NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda

Council of Governors Annual Members' Meeting

will be held on 29th September 2022 between 14:00 - 16:30 hours,
at Sands Venue Stadium (Glanford Park), Scunthorpe, DN15 8TD
with live MS Teams streaming via this link
For the purpose of transacting the business set out below

Elected governors are reminded that they have signed a declaration stating that they are eligible to vote as members of the Trust and that they are not prevented by any of the terms of the Constitution from being a member of the Council of Governors (CoG). Elected governors will be deemed to have confirmed that declaration by attending this meeting.

1.	**MEETING ITEMS**		14:00
1.1	**Chair's Opening Remarks** Sean Lyons, Trust Chair	Verbal	
1.2	**Apologies for Absence** Sean Lyons, Trust Chair	Verbal	
1.3	**Declaration of Interests** Sean Lyons, Trust Chair	Verbal	
1.4	**To receive the approved minutes from the previous meeting held on 13th September 2021** Sean Lyons, Trust Chair	Attached	
2.	**ANNUAL REPORT & ACCOUNTS**	Presentation	14:15
2.1	**Overview of Last Year including Annual Report & Accounts for 2021/22 and Trust Priorities for the Future** Dr Peter Reading, Chief Executive and Lee Bond, Chief Financial Officer		
2.1.1	**Annual Audit Report for 2021/22** Mark Surridge (Director) and Michael Norman (Senior Manager), Mazars, Trust's External Auditors	Attached	14:45

10 minute break

3.	**COG BRIEFINGS**		15:10
	3.1 **Integrated Care System (ICS) Update** Sue Symington, Chair, ICS	Presentation	
	3.2 **Emergency Department & the Future of Emergency Care Update** Natalie Till, Operational Matron in Medicine	Presentation	15:40
	3.3 **Lead Governor Elections Update** Ian Reekie, Lead Governor	Presentation	15:55
4.	**QUESTIONS FROM THE PUBLIC** Sean Lyons, Trust Chair	Verbal	16:00
5.	**REFLECTION OF FORMAT FOR FUTURE REVIEW MEETINGS** Sean Lyons, Trust Chair Are you satisfied with the agenda items, documentation and level of discussion at today's Council of Governors Annual Members' Meeting?	Verbal	16:10
6.	**ITEMS FOR INFORMATION (as detailed below)** Sean Lyons, Trust Chair **6.1** Acronyms and Glossary of Terms	Attached	16:20
7.	**ANY OTHER BUSINESS** Sean Lyons, Trust Chair	Verbal	16:25
8.	**DATE AND TIME OF NEXT COUNCIL OF GOVERNORS MEETING** Sean Lyons, Trust Chair Date: 13th October 2022 Time: 14:00 - 17:00 hours Venue: Forest Pines, Broughton, Scunthorpe, DN20 0AQ		16:30

Please notify the Membership Office of any apologies for these events

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

In accordance with Standing Order 2.4.3 (at Annex 6 of the Trust Constitution), any Governor wishing to submit an agenda item must notify the Chairman's Office in writing at least **10 clear days prior to the meeting at which it is to be considered.** Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chairman.
Governors are asked to raise any questions on which they require information or clarification in advance of meetings. This will allow time for the information to be gathered and an appropriate response provided.

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Minutes

COUNCIL OF GOVERNORS ANNUAL MEMBERS MEETING

Minutes of the Meeting held on Monday, 13th September 2021, from 14:00 to 17:00 hours
at the Sands Venue Stadium (Glanford Park), Scunthorpe

Present:

Linda Jackson	Acting Trust Chair	Joanne Nejrup	Staff Governor
Diana Barnes	Public Governor	Rob Pickersgill	Public Governor
Tony Burndred	Public Governor	Steven Price	Public Governor
Maureen Dobson	Public Governor	Ian Reekie	Lead Governor
Paul Grinell	Public Governor	Gorajala Vijay	Public Governor
Tim Mawson	Staff Governor		

In Attendance:

Ade Beddow	Associate Director of Communications and Engagement
Helen Harris	Director of Corporate Governance
Claire Hansen	Humber Acute Services Programme Director (representing Ivan McConnell)
Jenny Hinchliffe	Deputy Chief Nurse (representing Ellie Monkhouse and Joanne Loughborough)
Alison Hurley	Assistant Director of Corporate Governance
Jug Johal	Director of Estates and Facilities
Claire Low	Deputy Director of People
Shauna McMahon	Chief Information Officer
Michael Norman	Senior Audit Manager – Mazars Auditors
Fiona Osborne	Associate Non-Executive Director
Simon Parkes	Non-Executive Director
Gillian Ponder	Interim Deputy Chair, Non-Executive Director and Senior Independent Director
Michael Proctor	Non-Executive Director
Dr Peter Reading	Chief Executive Officer
Brian Shipley	Deputy Director of Finance (representing Lee Bond)
Maneesh Singh	Associate Non-Executive Director
Shaun Stacey	Chief Operating Officer
Michael Whitworth	Non-Executive Director
Dr Kate Wood	Medical Director
Zoe Hinsley	Senior Membership Officer (presentations)
Serena Mumby	Membership Officer (minutes)

Public Members:

Jon Clark
David Cuckson
Neil Gammon
Anthonia Nwafor
Kevin Page
Hugh Rogers

Stakeholders & Partner Trusts:	Janet Inman - Lincolnshire Clinical Commissioning Group (representing Sean Lyons) Simon Beeton - Navigo

The Council agreed to commence with agenda Item 2

2. MEETING ITEMS

2.1 CHAIR'S OPENING REMARKS

Linda Jackson welcomed everyone to the Council of Governors (CoG) Annual Members' Meeting (AMM), including Public Members and representatives from the Trust's stakeholder organisations. An overview of the meeting format was given and members of the public were advised that there would be an opportunity for questions as part of the meeting agenda.

