 in order to assess the Trust's progress with the implementation of actions following a previous visit by the National Guardian's Office. Whilst recognising there is further work to do, positive feedback on progress was received during the visit, noting specifically that the Pride and Respect Champions who met with the lead exuded passion and commitment and this had reenergised the Trust's approach to this critical aspect of listening to members of staff and promoting further changes in culture. The review also noted the Chief Executive and the Chair's commitment to tackle cultural challenges.

The Trust's current Freedom to Speak Up Guardian reports to the Trust Board on a quarterly basis to ensure the Trust and its board are kept updated and able to continue to support promotion of this function.

Patient outcomes: What does this mean for patients accessing Trust services?

Patient outcomes: What does this mean for patients accessing Trust services?

Theme 5 – Safe Staffing & Improved Staff Engagement:

- The Trust have demonstrated higher levels of registered nursing and midwifery staff and care staff available to cover rota hours on the Trusts wards.
- The Trust are currently below the national average in providing care hours per day but are aiming to improve this by linking this to ongoing ward establishment reviews and therefore more focussed on quality delivery.
- The numbers of vacant nursing and medical staff have reduced, with further improvements planned to ensure safe staffing.
- Patients receiving acute hospital care can be confident that they will not receive care that breaches mixed sex accommodation requirements.
- Feedback from patient experience initiatives is largely positive with a growing number of compliments. Where concerns are raised, the Trust has improved its processes to respond to these in a timely manner and to understand the feedback and work to improve provision of care to improve the patient's experience.
- The Trust is committed to improving engagement with its staff to result in improved staff morale. Whilst there is still further to go, the Trust has demonstrated that the changes made during 2018 have resulted in improvements and that the Trust are moving in the right direction.

Progress monitored, measured and reported: Progress with these indicators are monitored within the integrated performance report and as such is reported to the Quality Governance Group, Quality and Safety committee and the Trust Board.

Whilst the quality priority theme has remained the same throughout 2018/19, some of the indicators planned during 2018/19 to aid understanding of Trust performance have either not been measured or changed, these include:

- Wards having had an establishment review, this is an ongoing process and as such was determined to not be a helpful indicator, instead the care hours per patient day, the indicator has been used to link, more firmly, staffing to quality of care,
- Medical fill rate has not been an indicator used, with a focus being on medical staff vacancy rates instead,
- Establishment reviews continue across specialties and will be a useful indicator in support of the focus on reducing the medical staff vacancy rate going forward,
- The total agency spend was not used as an indicator in 2018/19 for quality as there was a focus on having appropriate skills for the patients. Whilst this was not used in this quality setting, it remains within the financial indicators, used to support the Trust's focus on good financial governance.

Relationship to 2019/20 Quality Improvement Priorities: Safe staffing indicators do not feature as part of the Trust's 2019/20 quality priority themes; these will be reported to the Board as performance indicators, monitored in detail for assurance (and recognising the links to quality of care/services) to the workforce sub-committee of the Board.Patient experience indicators will be featured within the quality priority focussing on flow and cancer pathways. Wider indicators relating to more general experience will feature as part of the Trust's Integrated Performance Report and the Patient Experience report going to Trust Board.

2.1f: Quality Priority planning for 2019/20

QUALITY PRIORITY THEMES 2019/20:

Five priority areas have been set as quality priorities for 2019/20:

1) **Clinical Effectiveness: Mortality reduction**
   a. Mortality case note review work by clinical staff, key performance indicators;
   b. Patients able to die in their preferred place of death (end of life quality indicator);
   c. Reduction in the Trust's Summary Hospital-Level Mortality Indicator (SHMI).
2) **Patient Safety: Improved management of the deteriorating patient:**
   a. Monitoring and action taken in response to National Early Warning Scores (NEWS);
   b. Compliance with the Sepsis Six care bundle;
3) **Patient Safety: Medication safety**
   a. Reduction in omitted doses;
   b. Reduction in incidents relating to insulin;
4) **Patient Experience: Improved patient flow**
   a. Embedding the use of the SAFER bundle to improve flow;
   b. Seven day services – improved performance against the priority four standards;
5) **Patient Experience: Cancer pathways**
   a. Increased availability of straight to test diagnostics for suspected cancers;
   b. Improved cancer pathways.

How the Quality Improvement Priorities are consulted on and agreed:

Reflecting on the Trust's performance against its quality priority themes set during 2018/19, the Trust's Acting Medical Director undertook a consultation exercise within the Trust starting November 2018 to determine what the quality priorities for 2019/20 should be to continue the Trust's improvement journey. As a result of this approach, the first draft contained a variety of proposed topics. Following subsequent discussion with public and staff governors, who represent the public at the Quality Review Group, discussion within the Trust with divisions at the Quality Governance Group, and also the Non-executive Director chaired Quality & Safety Committee, with CCG representatives present, the Acting Medical Director facilitated a gradually focussing lens to ensure the Trust and its board have clarity on what the organisations priorities are for quality improvement during 2019/20. The five chosen were agreed through the consultation process, as those which would have the biggest impact on patient outcomes. The quality indicators discounted as part of this process are no less important, however, the Trust wants to ensure that it prioritises delivery of these five areas as it is recognised that these represent the Trust's highest risks to quality.

Many of those other indicators suggested, but ultimately not included in the above quality priorities for 2019/20, will still feature, either in the Trust's already established Improving Together Programme (i.e. nutrition and hydration), or as part of already established improvement initiatives (i.e. waiting time indicators), or are considered business as usual and have processes in place to report key performance indicators to understand and track quality performance over time (i.e. pressure ulcers and falls). Going forward, the Trust will still make good use of the monthly Integrated Performance Report (IPR) and will continue to report and push improvement on these quality indices. Oversight of the quality priorities will be maintained throughout the year both through performance, within the divisional monthly quality performance reports and through assurance via the Executive led Quality Governance Group and the Non-Executive Director led Quality and Safety Committee. This is a sub-committee of the Board with commissioner representation.

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2018/19 Northern Lincolnshire and Goole NHS Foundation Trust provided and/or sub-contracted seven relevant health and care services.

Northern Lincolnshire and Goole NHS Foundation Trust has reviewed all the data available to them on the quality of care in seven of these relevant health and care services.

The income generated by the relevant health services reviewed in 2018/19 represents 100% of the total income generated from the provision of relevant health and care services by the Trust for 2018/19.

2.2b Information on participation in clinical audits and national confidential enquires

During 2018/19, 55 national clinical audits and 5 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 55 or 100% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2018/19 and those in which it participated in are as follows:

NB: The table which follows lists:

- The name of the national clinical audits and national confidential enquiries listed in HQIP's quality account resource,
- Which ones the Trust were eligible to participate in,
- The number of cases submitted for each audit against the number required, also expressed as a percentage (%),
- If action planning is taking place or has been completed to improve processes and practice following publication of findings.

National Clinical Audits 2018/19

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Acute care					
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	580	99.5%	Reporting
Case Mix Programme (CMP)	Yes	Yes	866	81%	Project not yet completed
National Emergency Laparotomy Audit (NELA)	Yes	Yes	196	88%	Awaiting Publication of Results
National Joint Registry (NJR)	Yes	Yes	813	92%	Awaiting Publication of Results
Blood and Transplant					
National Comparative Audit of Blood Transfusion programme					
Use of Fresh Frozen Plasma and Cryoprecipitate in neonates and children	No	N/A	N/A	N/A	N/A
Management of massive haemorrhage	Yes	Yes	5	100%	Awaiting Publication of Results
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance	Yes	Yes	13	100%	Yes
Mandatory Surveillance of bloodstream infections and clostridium difficile infection	Yes	Yes	104	100%	Yes
Cancer					
Lung cancer (NLCA)	Yes	Yes	333	On-going	Yes
Bowel cancer (NBOCAP)	Yes	Yes	243	100%	Project not yet completed
National Audit of Cancer in Older Patients (NABCOP)	Yes	Yes	242	100%	Awaiting National Report
National Prostate Cancer Audit	Yes	Yes	290	100%	Actions to be Agreed
Oesophago-gastric cancer (NAOGC)	Yes	Yes	108	100%	Actions to be agreed
Heart					
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	230	Ongoing	Awaiting Publication of Results
Adult Cardiac Surgery (NICOR)	No	N/A	N/A	N/A	N/A
Cardiac Rhythm Management (CRM)	Yes	Yes	303	Ongoing	Awaiting Publication of Results
Congenital Heart Disease (CHD)	No	N/A	N/A	N/A	N/A
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	294	Ongoing	Awaiting Publication of Results

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Heart Failure Audit	Yes	Yes	238	Ongoing	Awaiting Publication of Results
National Audit of Cardiac Rehabilitation	Yes	Yes	1005	100%	Yes
National Vascular Registry	No	N/A	N/A	N/A	N/A
National Cardiac Arrest Audit (NCAA)	Yes	Yes	148	93%	Project still underway
Long term conditions					
National Diabetes Audit - Adults (National Core Diabetes Audit)	Yes	Yes	1012	100%	Awaiting Publication of Results
National Diabetes Audit – Adults: National Diabetes Foot Care Audit	Yes	Yes	192	100%	Yes
National Diabetes Inpatient Audit – Adults Organisational (NADIA)	Yes	Yes	1	100%	Awaiting Publication of Results
National Diabetes Inpatient HARMS Audit (NADIA HARMS)	Yes	Yes	5	100%	Awaiting Publication of Results
Inflammatory Bowel Disease (IBD) programme – Biologicals Audit	Yes	Yes	293	100%	Awaiting Publication of Results
National COPD Audit	Yes	Yes	697	74%	Yes
National Asthma Audit	Yes	Yes	62	81%	Yes
National Clinical Audit for Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	58	Ongoing	Awaiting Publication of Results
Mental health					
Mental Health Clinical Outcome Review Programme (NCISH)	No	N/A	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A	N/A	N/A
Older people					
Falls and Fragility Fractures Audit Programme (FFFAP) • Fracture Liaison Service Database (FLS-DB)	Yes	Yes	591	100%	Yes
Falls and Fragility Fractures Audit Programme (FFFAP) • National Hip Fracture Database (submitted for all)	Yes	Yes	574	100%	Not yet complete
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit	Yes	Yes	675	100%	Yes
National Audit of Dementia (NAD)	Yes	Yes	100	100%	Yes

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Audit of Intermediate Care	No	N/A	N/A	N/A	N/A
National Audit of care at the End of Life (NACEL)	Yes	Yes	80	100%	Awaiting National Report
Sentinel Stroke National Audit Programme (Post-acute)	Yes	Yes	159 (April-Dec 2018)	100%	Reporting
Other or TBC					
Adult Community Acquired Pneumonia	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
Non-Invasive Ventilation – Adults	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
National Audit of Pulmonary Hypertension	No	N/A	N/A	N/A	N/A
Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
National Mortality Case Record Review Programme	Yes	Data collection underway	Project still underway	Project still underway	Project still underway
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	Project still underway	Project still underway	Project still underway
Feverish Children (care in emergency departments)	Yes	Yes	168	100%	Awaiting Publication of Results
Vital Signs in Adults (care in emergency departments)	Yes	Yes	221	100%	Awaiting Publication of Results
VTE Risk in lower limb immobilisation (care in emergency departments)	Yes	Yes	199	100%	Awaiting Publication of Results
Cystectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Nephrectomy Audit (British Association of Urological Surgeons)	Yes	Yes	16	36%	Project still underway
Percutaneous Nephrolithotomy (PCNL) (British Association of Urological Surgeons)	Yes	Yes	0	0%	Project still underway
Radical Prostatectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Female Stress Urinary Incontinence Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Elective surgery (National PROMs Programme)	Yes	Yes	559	70%	Yes
Surgical Site Infection Surveillance Service	Yes	Yes	248	100%	Not yet complete
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	N/A	N/A	N/A

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Neurosurgery Audit Programme	No	N/A	N/A	N/A	N/A
National Ophthalmology Database Audit	Yes	Yes	876	100%	Awaiting Publication of Results
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
National Audit of Anxiety and Depression	No	N/A	N/A	N/A	N/A
National Clinical Audit of Psychosis	No	N/A	N/A	N/A	N/A
Reducing the impact of serious infections (antimicrobial resistance and sepsis)	Yes	Yes	146	100%	Yes
Seven Day Hospitals Services	Yes	Yes	215	100%	Yes
UK Cystic Fibrosis Registry	No	N/A	N/A	N/A	N/A
Cystectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Women and Children's					
National Audit of Seizures and Epilepsies in Children & Young People	Yes	Yes	23 SGH 33 DPOW	100%	Currently data collecting
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	594	100%	Awaiting Publication of Results
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	4469 (Births between 01/04/16 – 31/03/17)	100%	Awaiting Publication of Results
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	41 (delivered in 18/19)	100%	Awaiting national report
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	17/18 203 submitted (18/19 still underway)	100%	Data collection underway
Paediatric Intensive Care (PICAnet)	No	N/A	N/A	N/A	N/A
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Perinatal Mortality Surveillance Report (June 2018)	Yes	Yes	48/48	100%	Yes
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Saving Lives, Improving Mother's Care (Nov 18)	Yes	Yes	1	100%	Reporting
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Breast cancer in Pregnancy (2019)	Yes	Yes	Not yet commenced	N/A	N/A
Total:	**74**				
Eligible for NLAG participation (NLAG participated in):	**55 (55)**				

National confidential enquires 2018/19

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning
Acute Heart Failure	Yes	Yes	2/2	10/11	11/11	GAP Analysis underway
Perioperative Diabetes	Yes	Yes	3/3	14/15 Surgical 13/15 Anaesthetist	14/15	GAP Analysis underway
Pulmonary Embolism	Yes	Yes	2/2	8/10	7/10 (8 excluded pts)	Awaiting Report
Bowel Obstruction	Yes	Yes	Not yet sent	1/11 (Recently assigned)	Ongoing Project	Ongoing
Long term ventilation	Yes	Yes	N/A	0/3 (not yet assigned)	Ongoing Project	Ongoing
Total:	**5**	**5**				
Eligible for NLAG participation:	**5**					

The reports of 25 national clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased information to patients/carers – Summary of some actions taken:

- Feverish Child (Care in Emergency Departments) – An information leaflet for patients will be developed and uploaded to A&E/ECC electronic system for instant printing access.
- VTE Risk in Lower Limb Immobilisation (Care in Emergency Departments) a patient information leaflet was developed and uploaded to the A&E/ECC electronic system.
- National Paediatric Diabetes (2017 cases, published July 2018): At SGH, a dietitian will discuss healthy eating with all families.
- MBRRACE: Perinatal Mortality (published July 2018): All parents of babies who die will be provided with unbiased counselling for post-mortem.

Increased awareness and education of staff – Summary of some actions taken:

- Feverish Child (Care in Emergency Department) – A paediatric Sepsis e-learning module is under development and will be made mandatory for clinical staff in relevant areas.
- Care in Emergency Department audits – The audit results have been regularly discussed at team huddles to drive improvements in practice. Posters are displayed in the emergency department reminding staff of national standards and current compliance levels.
- National Audit of Dementia – Delirium training has been incorporated into the dementia training.

- MBRRACE: Perinatal Mortality (published July 2018): Midwives and doctors to be provided with education / training on the following:
    - 'GROW' Package i.e. undertaking fundal height measurements / plotting fetal grow charts etc.
    - Smoking education
    - Reducing the stillbirth rate
    - How the families feel and how to support them
    - SANDS training to be provided on a bi-annual basis.
- National Cardiac Arrest Audit – Implementation of ReSPECT training for (Recommended Summary Plan for Emergency Care and Treatment) for staff has commenced and to be rolled out, including teaching regarding DNACPR.
- NNAP (2016 births, published 2017, action plan put in place during 2018): raise awareness to ensure all midwifery/medical/theatre teams are away of steps to be taken to reduce the chances of babies becoming too cold (i.e. hats ASAP following birth, baby dried immediately after birth, warm towels to be used).