It was noted that 2020/21 had been an unprecedented year . The challenges the Trust , and the NHS as a whole, faced due to the pandemic was exceptional and she complimented the agility of senior teams to repond on a day by day basis to the pandemic and the implementation of robust revised governance arrangements being put in place.

Linda Jackson thanked all staff for their remarkable efforts; passion, professionalism during this period and confirmed that staff were still turning up and delivering the best service possible despite the challenges the Trust are currently facing with winter approaching, elective recovery targets and CoVid cases on the increase
Linda Jackson stressed that whilst the response to the pandemic was the main priority for 2020/21 as cases increased and different innovative soloutions needed to be found this was by no means the only achievement by the trust throughout this period. Linda Jackson went on to say that she wanted to pick a few of these achievements out so that they could be reflected on in today's meeting :

NLAG was at the cutting edge of creating and implementing a BAME risk assessment tool developed by the Trust for Black Asian and Minority Ethnic (BAME) employees .This has been used nationally as a result of the excellent work in identifying those at greater risk. This resulted in the nomination of the Trust for the Health Service Journal's (HSJ) Freedom to Speak Up Organisation of the Year award.

Extensive building work at the three sites of the Trust has remained constant with facilities such as the new MRI and CT scanners being built and mobilised and commencement of work on the new urgent and emergency care centres at the SGH and DPoW sites. This was on top of all of the consequential work needing to be undertaken to facilitate the social distancing requirements of the pandemic working hand in hand with the exemplary work that was undertaken by our Infection Control team

Linda Jackson praised the strong partnership working that has continued throughout this period within the Humber Acute Services Review (HASR) and noteda detailed update will be captured later on the agenda.

Linda Jackson advised that the Trust had achieved it's financial targets for 20/21 and was on track to achieve its financial targets for the current year. The financial landscape has changes considerably through the pandemic and teams have responded well to adapting to the new requirements placed upon them

Linda Jackson flagged to members members that the Trust's innovative outpatient transformation project the 'Connected Health Network', had been successful in the Forward Healthcare Awards 2021. The project, which had been jointly developed by the Trust together with Meridian Health Group, won the early-stage pilot or early adapter of the year category. The project saw the creation of a new model of care where primary and secondary care (such as General Practitioners (GPs) and hospitals), work together as one clinical network.

Linda Jackson hoped she had given a flavour of some of the imnnovation being delivered by the Trust whilst being mindful not to repeat any items the Chief Executive may wish to cover. Linda queried whether anyone wished to comment or raise any questions. None were received.

Council Decision: The Council received the Chair's opening remarks

The agenda then resumed to the planned running order

1. PATIENT STORIES

1.1 Patient Stories during COVID-19

Jenny Hinchliffe shared a video entitled 'Annie's Story', which detailed Annie's experience as a daughter of a patient, the impact of COVID-19 on patient experience and the later experience as a new Family Liaison Assistant. The video highlighted the role of the Patient Experience team, the methods of communication available, and the importance of being a bridge between the patient and their family. It was reported that the Patient Experience team had made a major and positive impact on the wards in supporting staff and helping patients feel less isolated.

Linda Jackson thanked Jenny Hinchliffe for the update and commented on what a marvellous service enhancement these new roles have had and invited questions, none were raised.

2. MEETING ITEMS

2.2 APOLOGIES FOR ABSENCE

Linda Jackson provided apologies for absence as detailed below:

Public Governors: Kevin Allen, Jeremy Baskett, Brian Page and Liz Stones,
Stakeholder Governors: Cllr Stan Shreeve
Non-Executive Directors: Stuart Hall
Executive Directors: Lee Bond (Director of Finance - represented by Brian Shipley)
Ivan McConnell (Programme Director - Humber Acute Services - represented by Claire Hansen),
Ellie Monkhouse (Chief Nurse - represented by Jenny Hinchliffe),
Mark Surridge (Audit Manager - Mazars - represented by Michael Norman),
Public Members: Elizabeth Haddock, Pamela Brittain

Linda Jackson advised that Paul Grinell will be required to leave the meeting briefly and Simon Parkes may be approximately 30 minutes late.

Council Decision: The Council received apologies for absence

2.3 DECLARATION OF INTERESTS

Linda Jackson requested members of the CoG to raise any conflicts of interest relating to specific agenda items or provide any updates to their annual declaration of interests. None were received.

2.4 TO RECEIVE MINUTES OF THE PREVIOUS ANNUAL MEMBERS MEETING HELD ON 30th SEPTEMBER 2020

Linda Jackson invited members to receive the minutes of the CoG Annual Members' Meeting (AMM) held on the 30th September 2020, and advised the minutes had been approved at the CoG meeting held on the 15th October 2020.

Council Decision: The Council received the CoG minutes

3. ANNUAL REPORT & ACCOUNTS

3.1 Overview of Last Year Including Annual Report & Accounts for 2020/21 and Trust Priorities for the Future

Linda Jackson explained that the AMM was the occasion at which the Annual Report and Accounts were formally received and published by the Trust via the CoG.

Dr Peter Reading introduced himself, welcomed all in attendance, and provided an overview of the highlights of the past year. This included the

impact of COVID-19, an update on the Trust priorities for the remainder of 2021/22, the appointment of new executive directors, supporting strategies, Humber Acute Services Review (HASR) progress, delivery of the 2020/21 financial plan, national recognition by the Health Service Journal (HSJ) for becoming a centre of excellence for endometriosis, and improvement of the Summary Hospital-level Mortality Indicator (SHMI).

Simon Parkes joined the meeting at 14:34 hours

Further highlights included updates on the Care Quality Commission (CQC) and their impending visit to the Trust, electronic prescribing and digital letters to patients, and the largest ever capital programme at the Trust. Thanks were expressed to the outstanding staff who were now exhausted, and being asked to regroup and recharge before what could possibly be one of the most challenging winters recorded. Attention was drawn to the significant investment made by the Trust in the wellbeing of staff members and their mental health. Despite national shortages of NHS staff, the Trust had made progress in terms of recruitment and retention of staff by recruiting heavily from overseas.