Further evaluation/patient surveys – Summary of some actions taken:

- National Lung Cancer Audit –Deep dive audit underway to ascertain if opportunities were missed/ care pathway would have altered if a pathological diagnosis had been made.
- Procedural Sedation (care in Emergency Departments) –A re-audit is due to take place to test the embedding of changes following introduction of a new checklist.
- National Bowel Cancer Audit – To undertake a review of the cases with a stoma at 18 months.
- National Hip Fracture Database 30 Day Mortality Review – A Trust wide review to be carried out for all 30 day mortality patients with hip fractures for 2017 and 2018.
- NNAP (2016 births, published 2017, action plan put in place during 2018): An audit to be undertaken including all babies admitted to NICU with low temperatures in 2018.

Changes to service/process – Summary of some actions taken:

- National Comparative Audit of Blood Transfusion programme – Blood transfusion Integrated care pathway is currently being amended to incorporate NHSBT recommendations.
- National Audit of Inpatient Falls – A new delirium pathway has been developed to improve assessment and management of patients with delirium.
- National Emergency Laparotomy Audit - Introduction of NELA pathway, which prompts staff to follow guidance such as presence of consultant anaesthetist and surgeon for high risk cases, and prompts documentation of details.
- Falls and Fragility Fractures Audit Programme (FFFAP) National Hip Fracture Database – A business case has been approved for the implementation of 7 day cover for Physiotherapy which would support with the completion of the physiotherapy assessments and therefore enable them to achieve the Best Practice Tariff.
- MBRRACE: Perinatal Mortality (published July 2018): Trust to adopt the National Bereavement Care Pathway paperwork. (NLAG have been a pilot site since April 2018 but paperwork will be rolled out nationally from April 2019.

The reports of 24 local clinical audits were reviewed by the provider in 2018/19 and the Trust intends to take the following actions to improve the quality of healthcare provided (a sample of the actions agreed are summarised):

Increased awareness and education of staff – Summary of some actions taken:

- Medicine documentation audit/Emergency Care Centre documentation audit - Results shared with audit leads and clinicians in all medicine specialities via audit meetings; Business and Governance Meetings. Information Governance responsibilities discussed at ECC/A&E governance to raise awareness of need to have patient identifiable information on each page of the clinical record.
- Medicine documentation audit/Emergency Care Centre documentation audit – Royal College of Physicians standards distributed to all clinicians via and email, distributed at doctor inductions and discussed at Quality & Safety/Audit meetings.
- Audit of ultrasound locating devices for the placing of central vascular catheters: presentation to highlight to Anaesthetists that the central vascular catheter stickers should be used in all cases.
- Newborn Early Warning Trigger and Track (NEWTT): escalation process to be discussed with the nurses/health care assistants to ensure the correct process is always followed.
- Paediatric Early Warning Scores (PEWs): further training with A&E teams to be undertaken at the safety huddles.
- Customised growth charts: training to be undertaken for both hospital sites by an external company and information cascaded where required. E-learning package also be made available.
- Community record keeping audit: Raise awareness amongst staff to ensure patient details are recorded on SystmOne e.g. ethnicity, religion, next of kin details.

Changes to service/process – Summary of some actions taken:

- Diabetes foot risk assessment audit – Capillary blood glucose monitoring documented amended to include recording of date / time of foot risk assessment in order to provide assurance NICE guidelines are met.
- Medicine documentation audit/Emergency Care Centre documentation audit – The Trust's continuation sheets have been updated to include a field to record location of patient, in line with Royal College of Physician's standards.
- Paediatric Early Warning Scores (PEWs): new version of the charts to be implemented with the first row completed as an example of standard of entry.
- Swab checks in maternity: New sticker designed to be used where this is no designated space in the new notes for a swab check (e.g. FBS).

2.2c Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2018/19 that were recruited during that period to participate in research approved by a research ethics committee is 1,453.

2.2d Information on the Trust's use of the CQUIN framework

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust's income in 2018/19 was conditional on achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/cquin-17-19/

The areas of care which were included within the CQUIN scheme for 2018/19 included the following:-

- Improvement of health and wellbeing of NHS staff
- Sepsis
- Improving services for people with mental health needs who present to A&E
- Advice and guidance
- E-referrals
- Supporting proactive and safe discharge
- Alcohol and tobacco community
- Wound assessment community
- Personalised care community

The amount of income in 2018/19 which was conditional upon achieving quality improvement and innovation goals was £4.997 million. The monetary total value for 2017/18 CQUIN indicators was £6.427 million. The Trust received payment for £6.370 million during 2017/18.

2.2e Information relating to the Trust's registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is unconditional.

The CQC has not taken enforcement action against the Trust during 2018/19.

The Trust has not participated in special reviews or investigations by the CQC during the reported period.

Care Quality Commission (CQC) ratings grid for the Trust

(From their last visit of the Trust in May 2018, of which the report was published on 12 September 2018):

The Trust was pleased to receive again the overall rating of Good for caring. The Trust have fully accepted the CQC findings and is using these to inform the Trust's overall improvement programme, some details of which are provided as follows.

Action taken to improve further:

- The Trust's response to the CQC report was to take immediate action on those aspects requiring immediate response. The embedding of other quality improvements, related to the CQC visit's findings, and to other organisational challenges has been addressed by the Trust's Improvement Programme - ***Improving Together.***
- Improving Together focusses on six key work streams:
  - Leadership and Culture
  - Quality and Safety
  - Safe Staffing
  - Access and Flow
  - Finance
  - Strategy and Capital

- This programme of work is supported by a dedicated Improvement Team in place to support the project management and delivery of the individual work stream action plans. This is further overseen by the Trust Board and by other external stakeholders. Support has been provided to the Trust, and gratefully received, from external partners including NHS Improvement and NHS England.

Improvements to date:

- A selection of the changes and improvements made to date is summarised as follows:

  - Increased engagement with our doctors in training and improved training support leading to increase in Deanery fill rate from 68.80% in 2017 to 87.98% in 2018.
  - Turnover rates within the Trust continue to come down with a February 2019 Trust wide figure of 9.56%, a decrease of 1.80% over the last 12 months (11.36%). The Trust wide turnover figure has remained under 10.00% for the past eight months.

- The development of a Quality Improvement Strategy, endorsed by the Trust Management Board and Trust Board and the introduction of a Quality Improvement Training faculty.
- The latest staff survey figures for the Trust were released at the end of February 2019. They showed an improvement on many scores and some significant improvement in some areas such as staff feeling confident to raise concerns and overall staff engagement. However the results still show the Trust is some way behind the average and still has much work to do to improve morale and create a more supportive and open culture.
- A wholesale engagement programme is underway which includes divisions developing and acting on their own individual engagement plans, these will be monitored and the impact measured by an ongoing staff engagement pulse check. The Trust has also agreed to implement the Manchester Patient Safety Framework in the early stages of 2019/2020, this will see staff of all disciplines give their views on patient safety and help identify monitored actions for improvement.
- An additional 46.75 doctors are now employed at the Trust across a range of specialties.
- Where agency nurses are required, block booking arrangements are in place so that they can work on a regular ward, thus leading to better patient care and continuity of staff.
- Nursing staff trained in the use of the Safer Nursing Care Tool to enable us to better identify the correct staffing ratio for wards. This is currently being rolled out at DPOW.
- The Trust's mortality rate is reducing (particularly at Grimsby) with latest figures showing a SHMI of 113 and work continues to make sure this improvement is sustained.
- Reducing mortality is one of the Trust's five quality priorities for 2019/20 along with: identifying deteriorating patients; improving patient flow through the hospital (so patients are discharged in a timely way and there are beds available when needed); reducing medication incidents; and improving the time taken to treat patients with cancer.
- A recovery plan for the 52 week wait performance has been developed and this has improved from 320 at 31 March 2018 to 75 as at 3 March 2019 and continues to forecast no patient waiting over 52 weeks at 31 March 2019.
- Reduction in the size of the waiting list by around 3,000 patients.
- A&E performance in terms of A&E has been steady at around 86%. This is despite seeing an increase in the number of people attending A&E (up about 7 per cent compared to 2018).
- The patients from the 2016 backlog have been reviewed and seen where appropriate.
- There has been an overall reduction in our emergency length of stay from 5.3 to 4.8 This has been possible via the introduction of a number of new initiatives including:-
  - Development of Urgent Treatment Centres on both sites aimed at managing the operational 'front door'
  - Frail patients are now being managed as they attend A&E with assessments undertaken and referral on to a dedicated assessment area with the aim of providing the necessary support to facilitate a return home within 12 hours to avoid deconditioning of the patient, where possible.
  - The SAFER project is currently being rolled out across each of the inpatient wards, commencing in Medicine.
  - Introduction of 7 day physiotherapy in orthopaedics in Grimsby which has brought length of stay down (in conjunction with other measures) by 1.5 days.

2.2f Other External Visits and Reviews of Trust Services

Peer Review work during 2018/19

During 2018/19 the Trust continued to progress a number of clinical action plans related to NHS England overseen Peer Reviews. These visits are helpful to provide an external view of the Trust's services and assess where improvements in care are possible.

During 2017/18 the Trust had two peer review visits for the following services:

1. Neonatal Intensive Care Units (NICU) on each of the Trust's two main sites;
2. The Trust's Haemato-Oncology service, based on the Trust's two main hospital sites and including community provision of care.

Areas identified as requiring some improvement work included:

- Increased consultant presence on the neonatal unit at Scunthorpe General Hospital (SGH);
- Review of admissions and re-admission protocols and pathways to the units at both sites;
- Estates improvement work to ensure sufficient space in the unit for cots at both sites;
- Review of practice and use of specific interventions for patients with haematological cancers;
- Strengthening needed of prescribing practices and the move to more electronic prescribing;
- Strengthened governance processes;
- Challenges regarding staffing levels within the haemato/oncology service;
- Improved use of Systematic Anti-Cancer Therapy Dataset (SACT).

During 2018/19, the Trust maintained and updated NHS England on the progress made with the action plans developed following these reviews, with the majority of actions now completed. There are still some actions being worked through, and internally assurance is overseen by the Group Governance arrangements and will be further strengthened by the Quality Governance Group, chaired by the Trust's Acting Medical Director.

Peer review visits are linked to the self-assessment declarations the Trust must make to NHS England using the Quality Surveillance Tool (QST) process. This self-assessment is completed for all NHSE specialist commissioned services and some locally commissioned cancer services. The 2018/19 submission has been reviewed by the Trust's commissioners alongside NHS England and a number of areas are required to develop further improvement plans which will be overseen by the Quality Governance Group during 2018/19. The Trust has received notification that a peer review visit will take place during 2019 to assess the Trust's lung cancer service. The Trust will receive another planned peer review visit in March to review the services in place to provide cervical screening.

Other forms of external visits received by the Trust

The Trust have also received, around the same time as the CQC inspection, during May/June 2018 a review of maternity services led by the Royal College of Obstetricians and Gynaecologists (RCoG). This visit led to a number of recommendations being made. The Trust's response to these recommendations have been developed by the Trust's Women's and Children's division and the detail of the action plan and progress against this is overseen by their internal governance arrangements. This will also be overseen by the Trust's Quality Governance Group.

2.2g Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:
- Which included the patient's valid NHS Number was:
    - 99.6 per cent for admitted patient care
    - 99.9 per cent for outpatient care
    - 99.1 per cent for accident and emergency care.
- Which included the patient's valid General Medical Practice Code was:
    - 99.7 per cent for admitted patient care
    - 100.0 per cent for outpatient care
    - 100.0 per cent for accident and emergency care.

2.2h Information governance assessment report

2018/19 saw the release of the new 'Beta' Data Security and Protection Toolkit by NHS Digital. The Trust submitted its annual final submission in line with NHS Digital guidance on 28 March 2019 as 'Standards not Met (Action Plan Approved)'. The Improvement plan was approved by NHS Digital and will be closely monitored by the Trust IG Steering group and NHS Digital to ensure actions are met within the first two quarters and once all actions have been completed the Trusts final Submission will change to one of 'Standards Met'.

2.2i Information on payment by results clinical coding audit

The Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission.

2.2j Learning from Deaths

During 2018/19 1,526 of Northern Lincolnshire and Goole NHS Foundation Trust's patients died (this includes patients who died in the A&E department). This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 401 in the first quarter;
- 384 in the second quarter;
- 430 in the third quarter;
- 311 in the fourth quarter *[Jan-Feb 2019]*.

At 22 February 2019, 284 case record reviews and 8 investigations (undertaken as a Serious Incident investigation) have been carried out in relation to 1,526 of the deaths included above.

In one case a death was subjected to both a case record review and an investigation (undertaken as a Serious Incident investigation). The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 72 in the first quarter;
- 102 in the second quarter;
- 103 in the third quarter;
- 14 in the fourth quarter (as at the 22 February 2019).

Two, representing 0.13% of the patient deaths during the reporting period, are judged to be more likely than not to have been due to problems in the care provided to the patient *[definition: using Royal College of Physicians (RCP) question: "Avoidability of death judgement score" for patients with a score of 3 or less – see narrative below for more information]*.

In relation to each quarter, this consisted of:

0 representing 0% for the first quarter;
0 representing 0% for the second quarter;
2 representing 0.13% for the third quarter;
0 representing 0% for the fourth quarter.

These numbers have been estimated using the Structured Judgement Review (SJR) which includes a Six factor Likert scale ranging from "definitely not avoidable" to "definitely avoidable". The above estimate includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by the mortality clinical lead or appropriate specialty clinical lead. This process links into the Trust's Serious Incident Framework. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping improve quality of care.

63 case record reviews and 0 investigations completed after 1 April 2018 which related to deaths which took place before the reporting period.

One, representing 0.23% of the patient deaths before the reporting period [1,557 deaths during 01 April 2017 – 31 March 2018], are judged to be more likely than not to have been due to problems in the care provided to the patient.

This number has been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from definitely not avoidable to definitely avoidable. The above estimate includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale.

This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary.

It should be stressed that this data is not a reliable measure of deaths that were avoidable; rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

1 representing 0.23% of the patient deaths during the previous reporting period [01 April 2017 – 31 March 2018] are judged to be more likely than not to have been due to problems in the care provided to the patient.

For further information relating to mortality improvement work, please see part 2.3a

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2018/19; and,
Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2018/19

The Trust has not found, from the mortality reviews completed, evidence of systematic failings in care delivery leading to 'avoidable' deaths. The Trust views mortality review as an opportunity to review the quality of care provided to these patients. From these mortality SJR case reviews, the following quality improvement themes have been identified:

- Delays in provision of care was identified, relating to a variety of aspects including some delays in specialist review or referral, delay in diagnosis warranting follow-up investigations thereby delaying treatment, delayed review over weekends and delays to Theatre. The Trust is working on flow through its acute hospitals, as detailed earlier within this report. Delays relating to specific interventions are shared with those leading on improvement work around these areas.
- End of life pathway utilisation and management of patients in line with the pathway is an identified theme for improvement. Specific areas identified include the potential to start the end of life pathway sooner to prompt for review of medications and improved communication with families and carers. The Trust's end of life strategy group is aware of these themes and is working with wider stakeholders to improve the quality of care. A regular report containing end of life themes from mortality SJR reviews is received by the group.
- Do Not Attempt Cardio-Pulmonary Resuscitation (DNaCPR) themes have highlighted improvements in considering, discussing and documentation of the decision. The Trust is looking to undertake a more detailed review of this with the Trust's Mortality Clinical Leads.
- Monitoring and documentation surrounding the use of fluids continue to remain a theme for improvement. This has been shared across the trust with targeted learning from themes addressed to areas of concern. Additional work has been invested into changing the documentation to record this information and to act as a prompt for nursing staff to support improved recording. This is also a part of the Nutrition and Hydration improvement group's work. Additionally work has been undertaken during the year to develop an Acute Kidney Injury (AKI) pathway. Work is also currently underway to develop a Hyperkalaemia pathway and revised policy.
- Documentation issues relating to inaccurate death certificate documentation have been identified a theme for improvement in care. Specific recommendations for these to be reviewed and approved by senior clinicians have been made and work is underway in the Trust to initiate the Medical Examiner model within the Trust from April 2019, this role will support a review and completion of death certificates and will standardise the recording processes.
- Community and primary care themes have been identified relating to cases where hospital clinicians have felt the hospital admission was potentially avoidable. The Trust is working collaboratively with NEL CCG colleagues, headed up by their lead GP, to review these cases to identify key lessons for sharing with GPs and community colleagues. Other themes relating to GPs and community care are shared with the intention of developing collaborative improvement plans. The Trust is hoping to establish similar processes with the Trust's other commissioners and GPs in those geographical localities.
- The Trust has focussed on improving the process by which it undertakes mortality reviews with the intention of strengthening feedback loops of learning for sharing with clinical staff and embedding effective morbidity and mortality (M&M) review meetings. These feature as quality priorities for 2019/20.