An update on the Trust priorities for the remainder of 2021/22 in addition to managing COVID-19 was delivered.

Brian Shipley introduced himself and provided a review of the Trust's financial performance for 2020/21. It was confirmed that £210 million in loans to the Trust had been written off and replaced with Premium Disbursement Credit (PDC) funding which significantly improved the balance sheet, and left a £60 million debt outstanding.

Linda Jackson thanked Brian Shipley and invited questions.

Michael Whitworth left the meeting at 14:50 hours

Ian Reekie advised the range of improvements achieved over the 2020/21 financial year despite the challenges faced by COVID-19 were very encouraging, and asked what the Trust were doing to address the issues raised by the HSJ following findings that the Trust had the worst fill rates for junior doctors in the country for the gastroenterology specialty.

Michael Whitworth returned to the meeting at 15:00 hours

Dr Kate Wood confirmed it had been a very difficult year and that the negative experience of the junior doctors had been impacted by the ageing estate. The gastroenterology consultants were currently from a black, Asian, and minority ethnic (BAME) background and were shielding which had resulted in a lack of on-site consultant presence. In order to address this, the Trust had reviewed all specialties and changed the delivery of service, to include a consultant of the week responsible for ward-based care who junior doctor support. The Trust remained hopeful that the newly implemented changes would positively impact upon future feedback received.

Jug Johal responded to a query from Paul Grinell regarding the timescales involved in the construction of new Emergency Department (ED), anticipated improvement of ambulance handover times, Accident and Emergency (A&E) waiting times, and patient flow. The ED at Diana Princess of Wales (DPoW) hospital's completion target was confirmed at between April to May 2022, with Scunthorpe General Hospital's (SGH) ED being scheduled for completion in April to May 2023. Shaun Stacey added that ambulance handover times indicate the demand on the ED and the Trust had undertaken a rapid improvement programme to manage the increased demand. This included priority given to patients who require urgent care, to then allow their discharge home rather than waiting in the department which had been achieved through partnership working. This revised approach combined with the new environment would demonstrate a significant improvement in ambulance handover times. The prediction being that most ambulance handovers would occur within 15 minutes.

Tim Mawson queried the probability of receiving the £720 million funding from central government following the Trust's expression of interest, and queried why the Trust was spending money on a new ED if a new hospital build was likely. Dr Peter Reading reported that there was strong competition for the Trust against its neighbours in Doncaster, York, and the Humber, although eight spaces were available on the government's new hospitals programme. It was confirmed that the Trust had worked robustly to be ahead of most of the competition, which included the level of detail presented, the proposed care pathways and addressing government concerns. It was felt the Trust were in a better position than most other Trusts to date. Richard Barker, the Regional Director and Amanda Pritchard, the Chief Executive Officer (CEO) of NHS England and Improvement had received a tour of SGH to view the poor condition of the estate. A site had been identified for a new hospital should the Trust bid be successful.

In response to Tim Mawson's second query, Dr Peter Reading advised that there was a current need for a better A&E and Acute Assessment Unit (AAU) as there was a duty to provide the safest and best care possible. The timescales for the new hospital programmes were lengthy and would take a significant number of years to come to fruition, so the current works were still necessary.

Paul Grinell left the meeting at 15:18 hours

Rob Pickersgill queried if the Trust had plans to recover the backlog of patient on waiting lists using risk stratification. Shaun Stacey reassured the Council that the Trust would not be placing patients in a worse position, and advised that the risk stratification of patients would only be implemented for those with an identified clinical need. The Trust continued to maintain elective surgeries during lockdown, and despite shutting services for six weeks during the first lockdown, the Trust continued to manage patients and waiting lists. A winter plan had been established to sustain services during the winter period which would treat patients in order of priority.

Council Decision: The Council received an overview of 2019/20 including annual report & accounts for 2020/21 and Trust priorities for the future

3.1.1 Annual Audit Report for 2020/21

Linda Jackson introduced Michael Norman, Senior Audit Manager with Mazars who then presented an overview of the Trust's Annual Audit Report for 2020/21. The report summarised the auditor's views on the Trust's arrangements to secure value for money across the themes of financial sustainability, governance, improving economy, efficiency and effectiveness in the use of resources. Michael Norman reassured the Council that the report factored in ongoing work and the impact of COVID-19 and invited questions.

No questions were received.

Council Action: Membership Office to distribute the audit report to all attendees following the meeting

Council Decision: The Council received the annual audit report for 2020/21

4. STRATEGY & PLANNING

4.1 Humber Acute Services Progress

Claire Hansen presented an update on the Humber Acute Service Review (HASR). The presentation outlined the three strands of the programme; Interim Clinical Plan, Core Hospital Services, and Building Better Places together with the anticipated timeframes of each strand of the programme. Claire Hansen invited questions.

Gill Ponder left the meeting at 15:43 hours

Tim Mawson drew attention to the low response rate of the survey from staff members and queried how the Trust planned to improve response rates. Claire Hansen advised that there was more work to be done and there would be a greater push to capture responses in the canteen or at shift changeover times. Further suggestions were then sought.

Gill Ponder returned to the meeting at 15:51 hours

Ian Reekie thanked Claire Hansen for the presentation and highlighted that the pre-consultation business case was site agnostic as it did not refer to individual hospital sites. Attendance was encouraged for a governor focus group arranged for Monday, 11th October and it was queried whether this would be an opportunity to look at some of the site specific options. Claire Hansen confirmed that the Trust was working through the evaluations of proposals from steering groups to investigate implications of services and their sites. An evaluation criteria and

framework would be worked through with stakeholders over the coming months to ensure that the Pre-Consultation Business Case (PCBC) remained fit for purpose.