An assessment of the impact of the actions taken by the Trust during 2018/19

Whilst many of the actions described are still underway, there has been some positive impact as a result of the actions taken already by the Trust. These are summarised as follows:

a) **Access and flow: Improvements on the Diana, Princess of Wales Hospital site:** linked to the previously described local quality priorities detailed already within this report, the Trust has been working to improve access and flow. During September 2017, Diana, Princes of Wales Hospital implemented an Ambulatory Care model, mirroring this service already available at Scunthorpe General Hospital. Ambulatory care is designed to ensure suitable patients are seen by a senior clinician for access to diagnostics to support quick decision making and the management of the patient as an out-patient or day-case discharging them the same day, thereby reducing the number of patients admitted to hospital, therefore reducing some of the pressure on the hospital's finite number of beds and staffing.

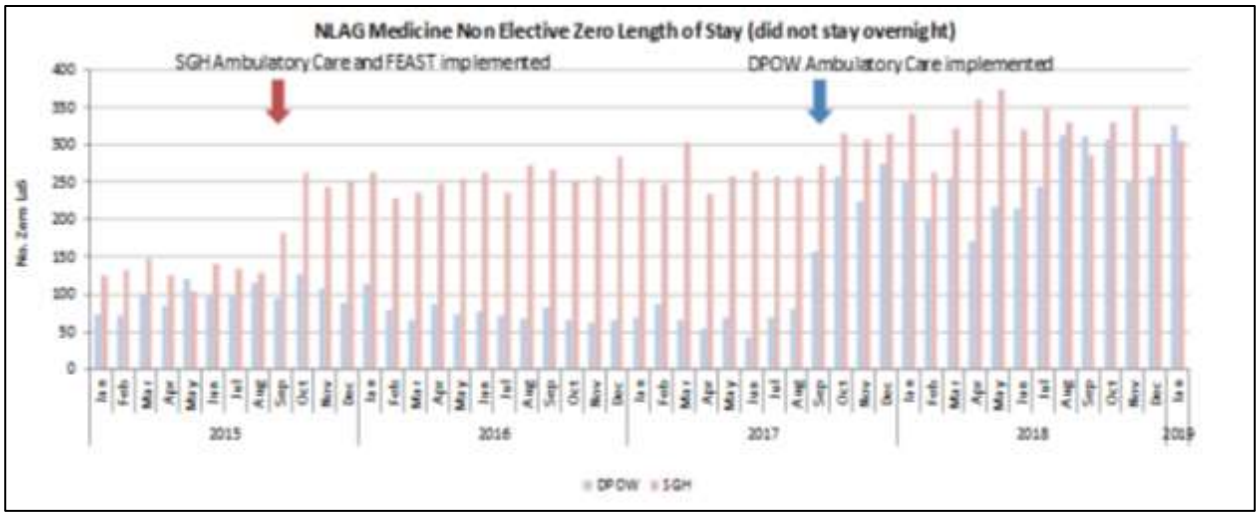


Figure 12 shows the number of patients accessing ambulatory care services with a zero length of stay which demonstrates an increased number of patients not being admitted to hospital

Source: Northern Lincolnshire and Goole NHS Foundation Trust- Information Services (Feb-19)

- The above chart demonstrates that the number of patients being reviewed and discharged from hospital on the same day (or as a 'zero length of stay') has increased significantly since the implementation of the Ambulatory Care services across both sites which has supported management of additional demand on Trust non-elective services.

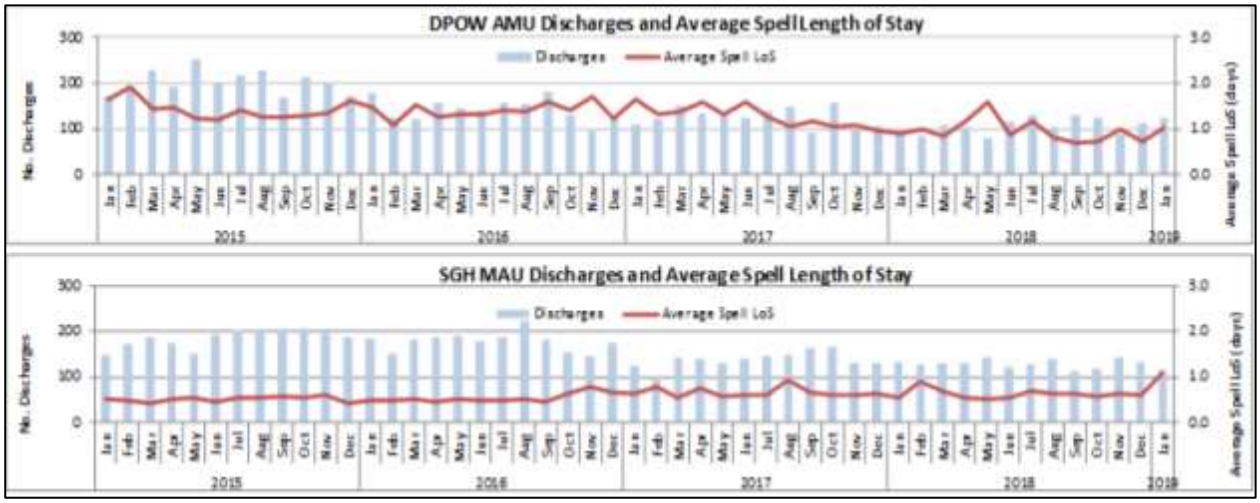


Figure 13 demonstrates the reduction in the average length of stay observed on the Trust's admission units which demonstrates some improvements on the DPoW site. This has moved closer towards the length of stay observed on the SGH site.

Source: Northern Lincolnshire and Goole NHS Foundation Trust- Information Services (Feb-19)

- The above chart again demonstrates that the average length of stay on the admissions ward at DPoW has reduced. This further supports new admissions to be cared for and moved to specialty wards for appropriate clinical management sooner.

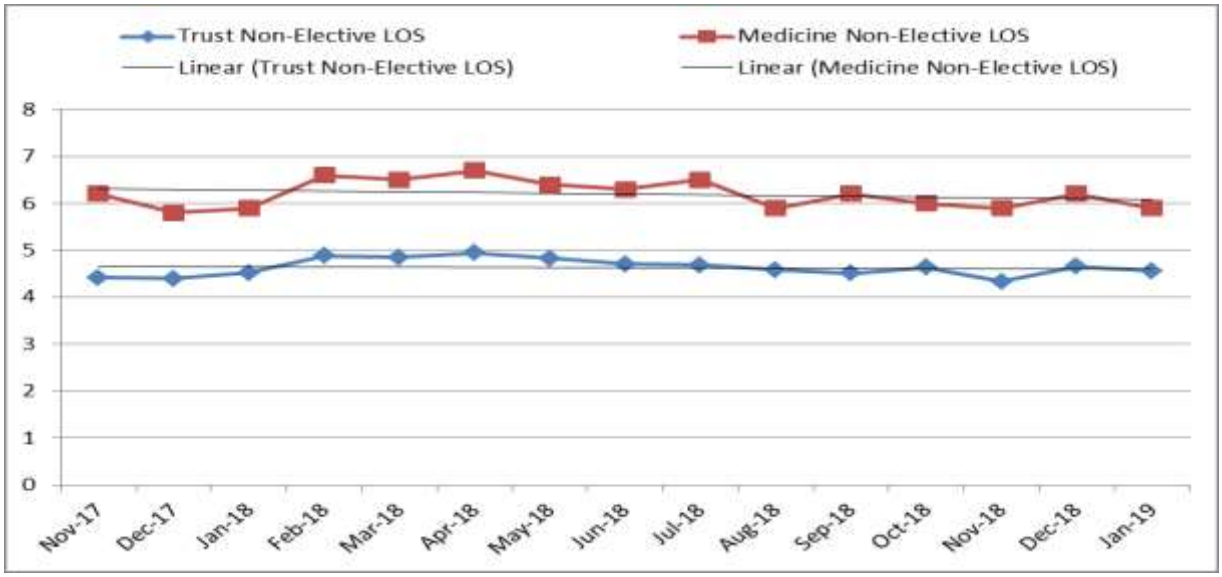


Figure 14 the chart outlines reductions in Trust non-elective LOS in comparison with Medicine non-elective LOS, both demonstrate reducing trends

Source: Northern Lincolnshire & Goole NHS Foundation Trust- Information Services (Feb-19)

- As well as reductions in length of stay on the medical assessment units, the Trust's non-elective length of stay has reduced both for the Trust as a whole and for medicine. This is in the context of increased pressure on Trust services.
- **b) Deteriorating patient:** The Trust's use of the electronic NEWS system to monitor in real time observations being recorded has demonstrated improvements during 2018/19 in recording. Feedback routes have been developed and this data is shared with ward areas using the deteriorating patient ward scorecards. Work continues as part of the Trust's deteriorating patient group to look at individual ward performance and ensure support arrangements are in place to support ward based and owned improvements in care.

- **c) Recording and coding:** During 2018/19, the Trust has commenced more focussed reviews of data forming the basis of the Standardised Mortality Ratios (SMRs) such as SHMI. Given these indicators provide a statistical construct of the actual mortality compared with the expected mortality, accurate recording is key. The Trusts work to date has been to select diagnostic groups with elevated SHMI scores and undertake a coding audit and a documentation audit to determine if improvements in either coding or recording quality are possible. This work remains underway. A policy has been drafted to support the Trust agree a methodological approach to investigate specific alerts related to SHMI or HSMR.
- More latterly, the Trust, with support from NHS Improvement, has been working with a statistician to explore the statistical data driving the SHMI and HSMR. This work is still underway, but it has enabled some improved understanding regarding hospital site differences. Key findings to date from this action include:
  - Palliative care recording on the two sites is different, mirroring the differences in service provision between the two sites and how palliative care services are delivered. Further work needs to be undertaken to determine if there is scope for improvements in this area.
  - Depth of recording and coding. The statistical data has demonstrated a significant difference on the DPoW site with the attribution of risk which ultimately informs the calculation of the SHMI and HSMR. Whilst public health data demonstrates that there is a higher incidence of premature mortality (<65 years of age) in North East Lincolnshire, the risk factors for mortality, currently being recorded, that informs this risk calculation appear to be potentially underreporting risk compared to SGH which may explain the differences between site based mortality.
  - There is also a disparity in hospital mortality (which is 'as expected') compared with out of hospital mortality which is 'higher than expected'. The ongoing work will seek to understand this in greater detail also.
- **d) Learning from deaths:** The Trust strengthened its processes during 2018/19 to support a focus on learning from mortality case reviews, the only way of assessing and quantifying the quality of care provided to patients. An element of this has been the aim of increasing the number of case reviews being undertaken to achieve a minimum 20% of deaths being reviewed. The Trust are on course to achieve this aim, and then during 2019/20 improve the process still further resulting in more case reviews completed and improved structures in place to ensure these cases are discussed by clinical teams to extract learning to enable this to be widely shared. Some significant steps have been taken already with effective processes being put in place within Cardiology, Haematology and Oncology, Women's & Children's and in development for Acute Medicine. To embed these more effective arrangements across the majority of specialties forms the bases of the quality priorities for 2019/20.

2.2k Clinical Standards for Seven day Hospital Services

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. With further input from the AoMRC, four of the ten standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These key standards are:

- Standard 2: Time to first consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

The Trust is required to be achieving these standards by 2020/2021. More information can be found at: https://improvement.nhs.uk/resources/seven-day-services/.

NHS England is supporting the Trust (and other Acute NHS Trusts) work towards full compliance with the four key standards by 2020. The Trust monitored performance against these standards using a biannual survey as agreed by NHS England. The next planned evaluation of performance against these key standards is scheduled during June 2019 using a new monitoring process. The Trust's lead for this project is the Medical Director with support being provided by the Chief Operating Officer's team and the Quality & Audit teams. As well as the ongoing audit support to the project, action plans are being developed at Divisional level, to implement the programme of work. NHS England continues to provide full support to this project. The findings from the evaluation have been fed back to clinical teams to support ongoing engagement and change management.

This new measurement system replaces the previous self-assessment survey and consists of a standard measurement and reporting template, which all providers of acute services will complete with self-assessments of their delivery of the seven day service clinical standards. The trial run for submission of the Board assurance template was 28 February 2019 with the formal submission scheduled for 28 June 2019.

2.3 Trust performance against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS Foundation Trust's indicators should be compared with:

a) **The national average for the same and**
b) **Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.**

This information should be presented in a table or graph (as seems most appropriate). For each indicator, the Trust will also make an assurance statement in the following form:

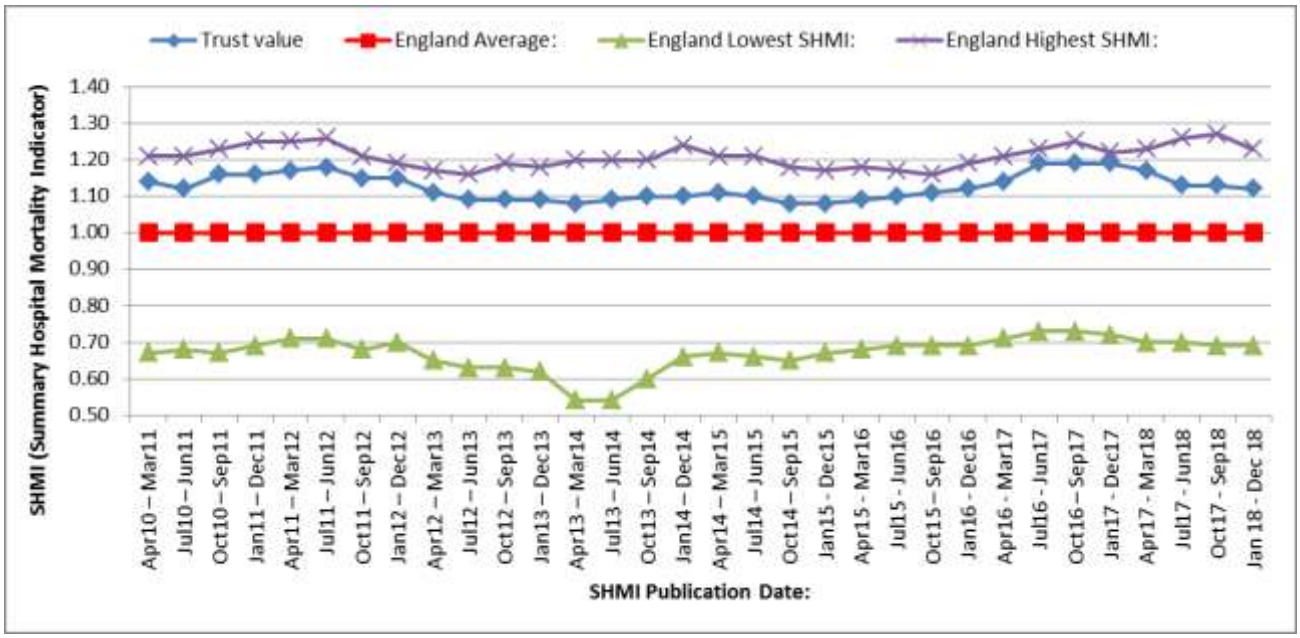
> The Trust considers that this data is as described for the following reasons *[insert reasons]*.
>
> The Trust *[intends to take or has taken]* the following actions to improve the *[indicator / percentage / score / data / rate / number]*, and so the quality of its services, by *[insert descriptions of actions]*.

Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore the following indicators reported on are only those relevant to the Trust.

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

The data made available to the Trust by NHS Digital with regard to:

b) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period;



	Oct-11	Jan-12	Apr-12	Jul-12	Oct-12	Jan-13	Apr-13	Jul-13	Oct-13	Jan-14	Apr-14	Jul-14	Oct-14	Jan-15	Apr-15	Jul-15	Oct-15	Jan-16	Mar-16	Jun-16	Sep-16	Dec-16	Mar-17	Jun-17	Sep-17	Dec-17	Mar-18	Jul-18	Sep-18	Nov-18	Feb-19	May-19
NLaG SHMI	1.14	1.12	1.16	1.16	1.17	1.18	1.15	1.15	1.11	1.09	1.09	1.09	1.08	1.09	1.1	1.1	1.11	1.1	1.08	1.08	1.09	1.1	1.11	1.12	1.14	1.19	1.19	1.19	1.17	1.13	1.13	1.12

Figure 15 shows the Trust's SHMI score, trended over time, compared to the absolute UK average (1.00) and highest and lowest reporting Trusts, the chart demonstrates positive progress seen in recent SHMI releases
Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed comes from the Office for National Statistics; this results in delay in the reporting of the SHMI. To illustrate the most recently available SHMI reports performance between January 2018 and December 2018 (publication date was May 2019).

This delay in reporting makes it difficult for the Trust to continuously undertake real-time monitoring of this area using SHMI alone, hence why the Trust uses this in collaboration with the 'provisional SHMI' indicator from the Healthcare Evaluation Data (HED). Using this 'provisional indicator' the Trust has access to more timely monthly information which demonstrates further improvements with mortality performance, illustrated graphically as follows.

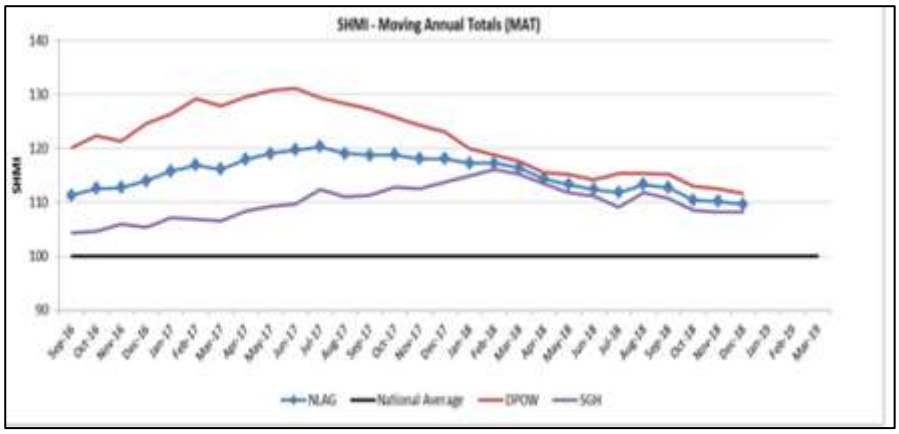


Figure 16 shows the HED SHMI for the Trust and demonstrates the reduction over time of the Trust's SHMI score as well as the individual sites SHMI score, with DPoW being higher overall. The HED data reports up to December 2018
Source: Healthcare Evaluation Data (HED), information services team

- The above chart illustrates that the Trust's HED SHMI provisional mortality performance has continued to reduce.
- The gap between both of the Trust's hospital sites has narrowed displaying a progressive declining trend. As cited previously, from some work being undertaken alongside NHS Improvement, statistical analysis of the SHMI and the principle data feeds has identified a disparity between the recording of 'expected' deaths or the risk factors that are used by the indicator to statistically calculate the 'expected' deaths at DPoW hospital. Given the known public health challenges in North East Lincolnshire, this disparity requires further review as part of the mortality improvement plan.
- Whilst 100 is the national England average and is commonly defined as 'expected' mortality, it is recognised that this statistical measure is not an absolute indicator of performance, rather there is confidence intervals that are classified as being 'as expected'. As a result of this, NHS Digital publish an organisation's position nationally, determining the national lowest and highest, as well as a Trust banding, which illustrates if an organisation is statistically an outlier, using 95 per cent confidence intervals. This is also presented as a funnel chart, as follows.

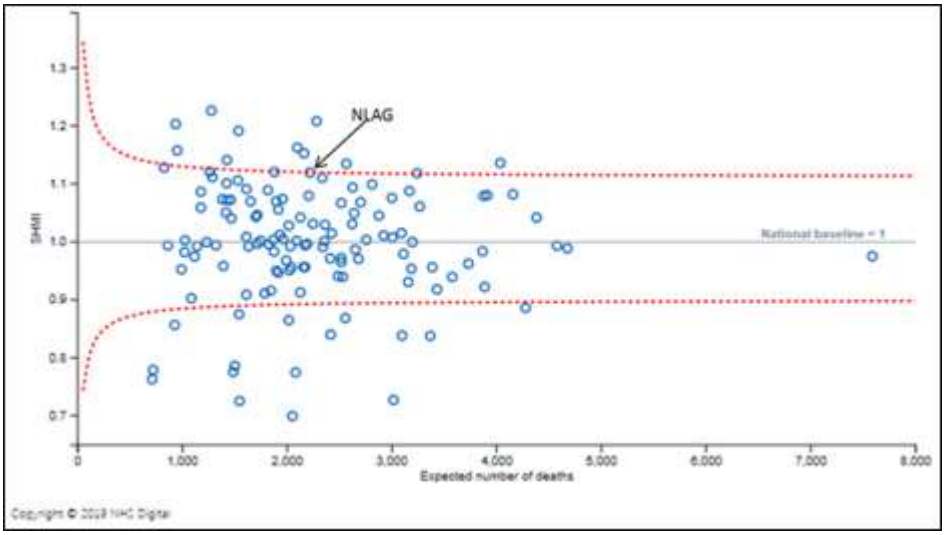


Figure 17 the chart above illustrates the Trust's 'official' SHMI. It is within the 'as expected' range within the funnel plot
Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

- The previous chart illustrates that the Trust is now within the 'as expected' range for SHMI performance.

c) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.

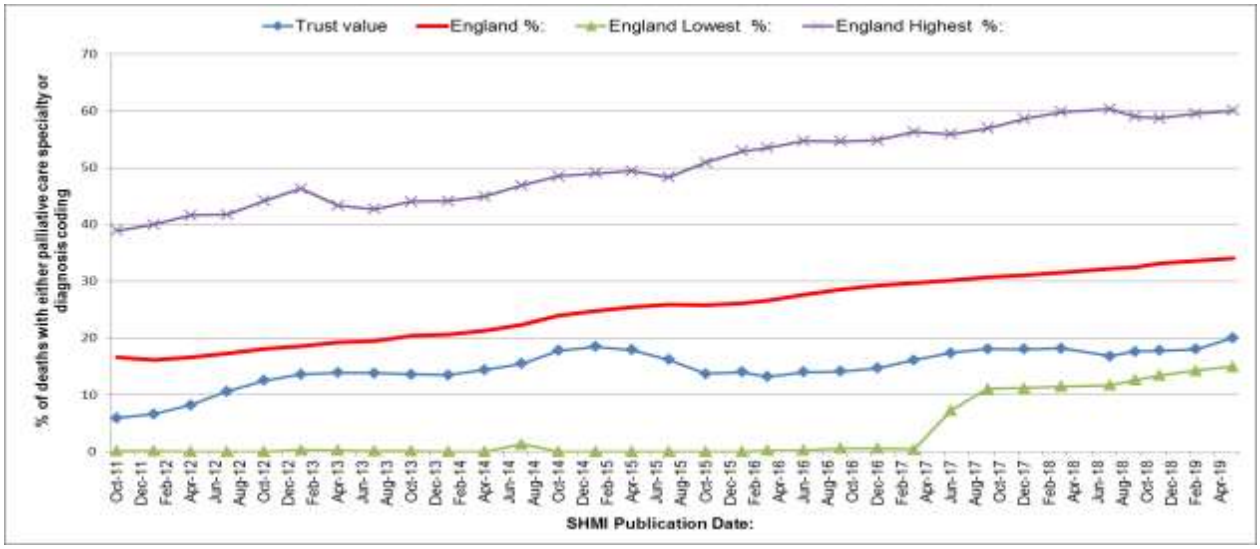


Figure 18 the chart visually illustrates the percentage of patients with a coded palliative care code at either diagnosis or specialty level
Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

- The above chart illustrates the percentage of patients with a palliative care code used at either diagnosis or specialty level.
- Palliative care coding is a group of codes used by hospital level coding teams to reflect palliative care treatment of a patient during their hospital stay. To ensure these are not exploited for minimising an organisation's reported standardised mortality ratio, Trusts are required to meet strict rules that govern the use of such codes to only those patients appropriately seen and managed by a specialist palliative care team.
- The SHMI does **not** exclude this group of patients, rather they are included and the appropriate risk factor for each is statistically determined according to the model. As palliative care coding is a key mortality indicator, the SHMI on publication each quarter include the above breakdown of data for Trusts to see the proportion of palliative care codes being used versus the national average.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust's commissioned review of the data that underpins SHMI has identified a disparity between sites in the use of palliative care codes, which mirrors the differences in service provision recognising there are different models used at the two hospital sites. More work is needed to scope out the need for a change in the service provision and to determine if more consultant palliative care input is needed on the DPoW site.
- It is important to note that SHMI cannot be regarded as a measure of quality, as concluded from research undertaken and published. Quality can only be measured from case note review work, hence the Trust's prioritisation of this as a quality priority during 2019/20.

- The Trust is committed to ensure that mortality case note reviews are undertaken in a steadily increasing proportion of cases and is working to embed effective arrangements within specialties to ensure that case note reviews lead to reflective practice, lessons identified which are shared and used to learn from thereby increasing the quality of services provided, which will impact positively on patient outcomes including mortality. To this end the Trust has established key learning from deaths key performance indicators to support the case note review processes become more effective. Process developments are underway to support this including the introduction of a mortality review e-form.

The Trust has taken the following actions to improve the indicator and percentage in indicators a and b, and so the quality of its services by:

- The Trust has two mortality clinical leads that are supporting the mortality improvement work. These support and oversee the project work, reporting to the Mortality Improvement Group (MIG) on a monthly basis. This group have approved a number of key documents aimed at supporting further improvement including the learning from deaths policy and a mortality improvement strategy.
- The mortality improvement strategy has been agreed which aims to target 3 specific areas:
    1. Medical model – to focus on improved access and flow around the Trust's hospitals. This is also linked to the quality priorities for 2019/20;
    2. Care of the deteriorating Patient – with links to the quality priorities for 2019/20 to support oversight and progress reporting;
    3. Care for patients at end of life – overseen by the Trust's EOL strategy group with established links with external stakeholders to the Trust and also with links to the 2019/20 quality priorities. This part of the strategy will closely align the Trust and community partners recognising that these indicators are a reflection on a healthcare systems performance, not just on the hospital provided care;
    4. Learning from deaths review work – with links to the quality priorities for 2019/20 to again focus on progress and delivery, with reporting to Board.
- The above strategy also links to the Trust's end of life work, overseen by the Trust's EOL strategy group with established links with external stakeholders to the Trust and also with links to the 2019/20 quality priorities. This is aiming to closely align the Trust and community partners recognising that these indicators are a reflection on a healthcare systems performance, not just on the hospital provided care;
- During 2018/19 the Trust also appointed a dedicated analyst to support the development of the learning from mortality and near misses (incidents) for wider sharing with clinical teams; this focus has helped prioritise improvement work. This support to clinical teams will evolve during 2019/20 as the focus on sharing lessons increases pace.
- The quality priorities for 2019/20, some of which have already been referred to, have significant links to the mortality improvement work programme as well. Deteriorating patient and sepsis quality priority themes will support the Trust's focus going forward.
- The Trust has been supported during 2018/19 by collaborative working with GP, CCG and community partners, this has helped identify key themes for sharing with the wider healthcare system, further close working relationships will remain an ongoing action for the Trust during 2019/20.

2.3b Patient Reported Outcome Measures (PROMS)

The data made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Groin hernia surgery
b) Varicose vein surgery (no longer performed by this Trust)
c) Hip replacement surgery
d) Knee replacement surgery.

During the reporting period.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Groin hernia	April 2011 – March 2012	0.084	0.087	0.143	-0.002
	April 2012 – March 2013	0.083	0.085	0.157	0.015
	April 2013 – March 2014	0.051	0.085	0.139	0.008
	April 2014 – March 2015	0.085	0.084	0.154	-0.006
	April 2015 – March 2016	0.128	0.088	No data available	No data available
	April 2016 – March 2017	0.109	0.086	No data available	No data available
	April 2017 – March 2018	No data available	No data available	No data available	No data available
Hip replacement (Primary)	April 2011 – March 2012	0.405	0.416	0.532	0.306
	April 2012 – March 2013	0.461	0.438	0.538	0.369
	April 2013 – March 2014	0.426	0.436	0.545	0.342
	April 2014 – March 2015	0.436	0.437	0.524	0.331
	April 2015 – March 2016	0.485	0.438	No data available	No data available
	April 2016 – March 2017	0.501	0.445	No data available	No data available
	April 2017 – March 2018	0.453	0.468	0.56	0.376
Knee replacement (Primary)	April 2011 – March 2012	0.317	0.302	0.385	0.180
	April 2012 – March 2013	0.357	0.319	0.409	0.195
	April 2013 – March 2014	0.332	0.323	0.416	0.215
	April 2014 – March 2015	0.339	0.315	0.204	0.418
	April 2015 – March 2016	0.349	0.320	No data available	No data available
	April 2016 – March 2017	0.361	0.324	No data available	No data available
	April 2017 – March 2018	0.323	0.338	0.416	0.233

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Comment:

- The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The four areas listed above are nationally selected procedures. Varicose vein surgery is not performed by the Trust, therefore no data is available.
- Reporting for groin hernia has been phased off due to the NHS England decision in October 2017 to discontinue the mandatory groin-hernia surgery national PROM collections. The rationale for this decision is that Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there is no condition-specific PROM for groin-hernia surgery, means that the existing PROM has limited value. The last available data ceased following May 2018.
- The above table shows the Trust's reported adjusted health gain against the EQ-5D index, which is a measure of the patient's own reported outcome following surgery within the Trust.
- 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.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health).

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The results for the latest available data release as at February 2019 demonstrates that the Trust was not a statistical outlier for any of the EQ-5D health gain outcomes reported. At the time of writing, groin hernia data is not yet available for the latest period of time (April 2017 – March 2018).
- Quarterly reports are received from NHS Digital that provide progress updates on both the participation rates both pre and post-surgery, and the overall health gain reported by patients.

The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:

- Presenting the patient level results at the surgery and critical care quality & safety days bi-annually as well discussing at clinical governance group and presenting to clinicians at the general surgery clinical audit meetings. The Trusts access to patient level data enables us to analyse in house and use findings to drive further improvements in patient reported outcomes.
- Continuing to review participation rates for each clinical procedure and making improvements in the internal monitoring of pre-operative questionnaire returns to ensure all eligible patients are given the opportunity to participate.

2.3c Readmissions to hospital

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

a) 0 to 15; and
b) 16 or over,

Readmitted to a hospital, which forms part of the Trust within 28 days of being discharged from a hospital, which forms part of the Trust during the reporting period.

Age group	Time frame	Trust Emergency readmissions (%)	National re-admissions (%)	National highest (%)	National lowest (%)
0 to 15	2011/2012	8.56%	10.01%	14.94%	0.00%
	2010/2011	8.19%	10.15%	25.80%	0.00%
	2009/2010	7.93%	10.18%	31.40%	0.00%
	2008/2009	7.59%	10.09%	22.73%	0.00%
16 or over	2011/2012	9.47%	11.45%	17.15%	0.00%
	2010/2011	9.18%	11.42%	22.93%	0.00%
	2009/2010	8.92%	11.16%	22.09%	0.00%
	2008/2009	8.64%	10.90%	29.42%	0.00%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Comment:

- There is an ongoing review by NHS Digital of emergency readmissions indicators. This data has not been published since 2014. As part of this review, two indicators will be published during early 2019.
- As there has been no updated information added to the NHS Digital Quality Account indicators site, the Trust cannot provide any further update on this section.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has been consistently below the national rates for re-admissions, as demonstrated in the locally available data to the Trust.

The Trust intends to take the following actions to improve these percentages, and so the quality of its services by:

- The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.

2.3d Responsiveness to the personal needs of patients

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.

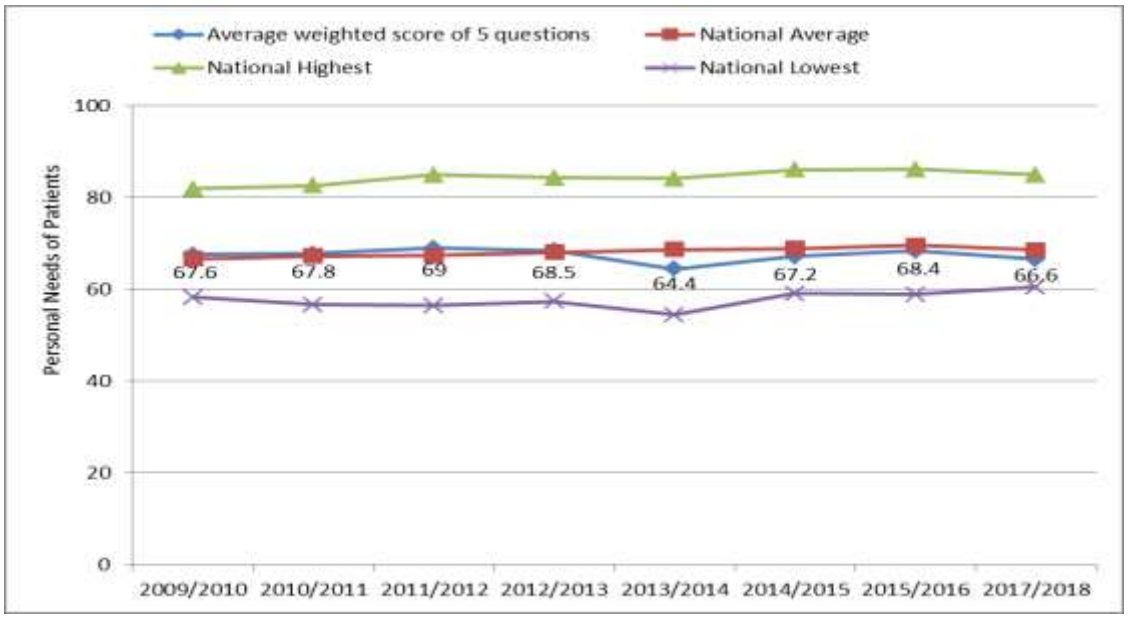


Figure 19 demonstrates Trust performance with five weighted scores from the national inpatient survey used to determine the Trust's responsiveness to patient's receiving care in its acute services
Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Comment:

- The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the highest and lowest performers within the NHS.
- The above figures are based on the adult inpatient survey, which is completed by a sample of patients aged 16 and over who have been discharged from an acute or specialist trust, with at least one overnight stay. The indicator is a composite, calculated as the average of five survey questions from the inpatient survey. Each question describes a different element of the overarching theme:

"*Responsiveness to patients' personal needs".*

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust results are broadly in line with the national average but it continues to aspire to reach beyond this.
- We know that by developing a positive culture, ensuring the workforce is adequate, competent and empowered will have a natural impact on care and the resulting patient perceptions.

The Trust has taken the following actions to improve this data, and so the quality of its services by:

- The Trust are focussing staff on "what matters most" to patients and supporting effective communication. By working with staff on projects such as, "what matters to you" bed boards and ALWAYS Events, the emphasis is building a culture of getting staff to re-engage with patients, carers and families to deliver person centred care and quality improvements.

2.3e Staff recommending Trust as a provider to friends and family

The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.

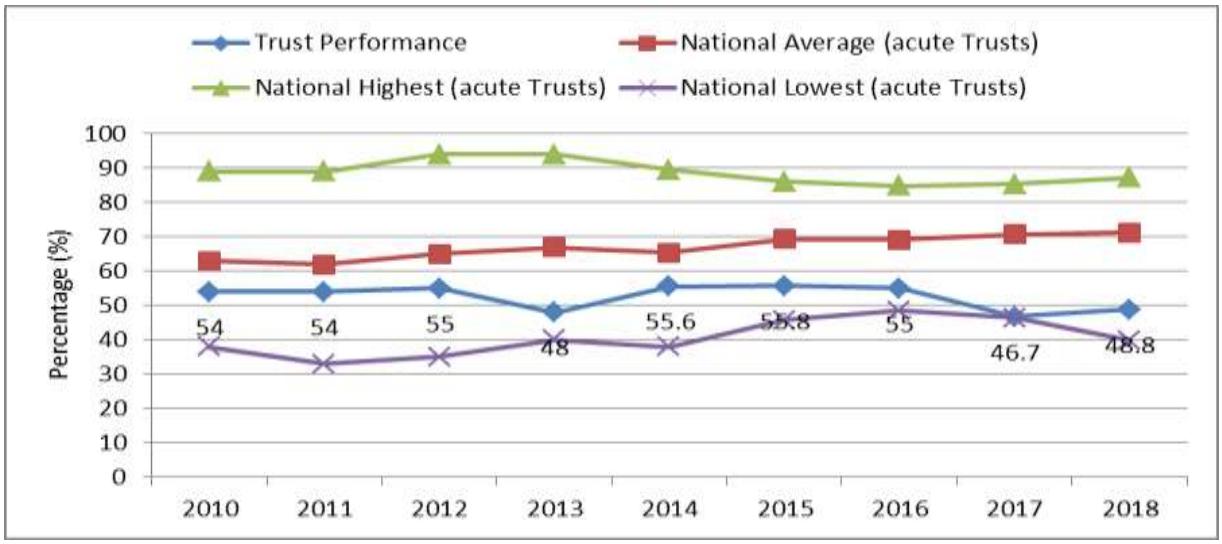


Figure 20 shows the Trust reported performance for staff recommending the Trust as a provider to family and friends
Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Comment:

- The above table illustrates the percentage of staff answering that they "Agreed" or "strongly agreed" with the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust".
- 49% of staff surveyed would recommend the Trust, which is an improvement from the previous year's survey result and demonstrates that Trust staff are seeing evidence of the improvements being made. The Trust recognises that whilst this is positive, more work is needed to continue improving.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- Despite some progress the Trust recognises there is still much more needing to be done to improve the overall score. Reviewing available comments the Trust believes staffs perceptions are built on concerns relating to staffing levels against increased patient activity and concerns over support from senior managers. This is having an adverse effect on workforce morale and their perception over the quality of care offered to patients.
- The Trust have identified these themes prior to the national staff survey being released and has been proactively working throughout 2018/19 to address the themes underpinning these findings.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- Prior to release of the NHS staff survey, action had already commenced, with culture being included as a specific and distinct work stream as part of the Trust's Improving Together Programme. Actions already taken include:
  - A key finding from the NHS Staff Survey was in connection with a lack of staff. The Trust continues to use innovative ways to recruit to posts that are challenging to fill. This has included the creation of new roles and the continued expansion of the Trust's apprenticeship programme to home grow future talent. To complement this the Trust continues to focus on the targeted recruitment and retention of staff.
  - The Trust is due to embark on a safety culture diagnosis across its clinical areas using the Manchester Patient Safety Framework tool. Starting in Clinical Support Services and Community and Therapies divisions in April 2019 the tool will be rolled out across all divisions in 2019/20. The output of the tool will allow divisions to create a meaningful action plan which endeavours to place clinical safety central to all the care they provide and their clinical practices.
  - Continued development of 'Pride and Respect (our anti-bullying campaign)' project provides staff and leadership teams with training regarding appropriate behavioural standards (linked to the Trusts values) and access to 'Lets Talk' the Trusts newly launched mediation service.
  - The Trust has through extensive staff engagement revised and is about to launched its new values; Kindness, Courage and Respect. Linked to this is a revised behavioural framework designed to complement the Trust's cultural transformation programme
  - The Trust is placing significant emphasis on staff engagement and the benefits of senior leadership teams increasing their level engagement. Divisions are creating bespoke staff engagement plans from which they will review the effectiveness of their staff two-way communication channels and how they provide staff with the means to make service improvement suggestions.

2.3f Risk assessed for venous thromboembolism

The data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.

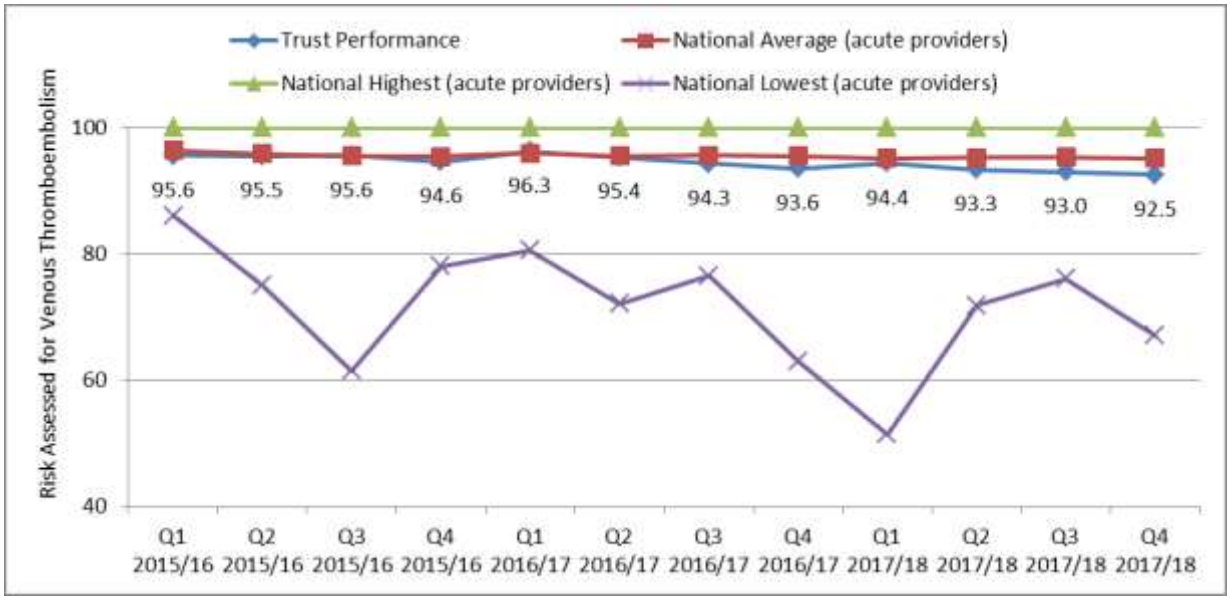


Figure 21 Trust performance for patients risk assessed for venous thromboembolism (VTE); Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2015/16. The Trust is not at present achieving the 95% target for this area.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust oversees compliance with VTE risk assessments and prophylaxis prescribed through monthly reporting through the Trust's performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding and improvement.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- A specific project is underway to work on improving VTE screening performance, being led on by the Trust's Deputy Medical Director.
- The Trust's VTE group has been re-established to focus on this area. The root causes behind why performance reported here is not yet achieving the target, and work to address this will be undertaken overseen by the Trust's Medical Director.
- The Trust has also been successful in their application to be a pilot site for the roll-out of an Electronic Prescribing and Medicines Administration (EPMA) system. As part of this, commencing from April 2019, it is anticipated that greater controls in place to support improved prescribing will lead to safety benefits including greater ability to ensure VTE risk has been fully assessed prior to prescribing or administration of medications.

2.3g *Clostridium Difficile* infection reported within the Trust

The data made available to the Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of *Clostridium difficile* infection reported within the Trust amongst patients aged 2 or over during the reporting period.

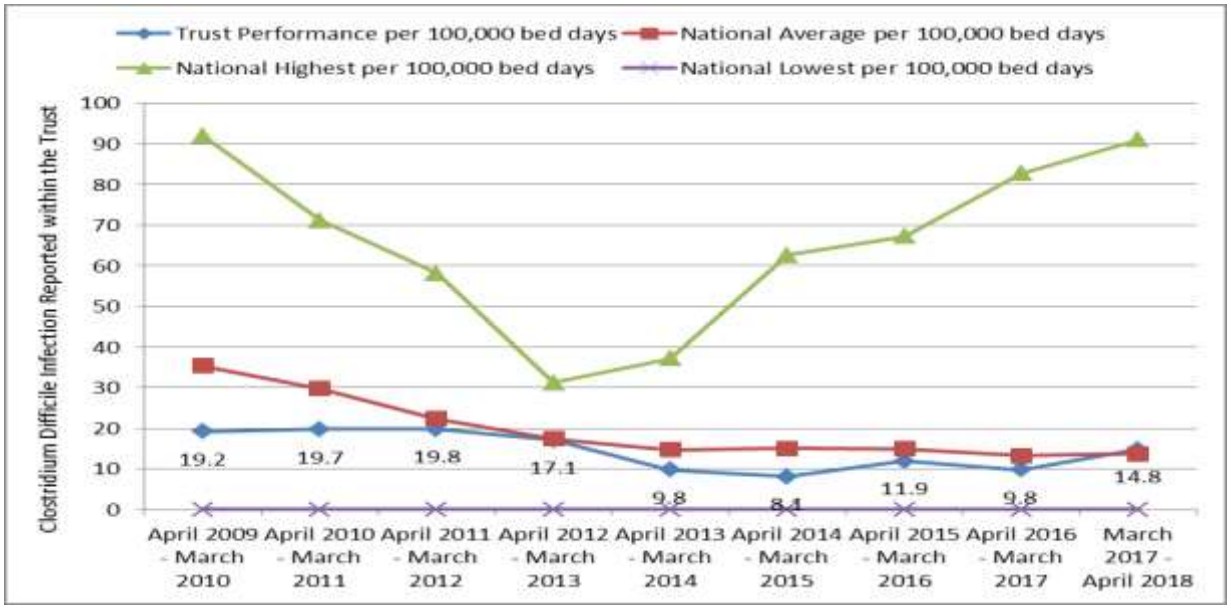


Figure 22 Trust performance for *C difficile* infections reported within the Trust per 100,000 bed days

Source: NHS Digital Quality Account Indicators Portal, Trust apportioned cases (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Key to abbreviations:

Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average,
National highest – The Trust/hospital/unit reporting highest rates per 100,000 bed days,
National lowest – The Trust/hospital/unit reporting lowest rates per 100,000 bed days.

Comment:

- The above table illustrates the rate of *C. difficile* per 100,000 bed days, for the Trust (Trust apportioned cases), for specimens taken from patients aged two years and over.
- During 2017/18, the most recent data available, the Trust reported a higher number of *C. difficile* infections than the UK average.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust ended the financial year on 37 cases of C.difficile toxin positive. The rise in number of cases may be partially attributed to the high level of influenza compared to the previous years, with many patients developing a secondary respiratory bacterial infection necessitating the use of antibiotics. The majority of cases of C. difficile infections were detected on the DPOW site as per the previous year.