Rob Pickersgill highlighted frustration within the primary care setting due to the difficulties of GPs in accessing information relating to patient pathways for patients who had been referred, and queried the extent of GP involvement during any of the consultations to date. Claire Hansen acknowledged the frustration of the GPs and provided assurance that the digital element of this piece of work would bring all of the information together, which would be available to primary care settings and care homes etc.

Claire Hansen advised that the Trust had been working with GPs who had assigned a lead GP for each of the specialties to ensure that acute and primary care are working together to determine the desired outcomes. The Trust was also working with primary care networks, clinical directors and leads of Clinical Commissioning Groups (CCGs), to Primary Care Networks (PCNs). This addressed opportunities for primary care to deliver the services from an outreach perspective to ensure processes were established in the appropriate way.

Linda Jackson thanked Claire Hansen and invited any comments or questions. None were received.

Council Decision: The Council received an update on the Humber Acute Services Review

5. QUESTIONS FROM THE PUBLIC

Alison Hurley reported that the Membership Office had received five questions in advance of the meeting and provided the responses as follows:

Question One - Is there any provision to attend virtually if that is a preference? Can the meeting be streamed?

Answer - On this occasion it was not possible to stream the meeting.

Question Two- What is the trust doing about the “Long Wait” which A&E patients are experiencing?

Answer - Waiting time reviews are undertaken on an ongoing basis throughout the day via the operations meetings. An integrated acute assessment unit model had been introduced including same day emergency care with an aim of increasing same day pathways and reducing admissions, easing pressure on beds and improving access through ED. The performance of these areas against key indicators identified that these areas are performing well, however the Trust is seeing an increased level of attendance, both ambulance and self-presenters, which is creating additional pressure on the ED.

The Trust had implemented the national ‘discharge 2 assess’ model and are work hard with community partners to ensure delays in discharge are minimised. All of these actions are aimed at reducing ED attendance and wait times.

Question Three - Are GPs aware increased referrals are being made to A&E, which possibly could be investigated by the GP in the first instance, and adding to pressures?

Answer – Yes, the Trust have informed GPs on numerous (through the GP leads and the Clinical Commissioning Groups (CCGs). The CCG's were aware of the inappropriate attendances being referred to the EDs which puts further pressure on an already fragile situation. This had also been addressed as part of A&E delivery Board meetings, Urgent and Emergency Care System Improvement Group meetings, Senior Responsible Officer (SRO) meetings, and other meetings.

Shaun Stacey provided additional assurance by advising that two audits had been undertaken during the summer to review A&E attendance. One audit highlighted the reasons for attendance. The second audit identified missed opportunities where care could had been accessed elsewhere if it had been available. Both audits demonstrated a greater public demand and desire for faster access into services, and led to rapid improvement in urgent care.

Question Four - The Green Sill company has become bankrupt. Have the Trust been dealing with this company?

Answer - The Trust has not used the Green Sill Company.

Question Five - A query about the construction work at the Trust was raised around demolition of the old buildings. Confirmation was also sought that this was funded separately to the cash injections from the government.

Answer - At the heart of the ongoing works at Scunthorpe General Hospital was the construction of the new multi-million pound Emergency Department. The Trust had secured £30 million funding from the Department of Health and Social Care and NHS England for a large-scale programme of work to build brand new Emergency Care units at the Scunthorpe and Grimsby sites. These new EDs were designed in consultation with the Trust's nursing and clinical teams to ensure the facilities required would be available to provide the very best care for the communities, both now and in the future.

The key requirements were:

- An increased waiting area to cope with demand and give the Trust space necessary to implement social distancing
- A dedicated play area for younger patients
- Additional 'flexible use' cubicles, to make it easier for the Trust to see patients more quickly, whatever their needs
- A dedicated ambulance bay, which would reduce the time for patient transfers arriving by ambulance into the Trust's care

In order to build this new unit at Scunthorpe, the Trust had unfortunately been required to demolish some of the older buildings, including the Courtyard Block and Administration Block. The decision to demolish them had not been lightly but ultimately, the priority was to give the communities the Trust serves the best possible care, and these buildings were no longer

fir for purpose. A huge amount of time was spent looking at how the Trust could best preserve as much of the heritage as possible, exploring every possible option. The Trust's first priority was to ensure the medical facilities in the new unit are the best they could be. The Trust's plan was to preserve the key memorial archway and date stones over the main entrance and incorporate them into the new building.

Memorial plaques currently housed in the building would be displayed alongside old photographs and pictures of the hospital on a new heritage wall and the Trust also created a heritage page on our website which details the history of the hospital.

Once the new EDs are complete, the Trust would then begin work on converting the current A&E departments into new AAU's which would be staffed by expert clinicians in a wide variety of disciplines. This would allow the Trust to diagnose and treat patients more quickly, without necessarily having to admit them to a ward first in order to access that expertise. Thus reducing the number of people admitted and the amount of time patients had to spend in hospital, without compromising the quality of care.

The £24.86 million for these units was announced last year and the development of full business cases is underway, working with NHS England and NHS Improvement.

Jug Johal provided assurance that funding received had conditions attached which prevents the money being used for alternative projects.

Linda Jackson thanked all members for their questions and invited any further questions or comments from those present in the meeting. No further questions were received.

Council Decision: The Council received an overview of questions from members of the public received in advance of the meeting

6. REFLECTION OF FORMAT FOR FUTURE REVIEW

Linda Jackson thanked everyone for their contribution to the meeting and invited feedback on the format of the meeting held.

David Cuckson had found the meeting very interesting and requested printed presentations in advance of the meeting for next year to provide attendees with a greater opportunity to view the information. This suggestion was agreed.

Kevin Page reported that the amount of abbreviations in the presentations made them difficult to understand. This concern was acknowledged and would be addressed accordingly.

Council Action: Membership Office to print presentations and ensure the use of acronyms is minimised for the CoG AMM in 2022

Council Decision: The Council discussed the format of the meeting for future review

7. ANY OTHER BUSINESS

Linda Jackson invited any other business. None was raised.