The Trust has taken the following actions to improve this rate, and so the quality of its services by:

- During 2018/19 the DPoW site has had its medical floor reconfigured and refurbished resulting in a net gain of 20 single rooms which can be used to increased isolation capacity to prevent infection spread. Particular wards with higher incidence of *C. difficile* on the medical floor, as part of this reconfiguration, have had their hand washing facilities increased significantly resulting in no further cases of *C. difficile* infection on this ward since the improvements were made.
- Capital and planning teams have factored the need to increase isolation capacity into future building schemes.
- The Trust has an evidence based *C. difficile* policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and post infection review is conducted for every hospital onset case.
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools.
- Themes learnt from PIR process will be monitored by the Infection Prevention and Control Committee and shared with relevant bodies.
- The development of a bespoke IPC WebV module that will alert IPC team to previous cases of *C. Difficile* infections readmitted into the trust. The system also should allow the interface with future electronic prescribing software to help identify prescribing habits.
- GPs will be sent an email to inform them of a patients *C.difficile* / GDH status again to help reduce the amount of antimicrobial use and prevent future *C. Difficile* cases.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention and Control group.
- The introduction of Ultraviolet non touch decontamination on the DPOW site to enhance deep cleaning process.
- The introduction of biocide impregnated privacy curtains across the Trust.
- A review of impregnated cleaning wipes with a switch to one biocide wipe for cleaning equipment as a standard across the Trust.
- PathLincs antimicrobial formulary reviewed with latest national standards.
- The development and publication of a new antimicrobial HUB site to make access to content easier for prescribers,
- Introduction and review of the cleaning materials used by facilities. This has resulted in a standardisation to one biocide cleaner as a routine across the Trust.

2.3h Patient safety incidents

The data made available to the Trust by NHS Digital with regard to:

a) The number and, where available, rate of patient safety incidents per 1,000 bed days reported within the Trust during the reporting period,

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2014 – September 2014	5,124	41.5	35.9	75.0	0.2
October 2014 – March 2015	5,483	43.2	37.1	82.2	3.6
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1
April 2017 – September 2017	6,347	52.4	42.8	111.7	23.5
October 2017 – March 2018	5,897	48.0	42.6	124.0	24.2

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)
NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

- The above table demonstrates the total number of reported patient safety incidents and the rate per 1,000 bed days reported.
- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS organisations. The Trust actively promotes and encourages staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicates a high level of safety awareness.

b) And the number and rate of such patient safety incidents that resulted in severe harm or death.

Time frame	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
April 2014 – September 2014	12	0.10	0.2	1.09	0.00
October 2014 – March 2015	6	0.09	0.2	1.53	0.02
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01
April 2017 – September 2017	24	0.20	0.15	0.64	0.00
October 2017 – March 2018	21	0.17	0.15	0.55	0.00

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)
NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- During 2018/19 the Trust reviewed its incident reporting function which included an updated version of the system and a dedicated analyst was appointed to support interrogation of incident data in greater detail to support a focus on sharing lessons.

- As part of this review in 2018, more stringent oversight arrangements were developed by the central team which included a strengthening of the validation process for any moderate and above incidents reported. Specifically this was around ensuring that incident reporting information was updated for accuracy following this validation and clinical review. It is likely that during 2017/18, whilst validation was undertaken, the master data housed within the Trust's incident reporting system was not updated following the clinical review, resulting in an over reporting of incidents resulting in severe harm or death.
- As a result of the strengthening of central team arrangements during 2018, the Trust would expect the next data download to be in line with the national average. The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.

The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:

- As alluded to already, one of the key actions taken during 2018 was to strengthen the central team validation of moderate and above incidents. This is likely to demonstrate a reduction in the number of incidents reported that lead to serious harm or death.
- Whilst the above action focussed on data quality, the Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities. The Trust has introduced a weekly Serious Incident panel to review incidents which may meet the criteria for requiring a Serious Incident investigation, including those of severe harm or death.

2.3i Information on and learning following Never Events and Serious Incidents

The Trust reported 3 never events during 2018/19. Never Events are considered to be preventable events because there should be robust systems and processes to prevent these. These events are indicative that processes could be strengthened. These can be broken down into the following categories, including historical context and related incidents:

	2014/15	2015/16	2016/17	2017/18	2018/19
Retained Foreign Object	0	2	1	1	1
Wrong implant	0	1	0	1	0
Wrong site nerve block / injection	0	1	1	0	2
Misplaced nasogastric tube	0	0	0	1	0

NB: It should be noted that the never event categories are reviewed annually and therefore are subject to change, making historical comparison difficult.

Learning and action taken following Serious Incident / Never Event investigation:

The Trust is committed to learning from errors, to help reduce the risk of future harm. Every Serious Incident investigation, including any Never Event, results in recommendations, actions and learning which the Trust follows to reduce the risk of future events. A brief outline of some key actions and learning following Serious Incidents or Never Events investigations in 2018/19 is provided here:

- **Wrong site nerve block (Never Event):** Work with staff to ensure the '5 Steps to Safer Surgery Policy' is consistently followed, including the 'Stop Before you Block'.
- Ensuring staff changeovers do not occur at critical stages of the patient journey, unless for an emergency, e.g. any section of the WHO Safety Checklist.
- Update the pre-operative checklist with addition of the second nurse check to the pre-theatre checklist within the nursing documentation, and an update of the Pre-Operative Marking Verification Policy.
- Simulation training undertaken and video recorded to embed practice and share the learning trust wide.

- **Retained Surgical Item:** All gynaecological examinations undertaken by nurses and / or medical staff with the use of swabs are to be counted, checked by a second person and documented within the medical records.
- Development of a guideline on counting of swabs, and other accountable items, in gynaecological examinations.
- Study session to highlight the expectations and standards for documentation

- **Pressure ulcers:** Intensive training and support delivered to ward staff by Tissue Viability Nurses working alongside staff for two days a week over a two month period. Training to focus on pressure area management documentation, including risk assessments, 28 point skin checks and repositioning accurate identification and grading of pressure ulcers.
- Embed into practice Registered Nurses undertaking a daily 1 x 28 point skin assessment.
- Inclusion of pressure ulcer status and actions in all handovers and safety huddles.

- **Medication:** Second checking process checks adhered to on the ward for all patients receiving IV medications, as per Trust policy, to be evaluated by priority Trust Quality and Audit project to test embedding.
- A second check to be introduced whereby two registered nurses confirm and sign that the correct insulin has been given and carried out. Audit to test embedding of practice to be undertaken.
- All Divisions to improve staff compliance in relation to insulin training as agreed at the Trust's Serious Incident Panel.

- **Delayed treatment / follow up in Ophthalmology:** Implementing a process for patients who are prescribed Lucentis who have had their appointment cancelled. These patients to be identified by the Specialty Administration Team, to enable monitoring with spot checks and failsafe's introduced to ensure follow ups requested are acted upon within the pathway timeframes.
- A specialty specific mailbox has been implemented to minimise the risk of human error from urgent emails not being seen or acted upon.
- A refreshed capacity and demand for Ophthalmology using the NHS Intensive Support Team model.
- A clinically developed risk stratification process to be developed to ensure patients are seen in clinical priority order and the development of a robust process to identify time-critical patients.

- **Non-action taken on results:** Handover templates and the safety huddle template modified to include investigations undertaken in order to ensure these are discussed.
- The Head of Radiology to review the process and pathway for communicating abnormal results to inpatient ward areas and implement improvements as appropriate.

Part 3: Other information

An overview of the quality of care based on performance in 2018/19 against indicators

3.1 Overview of the quality of care offered 2018/19

The Trust set out five key quality priority themes to focus on within 2018/19, which were:

1. Safety – specific focus on pressure ulcers, recognition of the deteriorating patient and mortality indicators.
2. Safe emergency care – specific focus on access to non-elective care and flow through our hospitals.
3. Safe planned care – specific focus on cancer care, 52 week waits and clinical harm reviews.
4. Safe maternity care.
5. Safe staffing, improved staff engagement and patient experience.

Understanding Trust performance against these themes has been based on a number of indicators that are reported on within the integrated performance report (or other internal reporting mechanisms) to the Trust's Board. Whilst the quality priority themes have remained the same, some of the indicators used to support understanding of performance against these themes may have changed or been refined during the 2018/19 year. The following outlines, key performance against these quality priority themes. For a more detailed narrative and explanation of performance, see part 2.1 of this report which provides greater detail.

THEME 1: SAFETY - Specific focus: Pressure Ulcers, Recognising Deteriorating Patient & Mortality		Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Jan-19				
1.1	Pressure Ulcers: Grade 2 (Acute)	35 R	40		30	Work underway to assess Trust benchmarked position with NHSi support	Local
	Pressure Ulcers: Grade 3 (Acute)	9 R	15		6		Local
	Pressure Ulcers: Grade 4 (Acute)	0 G	0		0		Local
		Feb-19	Jan-19				
1.2	Early Warning Score (NEWS) - Recorded on time	75.54% R	73.16%		>90%	No benchmark	Local
		Oct 17 - Sep 18	Jul 17 - Jun 18				
1.3a	Summary Hospital-Level Mortality Indicator (SHMI)	113	113		100	WORSE (117/131) Oct 17-Sep 18	National
	Position vs peers	Higher than expected R	Higher than expected		Within expected range		vs. Peer
		Dec-18	Nov-18				
1.3b	Hospital Standardised Mortality Ratio (HSMR)	110 G	110		100	SAME (As Expected)	National
		Mar-19	Feb-19				
1.4	Falls per 1,000 bed days	Not yet available	3.89		TBD	No benchmark	TBC
	Falls: No harm	79 G	74		80	No benchmark	Local
	Falls: Minior harm	37 G	48		40	SAME (65/132) Q2, ST Falls with harm	Local
	Falls: Moderate harm	0 G	2		0		Local
	Falls: Major or catastrophic harm	1 R	0		0		Local
1.5	MRSA (Hospital acquired) (Year to date: 0)	0 G	0		0	SAME	National
	C Diff: infection rate - lapse in care (Year to date: 5)	0 G	0		20 lapses in care	No benchmark	National
	Gram Negative Blood Stream Infections (GNBI) (Year to date: 76)	3 R	6		52	No benchmark	National
1.6	Venous Thromboembolism (VTE) Screening rate (%)	93.70% R	91.40%		95%	AMBER (Safety Thermometer)	National

THEME 2: SAFE EMERGENCY CARE - Specific focus: Access to Non-Elective Care and Flow Through Our Hospitals		Most recent data		Previous data	Trending	Target	Benchmark Data		Source of Target
		Mar-19		Feb-19					
2.1	A&E maximum waiting time of 4 hours from arrival to admission / transfer / discharge - All (inc. Goole) (%)	83.8%	A	79.8%		90%	AMBER (vs. National)	SAME (vs. Local Peer)	National
2.2	Number of super stranded patients - 21+ days	81	R	82		< 61	No benchmark		National
2.3	Non elective length of stay	4.86	R	5.05		< 4.10	WORSE (4.1 days)		Local
		Feb-19		Jan-19					
2.4	Non elective length of stay - Medicine Division	6.5	R	5.9		< 4.10	WORSE (4.1 days)		Local
2.5	Early Warning Score (NEWS) - Recorded on time in Emergency Department - DPoW	62.3%	R	63.87%		>90%	No benchmark		Local
2.6	Early Warning Score (NEWS) - Recorded on time in Emergency Department - SGH	69.0%	R	64.64%		>90%	No benchmark		Local

THEME 3: SAFE PLANNED CARE - Specific focus: Cancer Care, 52 Week Waits and Clinical Harm Reviews		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
3.1	Treatment started within 62 days of urgent GP referral (cancer)	78.9%	R	73.2%		85.0%	WORSE vs. Local Peers	National
3.2	Patients on an incomplete referral to treatment pathway waiting > 52 weeks	6	A	110		< 320 & Zero by 31 Mar	No benchmark	National
3.3	Patients on an incomplete RTT pathway: to be less than the Trust's March 2018 reported figure	28,551	G	27,055		< 29,396	WORSE vs. Local Peers	National
3.4	Clinical Harm reviews to be completed (cohort of patients with a due date prior to the 08 Aug 17)	100.0%	G	99.0%		100%	No benchmark	Local
3.5	WHO Surgical Safety Checklist (Theatres)	98.7%	G	99.5%		> 90%	No benchmark	Local
3.6	Maximum 6-week wait for diagnostic procedures	89.6%	R	92.5%		> 99.0%	WORSE 97.6% (Nat), 98.4% (Local)	Local

THEME 4: SAFE MATERNITY CARE		Most recent data		Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19		Feb-19				
4.1	Ratio of midwives to births - DPoW	Currently not available					No benchmark	Local
4.2	Ratio of midwives to births - SGH	Currently not available					No benchmark	Local
4.3	Where a woman needs an initial CTG, this is commenced within 30 minutes of arrival	91.0%	A	89.0%		100%	No benchmark	Local
4.4	Where a woman in labour has a CTG undertaken fresh eyes reviews should occur at least every 2 hours for the duration of monitoring	93.0%	A	94.0%		100%	No benchmark	Local
4.5	Rolling still birth rate (Year to date: 16)	1		1		TBD	BETTER Rolling 12 month 4.7 per 1,000 births (Nat)	TBC
4.6	1:1 care in labour for women not having a cesarean section	Not yet available		99.50%		TBD	No benchmark	TBC
4.7	Number of Serious Incidents relating to Maternity services (Year to date: 7)	1		1		TBD	No benchmark	TBC
		Q3 18/19		Q2 18/19				
4.8	Antenatal referral for suspected Small for Gestational Age (SGA) or Fetal Growth Restriction (FGR)	62.4%	G	51.6%		>above UK average	BETTER 47.6% (Nat)	National
4.9	Small for Gestational Age (SGA) detected antenatally	53.0%	G	53.0%		>above UK average	BETTER 42.6% (Nat)	National

	THEME 5: SAFE STAFFING, IMPROVED STAFF ENGAGEMENT & THE PATIENT VOICE	Most recent data	Previous data	Trending	Target	Benchmark Data	Source of Target
		Mar-19	Feb-19				
5.1	Safer staffing fill rate - registered staff	96.5% G	96.5%		80.0%	No benchmark	Local
5.2	Safer staffing fill rate - carer staff	100.00% G	99.00%		80.0%	No benchmark	Local
5.3	Care hours per patient day	Not yet available	7.3			WORSE 8.0 (Nat)	Local
5.4	Nursing staff vacancy - registered	8.6% A	8.4%		< 6.0%	No benchmark	Local
5.5	Nursing staff vacancy - unregistered	1.5% G	1.8%		< 2.0%	No benchmark	Local
5.6	Medical staff vacancy	14.50% G	14.00%		< 15.0%	No benchmark	Local
5.7	Proportion of temporary staff	8.80%	8.70%		TBD	No benchmark	TBC
5.8	Mixed Sex Accomodation breaches	0 G	36		0	No benchmark	National
		Mar-19	Feb-19				
5.9	Friends and Family Test Results - A&E	75.2% R	73.00%		≥ 95.0%	WORSE 87.1% (Nat), 86.1% (Local)	Local
5.10	Friends and Family Test Results - Inpatient	99.0% G	99.10%		≥ 95.0%	BETTER 95.5% (Nat), 96.3% (Local)	Local
5.11	Friends and Family Test Results - Maternity	100.0% G	100.00%		≥ 95.0%	No benchmark	Local
5.12	Friends and Family Test Results - Community	99.2% G	98.20%		≥ 95.0%	BETTER 96.3% (Nat)	Local
5.13	Complaints - thematic analysis	See narrative					
5.14	Staff engagement: Pride and Respect - the Trust's anti-bullying campaign	See narrative					
5.15	Staff engagement: Listening to Improve	See narrative					
		2018	2017				
5.16	NHS national staff survey - overall engagement	6.5 G	6.4		> 6.4	WORSE 7.0 (Average)	Local
5.17	NHS national staff survey - "I would recommend my organisation as a place to work"	47.3% G	43.0%		> 43.0%	WORSE 62.6% (Average)	Local

3.2 Performance against relevant indicators and performance thresholds

Performance against those indicators that form part of appendices 1 and 3 of the Single Oversight Framework (SOF) is presented as follows.

Indicator	Quarter 1 18/19			Quarter 2 18/19			Quarter 3 18/19			Quarter 4 18/19			18/19 Performance
	Apr-18	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	67.6%	70.2%	70.7%	71.0%	69.8%	69.3%	71.2%	72.7%	72.7%	73.9%	75.4%	76.1%	Average: 71.6%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	85.3%	88.3%	88.1%	84.0%	87.0%	89.2%	86.4%	86.8%	85.1%	80.5%	77.6%	82.2%	Average: 85.0%
All cancers: 62-day wait for first treatment from referral/screening	72.5%	69.1%	73.0%	75.0%	73.1%	74.7%	72.2%	75.0%	79.2%	71.1%	73.2%		Average: 73.5%
C.difficile: variance from plan [lapses in care] (target 21)	0	1	0	1	1	1	0	1	0	0	0	0	5
Maximum 6-week wait for diagnostic procedures	89.6%	82.9%	85.5%	86.6%	86.1%	89.0%	92.3%	91.7%	87.1%	88.0%	92.5%	89.6%	Average: 88.4%
Venous Thromboembolism (VTE) risk assessment	93.0%	92.7%	92.8%	92.8%	91.9%	92.5%	93.6%	94.4%	92.7%	93.4%	91.4%	93.7%	Average: 93.0%
Summary Hospital-level Mortality Indicator	September 2018 Release (Covering Apr 17 - Mar 18 data period): 1.19			November 2018 Release (Covering Jul 17 - Jun 18): 1.13			February 2019 Release (Covering Oct 17 - Sept 18): 1.13			May 2019 Release (Covering Jan 18 - Dec 18): 1.12			Average SHMI for Apr 17 - Dec 18 period: 1.14

This data, for the most part, has formed the basis of the Trust's quality priorities reported during 2018/19. For more detail regarding these see the executive summary and part 2 of this report.

3.3 Information on staff survey report

Summary of performance – NHS staff survey

Each year we encourage our staff to take part in the national staff survey. The survey results give each health trust a picture of how its staff think it's performing as an employer and as an organisation.

In 2018, 35% per cent of our staff completed a survey (an increase from 33.6% per cent the previous year).

The survey was open from September to December 2018, and all staff were encouraged to participate. The survey was offered via a mixed mode method; that is staff received either a traditional paper or on-line form depending on their role and access to PC's in their normal day to day activities. The survey was publicised in various internal communications across the organisation, including the staff bi-monthly magazine, weekly team brief, the Hub (intranet), all staff emails and at the chief executive's monthly senior leadership team cascade.

Detailed performance – NHS staff survey

The Trust undertook a census sample survey during 2018, offering 5,820 eligible staff the opportunity to participate. From this 2,020 surveys were completed and returned.

	2018		2017		Trust improvement/ deterioration
Response rate	**Trust**	**National average**	**Trust**	**National average**	
	35%	**44%**	**33.6%**	**45.5%**	1.4% improvement

Source: NHS Staff Survey

Staff Survey 2018 findings

In 2018 the staff survey nationally moved away from reporting 33 key findings, from which the top five and bottom five ranked scores were listed. Instead the staff survey now reports ten themes, as below:

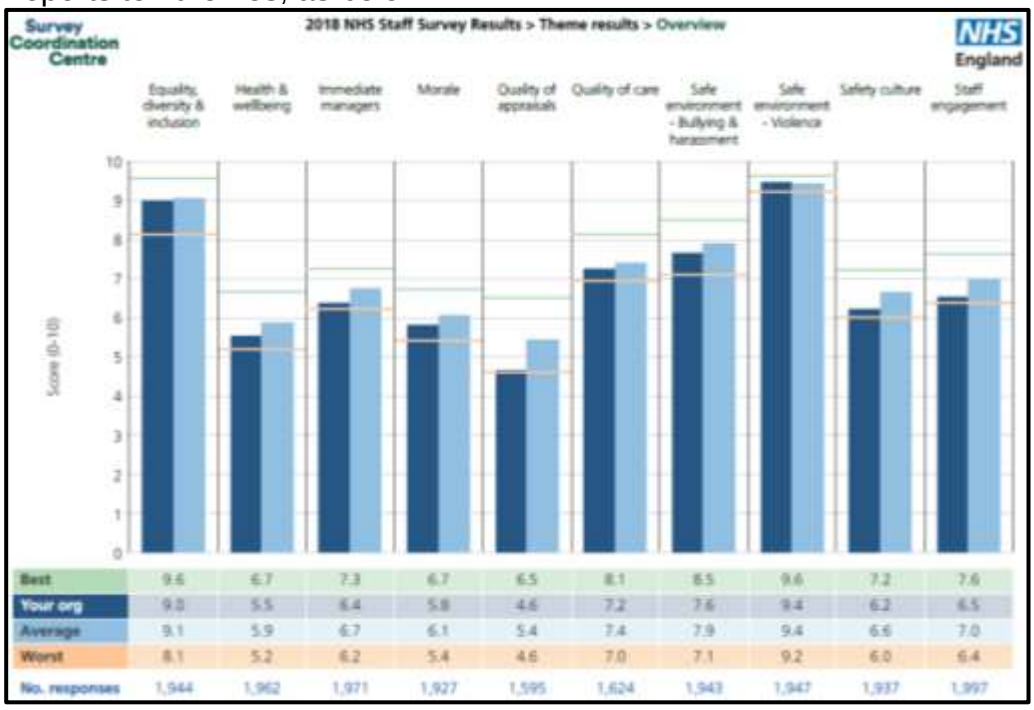


Figure 23 demonstrates the ten themes now reported in the national staff survey

Future priorities and targets

The Trust recognises that its greatest asset are its staff. As such the Trust's Improving Together plan contains numerous staff focused work streams, including (but not limited to):

- Continuing the Pride and Respect culture transformation work, including the delivery of behavioural standards training to all staff
- A review and redrafting of the Trust value statements with ratification by Trust Board in Q3 2018/19. The new values – Respect, Courage, Kindness – have an associated behavioural framework and are due to be formally launched Trust wide in Q1 19/20,
- The profile and importance of staff engagement has grown significantly over the last 12 months with all divisions being challenged by the CEO to create and deliver a bespoke staff engagement plan,
- The Trusts apprenticeship programme continues to grow in scope and credibility with national recognition for the work undertaken locally,
- To continued review of workshop establishments to enable the introduction of new roles such as Advanced Clinical Practitioners to support services,
- An extensive and targeted recruitment programme supported by a tailored Staff Retention Strategy and a wide range of retention deliverables,
- The emerging recognition that quality improvement, coupled with a collaborative leadership style, will support the continuous service improvement agenda, provide staff with the mechanism to bring their service improvement ideas on line and provide alternative management practices based on QI methodologies and statistical performance analysis

The above work streams performance and outputs are monitored through the Trusts Improving Together Oversight Committees and Improving Together Board. These work streams will positively contribute to overcoming staffs concerns within the 2018 staff survey. Importantly though the Trust continues to recognise the need for positive organisational culture change and the above programme of work illustrate the ongoing determination to rebuild the Trust, improve the working lives for staff and in doing so to improve the quality of care and patient experience. It is therefore pleasing to see that although the majority of the Trust's staff survey results are below the national average there is positive movement in the vast majority of the individual question scores.
To continue this direction of travel the Trust, rather than embarking on a multi-stranded transactional action plan, is intending to invest in two main work streams which very much build on the above work:

- **Staff Survey Work stream 1:** The continued corporate focus on staff engagement, including investing heavily in increasing staff voice to improve clinical/non-clinical services. To build on 2017/18 progress this work stream will now be linked to the quality improvement work to provide staff and leadership teams with the skills and QI methodologies to take staffs service improvement ideas forward.
- **Staff Survey Work stream 2:** Invest in Divisional Staff Survey Action Teams. Each Divisional leadership team, supported by their HR Business Partner and the Organisational Development Team, to work in partnership with their own staff, to jointly agree between themselves a maximum of three areas from within the survey that they want to improve within their area of work.

The above two work streams will be monitored through the 'Leadership and Culture' Improving Together work stream. Additionally progress reports will be presented at the Trust Management Board and Trust Board itself. The staff survey transformational work streams commence April 2019. The measure of success will be taken from quarterly pulse check surveys aligned to staff survey key finding and ultimately by the findings within the 2019 staff survey report.

3.4 Information on patient survey report

Introduction
The National Inpatient Survey for 2018 was sent out to 1250 of patients who stayed in our Trust, 45% choose to respond. This extensive questionnaire helps provide a more detailed insight into their care received and provides a mechanism by which we can focus our improvement priorities in a patient led way.

Response rate compared with previous year:

	2018		2017	
Response rate	Trust	National average	**Trust**	**National Average**
	45%	43%	**41.1%**	**38.3%**

Source: NHS Patient Survey
Key to abbreviations: Trust – NLaG
National average – The United Kingdom average

These are the highlighted areas where we performed higher than the 77 Trusts we were benchmarked against and also the areas where we can focus our attention for improvement during the coming year.

	Top 5 scores (compared to average)
87%	Q21+. Hospital: got enough help from staff to eat meals
97%	Q20. Hospital: offered a choice of food
61%	Q60. Discharge: was not delayed
98%	Q72+. Overall: well looked after by non-clinical hospital staff
60%	Q19+. Hospital: food was very good or good

	Bottom 5 scores (compared to average)
61%	Q8. Planned admission: was admitted as soon as necessary
53%	Q58. Discharge: patients given written/printed information about what they should or should not do after leaving hospital
55%	Q9. Admission: did not have to wait long time to get to bed on ward
55%	Q60+. Discharge: told of danger signals to look for
48%	Q58+. Discharge: told side-effects of medications

	Most improved from last survey
87%	Q21+. Hospital: got enough help from staff to eat meals
55%	Q9. Admission: did not have to wait long time to get to bed on ward
81%	Q61+. Discharge: family or home situation considered
61%	Q60. Discharge: was not delayed
11%	Q62. Discharge: delayed by no longer than 1 hour

	Least improved from last survey
15%	Q71. Overall: received information explaining how to complain
61%	Q8. Planned admission: was admitted as soon as necessary
68%	Q63. Discharge: told who to contact if worried
11%	Q70. Overall: asked to give views on quality of care
60%	Q19+. Hospital: food was very good or good

Actions to be taken as a result:

Divisional action plans will be created and the Patient Experience Group will monitor this over the coming year. The Patient Experience team will also be looking at improving engagement with the national inpatient survey results as an ongoing piece of work.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
This statement has been prepared in collaboration with the following Clinical Commissioning Groups:

- **North East Lincolnshire CCG,**
- **North Lincolnshire CCG,**
- **East Riding of Yorkshire CCG,**
- **Lincolnshire East CCG.**

This statement has been prepared in collaboration with the following Clinical Commissioning Groups; North East Lincolnshire; North Lincolnshire; Lincolnshire East and East Riding of Yorkshire.

We commend Northern Lincolnshire and Goole NHS Trust on achieving an improved overall CQC inspection rating in 2018, moving the rating from Inadequate to Requires Improvement. Whilst this is a significant achievement commissioners recognise the importance that the Trust maintain a continued focus on their improvement journey to achieve good quality care.

There are specific areas to celebrate with the Trust from their achievements in 2018/19. The focused improvement work around the acute hospital pressure ulcer care, a reduction in the medical vacancy, the move from a Requires Improvement CQC rating in maternity to Good and the activity in the Pride and Respect work streams are extremely positive.

The Trust has strengthened its clinical leadership to support improvements in both culture and quality and safety and commissioners welcome this approach. Commissioners acknowledge the work the Trust is undertaking in addressing the nurse vacancy rates. This is a national challenge and commissioners welcome the innovative approaches the Trust is involved in to address the vacancy rates. Commissioners recognise the significant achievement of the Trust in having no 52 week breaches at the close of the financial year.

The annual staff survey saw improvement across the majority of questions but the response rate, which had improved from the previous year, remained low and below the national average.

Although the position indicates that the Trusts Improving Together Plan to engage staff and support workforce is having an impact on culture the importance of continuing the work stream to influence further progression next year in these areas is clear, as is a focus on improving the staff survey response rate as it is below national average.

Whilst Commissioners acknowledge the progress and improvement against the Trust Improving Together Plan, there remain a number of areas where we would like to see a significant change in the pace, scale of improvement or maintaining the improved position in the coming year.

Commissioners are keen to see improvement expedited or maintained in the management of the deteriorating patient, Trust mortality, diagnostics, complaints management and management of waiting lists.

We are continuing to work closely with the Trust to support improvement and seek assurance in this regard. We acknowledge the work to improve the Trust's Serious Incident Process and how the Trust learns when things go wrong. We are keen to see this work come into fruition in 2019/20.

The Trusts quality priorities for 2019/20 are welcomed by commissioners. It is recognised that the focused areas for improvement in clinical quality have the potential to have a significant impact on improving safety, effectiveness and experience.

Whilst we recognise that some Trust priorities from 2018/19 have continued into 2019/20 we are keen to observe pace and achievements in these areas. In general the priorities of the Trust reflect those of the local and national health and social care systems in improving; the general quality of healthcare services; flow through the system; cancer outcomes and the provision of safe care.

Overall, the Quality Account is well presented and the information included in the report provides a balanced view of the Trust's performance. The Trust has identified action to be taken, and in some cases already taken, in response to the areas of concern highlighted above. Commissioners welcome the Trust's desire to ensure these actions become embedded into usual practice.

Finally, we confirm that to the best of our knowledge, the report is a true and accurate reflection of the quality of care delivered by Northern Lincolnshire and Goole Foundation Trust and that the data and information contained in the report is accurate.

Commissioners remain committed to working with the Trust and its regulators to improve the quality and safety of services available for the population of each CCG area in order to improve patient outcomes.

Annex 1.2: Statement from Healthwatch organisations

Feedback from:
Healthwatch North Lincolnshire
Healthwatch North East Lincolnshire
Healthwatch East Riding of Yorkshire

Statement on North Lincolnshire and Goole NHS Foundation Trust Quality Account for 2018/2019

Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire and Healthwatch East Riding of Yorkshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust and have agreed to provide a joint statement.

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from North and North East Lincolnshire Healthwatch and Healthwatch East Riding of Yorkshire.

We acknowledge that the trust has made some improvements in 2018-2019, in many of the indicators within the document, however more needs to be done to ensure that Northern Lincolnshire and Goole NHS Foundation Trust continue to improve against national standards.

It is encouraging to see improvements in staffing and vacancy rates have decreased; and all 3 Healthwatch are pleased to see the trust taking a more innovative approach to attract new medical and nursing staff as well as addressing retention of the Trust's existing Workforce.

However, continued improvement is still needed in improving staff morale and we would hope to see improvements in this area in 2019-2020.We recognise the concerted effort to continue to improve the quality and safety of services within the trust and we look forward in continuing to work more closely with Northern Lincolnshire and Goole NHS Foundation Trust in the future and seeing how their new priorities are developed

Healthwatch Lincolnshire

Healthwatch Lincolnshire believe NLAG priorities set out in your Quality Account cover many important healthcare needs at this time. However from a Lincolnshire patient perspective, where referrals are made for our counties patients into NLAG services, over the past year we have received from patients and carers, a mix of both positive and negative comments. Some of the negative comments link to the need for better communications between in and out of county services where patients are accessing cross border services. In addition, we are acutely aware of the fragility of services at both ULHT and NLAG and welcome proactive approaches to continual open dialogue between the Trusts and other healthcare services. We believe it is important to also highlight positive comments which include patient views that your staff are caring and compassionate.

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel's Quality Accounts comments for Northern Lincolnshire and Goole NHS Foundation Trust

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment as part of Northern Lincolnshire and Goole NHS Foundation Trust's (NLG) Quality Account. NLG are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years. Our day-to-day contact with the Trust is always handled in a timely, professional manner, and NLG representatives have always expressed a willingness to provide information and assist with specific issues. The panel would wish to pass on our sincere appreciation for this.

For a number of years, the panel has used this opportunity to raise serious concerns about the Trust's overall performance in many areas and its future sustainability. However, whilst the Trust acknowledges that there is obviously much work still to do, the panel is genuinely glad to see some signs of recovery in 2018/19. Most apparently, this is shown in the September 2018 CQC rating of 'Requires Improvement' from the previous 'Inadequate'. The CQC's report on the Trust also shows noticeable improvements in many areas of operation, and trends on issues previously of concern such as 52-week referrals are particularly encouraging.