8. DATE AND TIME OF NEXT COUNCIL OF GOVERNORS MEETING

Date: 19th October 2021
Time: 14:00 - 17:00 hours
Venue: Sands Venue Stadium (Glanford Park)

Please notify the Membership Office of any apologies for these events.

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

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• Governors were asked to raise any questions on which they require information or clarification in advance of meetings. This would allow time for the information to be gathered and an appropriate response provided.

Linda Jackson thanked members for their attendance and contributions. The meeting closed at 16:10 hours.

Agenda Number: CoG (09/22) Item: 2.1.1

Name of the Meeting	**Council of Governors Annual Members' Meeting**	
Date of the Meeting	29 September 2022	
Director Lead		
Contact Officer/Author	Mark Surridge, Director (Mazars) Michael Norman, Senior Manager (Mazars)	
Title of the Report	**Annual Auditor's Report 2021 2022**	
Purpose of the Report and Executive Summary (to include recommendations)	The Annual Auditor's Report summarizes the auditor's views on the Trust's arrangements to secure value for money across the themes of financial sustainability, governance and improving economy, efficiency and effectiveness in the use of resources.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Auditor's Annual Report

Northern Lincolnshire and Goole NHS Foundation Trust – year ended 31 March 2022

June 2022

mazars

Contents

01

Section 01:

Introduction

1. Introduction

Purpose of the Auditor's Annual Report

Our Auditor's Annual Report (AAR) summarises the work we have undertaken as the auditor for Northern Lincolnshire and Goole NHS Foundation Trust ('the Trust') for the year ended 31 March 2022. Although this report is addressed to the Trust, it is designed to be read by a wider audience including members of the public and other external stakeholders.

Our responsibilities are defined by the Local Audit and Accountability Act 2014 and the Code of Audit Practice ('the Code') issued by the National Audit Office ('the NAO'). The remaining sections of the AAR outline how we have discharged these responsibilities and the findings from our work. These are summarised below.

Opinion on the financial statements

Our audit report issued on 17 June 2022 gave a unqualified opinion on the financial statements for the year ended 31 March 2022.

Value for Money arrangements

In our audit report issued on 17 June 2022 we reported that we had not completed our work on the Trust's arrangements to secure economy, efficiency and effectiveness in its use of resources and had not issued recommendations in relation to identified significant weaknesses in those arrangements at the time of reporting. Section 3 confirms that we have now completed this work and provides our commentary on the Trust's arrangements.

Following the completion of our work we have issued our audit certificate which formally closes the audit for the 2021/22 financial year.

Wider reporting responsibilities

In line with group audit instructions issued by the NAO, we have reported that the Trust's consolidation schedules are consistent with the audited financial statements.

02

Section 02:

Audit of the financial statements

2. Audit of the financial statements

The scope of our audit and the results of our opinion

Our audit was conducted in accordance with the requirements of the Code, and International Standards on Auditing (ISAs). We do this by expressing an opinion on whether the statements are prepared, in all material respects, in line with the financial reporting framework applicable to the Trust and whether they give a true and fair view of the Trust's financial position as at 31 March 2022 and of its financial performance for the year then ended.

Our audit report issued on 17 June 2022 gave a unqualified opinion on the financial statements for the year ended 31 March 2022.

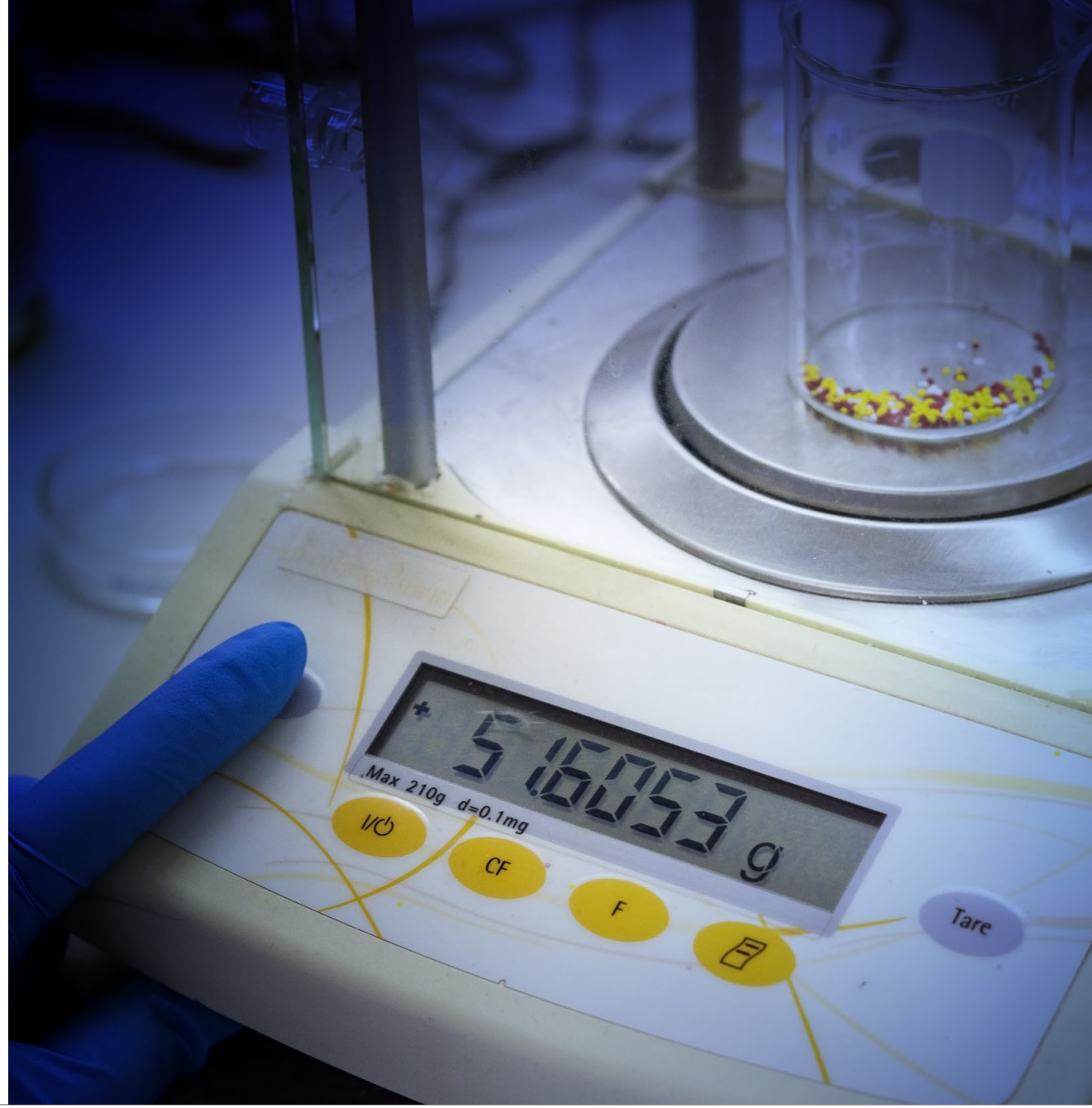
03

Section 03:

Our work on Value for Money arrangements

3. VFM arrangements

Overall Summary



3. VFM arrangements – Overall summary

Approach to Value for Money arrangements work

We are required to consider whether the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The NAO issues guidance to auditors that underpins the work we are required to carry out and sets out the reporting criteria that we are required to consider. The reporting criteria are:

- **Financial sustainability** - How the Trust plans and manages its resources to ensure it can continue to deliver its services
- **Governance** - How the Trust ensures that it makes informed decisions and properly manages its risks
- **Improving economy, efficiency and effectiveness** - How the Trust uses information about its costs and performance to improve the way it manages and delivers its services

Our work is carried out in three main phases.

Phase 1 - Planning and risk assessment

At the planning stage of the audit, we undertake work so we can understand the arrangements that the Trust has in place under each of the reporting criteria; as part of this work we may identify risks of significant weaknesses in those arrangements.

We obtain our understanding or arrangements for each of the specified reporting criteria using a variety of information sources which may include:

- NAO guidance and supporting information
- Information from internal and external sources including regulators
- Knowledge from previous audits and other audit work undertaken in the year
- Interviews and discussions with staff and directors

Although we describe this work as planning work, we keep our understanding of arrangements under review and update our risk assessment throughout the audit to reflect emerging issues that may suggest there are further risks of significant weaknesses.

Phase 2 - Additional risk-based procedures and evaluation

Where we identify risks of significant weaknesses in arrangements, we design a programme of work to enable us to decide whether there are actual significant weaknesses in arrangements. We use our professional judgement and have regard to guidance issued by the NAO in determining the extent to which an identified weakness is significant.

Phase 3 - Reporting the outcomes of our work and our recommendations

We are required to provide a summary of the work we have undertaken and the judgments we have reached against each of the specified reporting criteria in this Auditor's Annual Report. We do this as part of our Commentary on VFM arrangements which we set out for each criteria later in this section.

We also make recommendations where we identify weaknesses in arrangements or other matters that require attention from the Trust. We refer to two distinct types of recommendation through the remainder of this report:

- **Recommendations arising from significant weaknesses in arrangements**

  We make these recommendations for improvement where we have identified a significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. Where such significant weaknesses in arrangements are identified, we report these (and our associated recommendations) at any point during the course of the audit.

- **Other recommendations**

  We make other recommendations when we identify areas for potential improvement or weaknesses in arrangements which we do not consider to be significant but which still require action to be taken.

The table on the following page summarises the outcomes of our work against each reporting criteria, including whether we have identified any significant weaknesses in arrangements or made other recommendations.

3. VFM arrangements – Overall summary

Overall summary by reporting criteria

Reporting criteria	2020/21 Actual significant weaknesses identified?	2021/22 Commentary page reference	2021/22 Identified additional risks of significant weakness?	2021/22 Actual significant weaknesses identified?	2021/22 Other recommendations made?
Financial sustainability	**Yes Page 24**	11-14	No	No new matters arising in 2021/22. However, the significant weakness reported from 2020/21 remains in place for 2021/22	No
Governance	No	15-17	No	No matters arising in 2021/22.	No
Improving economy, efficiency and effectiveness	**Yes Page 23**	18-21	No	No new matters arising in 2021/22. However, the significant weakness reported from 2020/21 remains in place for 2021/22	No

3. VFM arrangements

Financial Sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria

Significant weakness in 2020/21	In 2020/21, we identified a significant weakness in arrangements relating to the Trust's financial sustainability.
Additional significant weaknesses identified in 2021/22	Nil.

Position brought forward from 2020/21

As set out in the table above, we reported a significant weakness in the Trust's arrangements for 2020/21. Our commentary on the progress made against these actions is set out on page 24. No additional significant weaknesses were identified for 2021/22.

Background to the NHS financing regime in 2021/22

Following the onset of the Covid-19 pandemic in March 2020, the original NHS Planning Guidance 2020/21 was suspended and a new financial regime was implemented. For the second half of the 2020/21 year (October 2020 to March 2021) there was a move to "system envelopes", with funding allocations covering most NHS activity made at the system level, including resources to meet the additional costs of the Covid-19 pandemic. The 2021/22 financial year was also split into two halves, with a different funding regime in each. However, the regimes were largely a continuation of those introduced in 2020/21 in response to COVID-19, where system envelopes and block payment arrangements remained in place.

The 2021/22 H1 (April 2021 to September 2021) envelopes comprised of adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H2 2020/21 envelopes, adjusted for known pressures and policy priorities. The 2021/22 H1 NHS guidance also confirmed that block payment arrangements would remain in place for relationships between NHS commissioners and NHS providers. The guidance for H2 (October 2021 to March 2022) confirmed that the arrangements would stay broadly consistent with a continuation of the H1 framework. The 2021/22 H2 "system envelopes" contained adjusted CCG allocations, system top-up and COVID-19 fixed allocation, based on the H1 2021/22 envelopes adjusted for additional known pressures, such as the impact of pay awards, and increased efficiency requirements.

Over the course of the year and into 2022/23, the focus of the funding regime has shifted from responding to the immediate challenges caused by COVID-19 to supporting recovery in the healthcare system. This has facilitated the need for collaborative working between commissioners and providers, as local systems were expected to work together to deliver a balanced position in 2021/22, with additional funding available for those systems exceeding target activity levels through the Elective Recovery Fund. The planning guidance for 2022/23 supports the transition back to local agreement of contracts, and requires systems to achieve a break even position each year. This will necessitate further collaboration through the planning process, as individual organisations work together to achieve system-level outcomes.

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria (continued)

Overall responsibilities for financial governance

We have reviewed the Trust's overall governance framework, including Board and committee reports, the Annual Governance Statement, and Annual Report and Accounts for 2021/22. These confirm the Trust Board undertook its responsibility to define the strategic aims and objectives, approve budgets and monitor financial performance against budgets and plans to best meet the needs of the Trust's service users.

The Trust's financial planning and monitoring arrangements

Through our review of board and committee reports, meetings with management and relevant work performed on the financial statements, we are satisfied that the Trust's arrangements for budget monitoring remain appropriate, and these include:

- Standing Financial Instructions with relevant provisions for budgetary control and reporting, including arrangements for Finance Managers to provide reports and support to budget holders and teams to support effective financial management of those component parts of Trust financial performance. Clear responsibilities are outlined for budget holders and the Trust's Standing Financial Instructions include specific provisions for the preparation and approval of the Annual Plan and budget.
- Oversight from the Trust Board and its Committees, through an Integrated Performance Report and Finance Report, have received regular reports on financial performance and planning.
- Alignment between the Trust's Strategic Objectives ('to live within our means') and the Board Assurance Framework (BAF) which sets out the controls, sources of assurance and plans to address the risks to this objective. We have confirmed there continues to be ongoing review, challenge and action by the Trust in relation to any control gaps identified within the BAF relating to this Strategic Objective.
- Established arrangements for effective year end financial reporting; statutory deadlines have been met for 2021/22 and in previous years. No significant concerns were reported in our Audit Completion Report which adversely impact on this commentary and the final financial outturn was broadly in line with the forecast position during the year.

The Trust's financial outturn for 2021/22 does not indicate any significant VFM issues. The Trust's audited financial statements showed an operating surplus of £15.4m (£3.7m deficit in prior year) against operating expenditure of £495.3m. After taking account of specific measures, this equated to a £86k surplus (£164k in prior year) against the control total. There were no significant unexpected adverse movements in the Statement of Financial Position. The Trust declared savings of £11.9m against the target of £10.6m for the year.

2021/22 Outturn

The Consolidated Statement of Comprehensive Income we audited includes a separate disclosure relating to the Trust's financial performance against its control total, which we have re-produced in the table below as well as showing the two major components of Taxpayer's Equity: Public Dividend Capital and the Income & Expenditure Reserve. Figures in brackets represent a deficit position.

	2019/20 (£'000)	2020/21 (£'000)	2021/22 (£'000)
Control Total Performance			
Audited surplus/(deficit for the period)	(22,172)	(6,717)	10,523
Net adjustments to control total basis	(3,104)	6,881	(10,437)
Adjusted financial performance	(25,276)	164	86
Taxpayer's Equity			
Public Dividend Capital	130,690	369,433	401,318
Income and expenditure reserve	(200,933)	(207,839)	(197,447)
Total Taxpayer's Equity	(49,064)	177,720	224,443

The increase in Public Dividend Capital reflects the capital funding received to support significant schemes in the year. There were no unplanned movements on the Trust's borrowings. The cumulative I&E Reserve deficit continues to be material. We have confirmed that the Audit, Risk and Governance Committee received reports from management to support its consideration of the continuation of the Trust as a Going Concern.

3. VFM arrangements – Financial Sustainability

Overall commentary on the Financial Sustainability reporting criteria (continued)

The Trust's arrangements and approach to Financial planning 2022/23

We reviewed the 2022/23 financial plan submitted in April 2022 and discussed it with management.

For 2022/23 the NHS has reverted to contracting arrangements instead of the block payments system introduced in 2020/21 to simplify arrangements during the Covid pandemic. The financial plan submitted in April 2022 showed an I&E deficit of £6m, within the overall Humber and North Yorkshire Health and Care Partnership (the ICS) deficit of around £56m. The plan included targeted efficiency improvements of around £20.6m which was in line with the thresholds set out in the planning guidance. Although some specific areas of planned saving had not been firmed up it was expected that the risks could be managed through cost control and reserves.

NHS England nationally required that plans be resubmitted by 20 June 2022 and offered ICSs additional funding to help broker breakeven positions in local plans. The local ICS was offered around £25m of additional funding. The Trust worked with its ICS colleagues and internally to update its planning and the Trust's resubmitted plan shows a breakeven position for 2022/23.

The creation of the Statutory ICS in 2022/23, along with the introduction of new financial/contracting arrangements, will lead to the opportunity to develop more medium-term financial and operational plans. The Trust will continue to work with partners in the ICS, to shape new management arrangements and deliver improved service configurations in the coming years. This is a challenging task; the Trust's long term financial sustainability is dependent, amongst other things, on the resolution of long-standing issues in relation to the local configuration of services and workforce, which is the focus of the ongoing Humber Acute Services Review and the work with Hull University Teaching Hospitals NHS Trust to complete the Interim Clinical Plan. The Trust has remained in Financial Special Measures, and now the RSP, for Finance throughout 2021/22 and into 2022/23. The Trust has continued to engage with NHSE/I regarding its improvement priorities and worked with local partners on workforce and service matters, including through the development and agreement of a 2022/23 plan. However, the Trust's regulator has determined that it is not yet satisfied sufficient progress has been made for it to exit the RSP.

In our view, there is therefore insufficient evidence to demonstrate that sufficient and sustainable progress has been made to the Trust's underlying arrangements to address the significant weakness previously identified.

3. VFM arrangements

Governance

How the body ensures that it makes informed decisions and properly manages its risks

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria

Significant weakness in 2020/21	Nil.
Additional significant weaknesses identified in 2021/22	Nil.

Position brought forward from 2020/21

As set out in the table above, we reported no significant weakness in the Trust's Governance arrangements for 2020/21. No additional significant weaknesses were identified for 2021/22.

Overall Governance Arrangements

Based on our work, we are satisfied that the Trust continues to have established governance arrangements and not identified any significant weaknesses in its Governance arrangements

The Trust has a full suite of governance arrangements in place, supported by the Trust's Constitution and Scheme of Delegation . These are set out in the Trust's Annual Report and Annual Governance Statement. We reviewed these documents as part of our audit and confirmed they were consistent with our understanding of the Trust's arrangements in place.

Our review of the Trust's governance framework confirms arrangements are in place, with the Trust Board being overall responsible for the performance of the Trust and having a clear set of strategic and supervisory roles. The Trust has established Committees to support these roles. The Trust carries out annual evaluation of the Board and its sub-committees. There is a Board Development Programme in place with bi-monthly sessions scheduled for development activities, briefings on key risk topics and focussed discussion regarding future strategy. We consider the committee structure of the Trust is sufficient to provide assurance that decision making, risk and performance management is subject to appropriate levels of oversight and challenge.

The 2021/22 Annual Report and Annual Governance Statement set out the steps taken in the year to strengthen compliance with NHS Improvement's Well-Led framework. The Care Quality Commission's latest (2019) inspection resulted in a rating for this domain of 'Requires Improvement', a change from the previous 'Inadequate' assessment. The Board Development Programme includes specific sessions on well-led.

The Trust carries out an ongoing programme of work to ensure that its governance procedures are in line with the principles of the NHS Foundation Trust Code of Governance. The Annual Report includes a summary of the Trust Board's assessment of its arrangements against the Code's expectations. the Board has reported that it considers that it was fully compliant in 2021/22 with the provisions of the Code.

The Trust Board holds an annual self-certification event to assess and confirm compliance with the requirements of its NHS Provider Licence including the condition relating to governance. This work is supported by an Internal Audit review of the assurances in place to support the required declarations.

The Annual Report sets out the arrangements in place for the Council of Governors (CoG) to carry out its roles and meet its responsibilities as set out in the Trust Constitution. These include the arrangements for making the Trust accountable for the services it provides The Annual Report states that there has been regular engagement by the CoG and individual Governors with the Trust Board and that the CoG is satisfied with its interaction and relationship with the board of directors.

3. VFM arrangements – Governance

Overall commentary on the Governance reporting criteria - continued

The Trust has a comprehensive risk management system in place which is embedded into the governance structure of the organisation. The processes are supported by the Trust-wide Governance and Risk Management Strategy and the Trust leadership plays a key role in implementing and monitoring the risk management process.

The Trust records strategic risks in the Board Assurance Framework (BAF) and our review confirms it is sufficiently detailed to manage the Trust's key risks, identify controls, gaps in controls and obtain the assurance required to work towards a targeted risk score. 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 committees with our review of agendas confirming the relevant risks being aligned to and reviewed by the relevant committees quarterly. The Trust Board also annually reviews the organisation's 'Risk Appetite'. Our review of reports as well as attendance at Audit, Risk and Governance Committee meetings confirms the BAF is regularly updated and in sufficient detail to allow for adequate review including primary risk controls, gaps, plans to improve controls and any additional actions required. Internal Audit carry out an annual review of the BAF and the risk management systems and process which underpin it. Internal audit provided a 'significant assurance' rating on these arrangements for 2021/22.

The Audit, Risk and Governance Committee considers the BAF, Annual Report and Accounts and Annual Governance Statement and monitors progress with internal and external audit plans. It also regularly receives updates on losses and compensation payments, single tender waivers. Our attendance at Audit, Risk and Governance Committee has confirmed there is an appropriate level of effective challenge.

We reviewed the 2021/22 Annual Governance Statement and are satisfied it fairly reflects the arrangements in place. The Statement identifies the significant internal control issues that the Trust is focused on addressing. These include Regulators' judgements on financial sustainability and quality of services, information governance and the challenge of meeting constitutional and regulatory performance requirements.

The Trust's Internal Audit is provided by an independent third party who provide Annual Plan, Annual Report and regular progress reports to the Audit, Risk and Governance Committee, which we have read. The Head of Internal Audit Opinion is reflected in full alongside the published Annual Governance Statement. In respect of the 2021/22 period Internal Audit's opinion was that "Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently". The overall opinion and the detailed reports issued in the year do not identify any significant weaknesses in the Trust's VFM arrangements.

The Trust hosts and manages an in-house counter fraud collaborative, known as Counter Fraud Plus (CFP), between itself and four local trusts, This collaborative arrangement is intended to provide a more resilient counter fraud service between the organisations involved. The Audit, Risk and Governance Committee has received regular progress reports on the agreed annual counter fraud plan and provided oversight and challenge as required. We have reviewed the reports provided and they do not highlight any significant weaknesses in the Trust's VFM arrangements.

3. VFM arrangements

Improving Economy, Efficiency and Effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria

Significant weakness in 2020/21	In 2020/21, we reported on a significant weakness in the Trust's arrangements due to the Trust being under Quality Special Measures.
Additional significant weaknesses identified in 2021/22	Nil.

Position brought