Similarly, the panel notes the small but consistent improvements on many indicators in the Annual Staff Survey, particularly around safety culture, support from management, and providing a safe environment for staff. However, whilst the panel notes the improvement in the number of staff who report that they would be happy for a friend or relative to receive care at NLG, the panel remains concerned that the Trust still performs well below the national average.

The panel's main contact with the Trust in 2017/18 has unfortunately focussed on a number of administrative problems that were identified. Most notably, the Trust reported errors around some 4,584 discharge summary letters not being sent to GPs and some 188 letters reporting the results of cervical screening being missed. Naturally, the panel finds this very concerning, particularly where they could negatively impact on the health and wellbeing of patients. The panel also received updates in 2018/19 regarding the 'missed referrals' Serious Incident (SI) which was referenced in our comments from 2017/18. Whilst the panel welcomes the fact that NLG is a high-SI-reporting Trust, of course we remain concerned about the instances of patients coming to harm (page 28), or the two cases referred to on page 62 where patients have died, "more likely than not… due to problems in the care provided to the patient". The panel has therefore asked the Trust for a detailed briefing on SIs in summer 2019.

As described during each of the panel's submissions since 2014/15, and prior to this, set out in the panel's June 2013 scrutiny report on this subject, members remain concerned that the Trust's SHMI rate remains in the 'higher than expected' banding. Whilst the panel notes the downward trend, members have long advocated for a genuine whole-system approach to reducing mortality which aims to overcome operational and organisational boundaries.

The panel generally welcomes the quality priorities agreed by the Trust and set out within the Quality Account. In particular, the panel fully supports the prioritisation given to improving patient experience, clinical effectiveness and patient safety. Despite this, the panel notes the performance on staff recommending the Trust as a place to work, safer staffing fill rate, and medical staff vacancies, and believes that challenging targets for these important indicators should be set for 2019/20. In particular, the panel believes that, whilst the recent improvements should be welcomed, the target for staff recommending the Trust as a place to work should be set at least to match the national mean.

In summary, the panel welcomes the improvements on many issues in the previous 12 months, but shares the Trust's view that there is much more to do.

East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Owing to the upcoming local and parish elections, and the period of purdah immediately preceding the elections, East Riding of Yorkshire Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee has declined to comment on this year's Quality Accounts.

North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

The North East Lincolnshire Council Health and Adult Social Care scrutiny panel has continued to observe the progress being made by NLaG (the Trust) through regular reports and by stakeholder attendance of the Council of Governors.

Panel members have commented on more than one occasion on the progress being made in delivering efficiency and more importantly cultural change within the Trust. We were pleased to note the improvement in the CQC rating but remain aware that there is still much to do, particularly in relation to future sustainability and the Trusts role within the greater STP. It is important to all residents of North East Lincolnshire that there is an acute hospital within the borough.We note the progress made in filling vacancies, especially within nursing, but remain concerned about the high vacancy levels generally and particularly for doctors. We believe that the newly opened accommodation block will help to attract more candidates.

We have noted the progress in addressing waiting lists, but remain concerned that patients are still waiting too long to be appointed.

Cultural changes that the Trust aspires to are noteworthy, as is the progress being made, but the concerns of highly pressured staff remain THE challenge, and the scrutiny panel will turn its focus more towards this in the coming years.

We welcome the publication of the Quality Account and appreciate the vast amount of detail contained herein. This is a high quality, plain English, and well-illustrated report which clearly delivers an open and transparent account of the Trusts journey.

Lincolnshire – Health Scrutiny Committee for Lincolnshire

The Health Scrutiny Committee for Lincolnshire is grateful for the Trust sharing its draft Quality Account for 2018/19 and recognises the Trust's provision of acute hospital services for significant number of residents in the northern part of the county. For this year, the Committee is focusing on the quality accounts of two other local trusts.

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Trust's Lead Governor

The Council of Governors is very appreciative of the progress the Trust has made throughout the year whilst dealing with the unenviable position of being in double special measures. The emphasis has been on working towards improving on 5 quality priority themes with indicators to measure performance against each one.

Trust progress is regularly presented to the Board, relevant committees and the Council of Governors by means of the Integrated Performance Report. Governors are now attending some of the key committee meetings in addition to holding their own sub-committees such as the Governor Assurance Group and the Quality Review Group, which assist in reassuring the Council that it has an accurate and current understanding of Trust progress.

The Council is encouraged to note that during the year 2018/19 there has been a great deal of improvement in the area of staff engagement. Staff have more opportunities to comment on issues through various initiatives such as Listening to Improve, Pride and Respect and the 'Ask Peter' Chief Executive question sessions. There has been better retention of medical staff with a lower staff turnover rate than the previous account. The new £16.4 million staff accommodation block has been opened on the Diana Princess of Wales Hospital site which should assist in encouraging new staff to come to the area. There have also been great improvements in patient experience with emphasis being on reducing the 52 week waiting list and prioritising patients on cancer pathways waiting the longest time.

The Quality Account is very well presented and reflects the hard work done by the Board and all staff to help improve the staff and patient experience. The layout is easy to follow as each of the five themes is explained below the relevant data in a series of key points. Each theme also lists the patient outcomes in easy bullet points displayed in a green box.

Governors are encouraged to see the Quality Priorities for 2019/20 are set to further improve the patient experience and their safety.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust is grateful for the stakeholder comments and is pleased that the Trust's progress on its improvement journey has been acknowledged. The Trust will continue during 2019/20, using its quality priorities, to focus on further improvements.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report [Available during May 2019]

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year. NHS Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report. In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19 and supporting guidance;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2018 to the 7 May 2019
  - Papers relating to quality reported to the board over the period April 2018 to 7 May 2019
  - Feedback from commissioners dated 25 April 2019
  - Feedback from governors dated 2 May 2019
  - Feedback from Local Healthwatch organisations dated 15 April 2019 and 24 April 2019
  - Feedback from Overview and Scrutiny Committees dated 1 April 2019, 16 April 2019, 16 April 2019 and 26 April 2019
  - The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 7May 2019
  - Latest national patient survey 2019
  - Latest national staff survey 2019
  - The head of internal audit's annual opinion of the Trust's control environment dated 9 May 2019
  - CQC inspection report dated 12 September 2018.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate; except in the case of waiting list information, where the Trust's internal scrutiny and review has identified that reported waiting list data did not provide a true picture of performance;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The majority of data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. From these internal controls and scrutiny and review of data during 2018/19, the Trust determined that the waiting list data did not provide a true picture of the Trust's waiting list position. The directors are confident that the extent of the data quality issues are being understood and a robust and reliable plan of action is in place to ensure the required data quality standards and prescribed definitions for waiting list data are adhered to and are assured that progress in this area will be reported to directors of the board; and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board: 21 May 2019  Chair

21 May 2019  Chief Executive

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust to perform an independent assurance engagement in respect of Northern Lincolnshire and Goole NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to our limited assurance conclusion (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by Monitor (operating as NHS Improvement) ("NHSI"):

Specified Indicators	*Specified indicators criteria* (exact page number if possible, or title of section where criteria can be found)
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge	See Section 2.1b 'Theme 2: Safe Emergency Care – Specific focus on access to non-elective care and flow through our hospitals' (Pages 22-25) and Annex 5: Mandatory Performance Indicator Definitions (Page 108-109)
Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer	See Section 2.1c 'Theme 3: Safe Planned Care – Specific focus on cancer care, 52 week waits and clinical harm reviews' (Pages 26-28) and Annex 5: Mandatory Performance Indicator Definitions (Page 109)

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the 'Detailed requirements for quality reports 2018/19' issued by NHSI. The Directors are also responsible for the conformity of the specified indicators criteria with the assessment criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19' issued by NHSI and for reporting the specified indicators in accordance with those criteria, as referred to on the pages of the Quality Report listed above.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19'; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially consistent with the following documents:

- Board minutes for the financial year, April 2018 and up to the date of signing the limited assurance report ("the period");
- Papers relating to quality reported to the Board over the period;
- Feedback from the Commissioners (North East Lincolnshire CCG, North Lincolnshire CCG, East Riding of Yorkshire CCG and Lincolnshire East CCG) dated 25/04/2019;
- Feedback from Governors dated 02/05/2019;
- Feedback from local Healthwatch organisations Healthwatch North Lincolnshire, Healthwatch North East Lincolnshire, Healthwatch East Riding of Yorkshire dated 15/04/2019 and Healthwatch Lincolnshire dated 24/04/2019;
- Feedback from the Overview and Scrutiny Committee's dated 01/04/2019 (North Lincolnshire Council – Health Scrutiny Panel), 16/04/2019 (East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee & North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel) and 26/04/2019 (Lincolnshire – Health Scrutiny Committee for Lincolnshire)
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 17/05/2019;
- The latest national patient survey dated January 2019;
- The latest national staff survey dated January 2019;
- Care Quality Commission inspection report, dated 12/09/2018; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 09/05/2019.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We complied with the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour. We apply International Standard on Quality Control (UK) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust as a body, to assist the Council of Governors in reporting Northern Lincolnshire and Goole NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northern Lincolnshire and Goole NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;
- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis, of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable, measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the criteria set out in the FT ARM and 'Detailed requirements for quality reports 2018/19'.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Northern Lincolnshire and Goole NHS Foundation Trust.

Basis for Disclaimer of Conclusion – patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

No supporting clinical documentation was available for patients to support the time of admission, transfer or discharge (clock stop) within the tested sample. As a result, we have been unable to obtain evidence for the waiting period from arrival to admission, transfer or discharge reported across the year.

Conclusion (including disclaimer of conclusion on patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge)

Because the data required to support the indicator is not available, as described in the Basis for Disclaimer of Conclusion paragraph, we have not been able to form a conclusion on the patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge indicator.

Based on the results of our procedures, nothing has come to our attention that causes us to believe that for the year ended 31 March 2019:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the 'Detailed requirements for quality reports 2018/19';
- The Quality Report is not consistent in all material respects with the documents specified above; and
- The indicator 'Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer' has not been prepared in all material respects in accordance with the criteria set out in the FT ARM and the 'Detailed requirements for external assurance for quality reports 2018/19'.

PricewaterhouseCoopers LLP
Central Square
29 Central Square
Leeds
LS1 4DL

29th May 2019

The maintenance and integrity of the Northern Lincolnshire and Goole NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Annex 4: Glossary

Acuity: Defined as the severity of a patient's condition (physical or psychological) and the intensity and complexity of care and corresponding workload required by a patient/group of patients) on the Trust's healthcare professionals.

CQUIN or Commissioning for Quality & Innovation Framework: The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Friends and Family Test – Methodology: The Trust introduced the new friends and family test in April 2014, when it was launched across the country. Within 48 hours of receiving care or treatment as an inpatient or visitor to A&E, patients are given the opportunity to answer the following question:

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

Service users are then asked to answer how likely or unlikely along a six-point scale they would answer the above question. There is also an opportunity to elaborate on the reasons for their answer and all feedback will be encouraged whether positive or negative. 'Positive feedback' defined as the percentage of patients/service users answering 'extremely likely' and 'likely'

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Healthcare Evaluation Data (HED)

- As a result of the time lag in reporting of SHMI, the Trust has purchased an additional information toolkit from the University of Birmingham Hospitals NHS Foundation Trust, called Healthcare Evaluation Data (HED).
- HED uses the same methodology as the official SHMI, but enables a much more recent timeframe to be reported. The official SHMI publication in January 2016 reported data up to June 2015, the HED information reports data to the end of October 2015. As it is not the official SHMI indicator, it is treated by the Trust as a 'provisional' SHMI indication, but from rigorous reconciliation work, it has proved to be an accurate data source that reflects the official SHMI on publication.
- As a result of this, the Trust uses both the official SHMI and the HED provisional SHMI indication as markers of performance.

Mortality Data: - How is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

NEWS stands for the National Early Warning Score which is a nationally defined way of monitoring patients observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Patient Experience: This Trust has set the goal of being the hospital of choice for our local patients. Being the hospital of choice is a far different thing than being the hospital of convenience, proximity or default. We measure patient experience using methodologies employed by the NHS National Patient Experience Survey against two key indicators to help us determine that our hospitals are the ones our patients would choose if the practical factors were removed. The Trust uses *The Menu Card Survey* which helps the Trust understand patient experience and is attached to inpatients' menu cards. It measures the patients' experience in real time.

Rate per 1000 bed days: So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report in different ways, and their patients may be more or less vulnerable than our patients.

Readmission Rate (RA): This measure shows the percentage of patients who were readmitted to hospital as an emergency within one month of being discharged. It can serve as an indicator of the quality of care provided and post-discharge follow up. A low readmission rate is an indicator of the quality of care in that it reflects a healthy care balance. Where rates are low, patients do not have to come back to the Trust for care of the same complaint. Conversely, a high readmission rate potentially signals that an organisation is releasing patients home too soon or otherwise not addressing all elements of their clinical condition.

SAFER Care Bundle consist of the following principles: **S**enior Review before midday, **A**ll patients have an expected date of discharge, **F**low of patients from assessment and admission units as early as possible, **E**arly Discharge before midday and **R**eview by MDT for patients with extended lengths of stay (>7 days).

Stranded patients are those in hospital for 7 or more days.

Super stranded patients are those in hospital for more than 21 days.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge,
- Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers,
- Summary Hospital-level Mortality Indicator (SHMI).

Have been subject to external audit in line with the following criteria:

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge:

Source of indicator definition and detailed guidance

The indicator is defined in the technical definitions that accompany Everyone counts: planning for patients 2014/15 - 2018/19 at https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf.

Detailed rules and guidance for measuring A&E attendances and emergency admissions are at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf.

Additional information:

Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance:

We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?

Such attendances can be recorded by the trust in the following circumstances.

a) The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust's involvement is limited to clinical governance.

b) The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.

Where an NHS foundation trust has applied criterion (b) and is including type 3 activity run by another provider on the trust site as part of its reported performance, this will therefore be part of the population of data subject to assurance work.

In rare circumstances there may be challenges in arranging for the auditor to have access to the third party data. In this scenario the NHS foundation trust may present an extra indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

Numerator

The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:

(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator

The total number of unplanned A&E attendances

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: https://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution measures).

Indicator format

Reported as a percentage

Maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers

Detailed descriptor[2]
PHQ03: Percentage of patients receiving first definitive treatment for cancer within 62 days of an urgent GP referral for suspected cancer

Data definition
All cancer two-month urgent referral to treatment wait

Numerator
Number of patients receiving first definitive treatment for cancer within 62 days following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Denominator
Total number of patients receiving first definitive treatment for cancer following an urgent GP (GDP or GMP) referral for suspected cancer within a given period for all cancers (ICD-10 C00 to C97 and D05)

Accountability
Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: NHS Constitution measures).

[2] Cancer referral to treatment period start date is the date the acute provider receives an urgent (two-week wait priority) referral for suspected cancer from a GP and treatment start date is the date first definitive treatment starts if the patient is subsequently diagnosed. For further detail refer to technical guidance at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_131880

Summary Hospital-level Mortality Indicator (SHMI)

The SHMI is not calculated by trusts; it is provided by NHS Digital. As explained in NHS Digital's guidance (https://files.digital.nhs.uk/73/EB4673/SHMI%20FAQs.pdf), the indicator is computed by NHS Digital using information provided by the trust and other information. The assurance work performed need only concentrate on the information provided by the trust which is used in computing the indicator. We recommend that the auditor makes the scope of work clear in the governors' report. The auditor's work should focus on the trust's Secondary Uses Service (SUS) data submissions, and the information used from that in the computation of observed deaths and expected deaths.

More information on the data specification can be found at: https://files.digital.nhs.uk/3F/80BAA0/SHMI%20specification.pdf.

Page 252 of this document lists the Hospital Episode Statistics (HES) data fields taken from SUS data used to compute the SHMI. Only a subset of these are expected to be included in sample testing performed by the auditor: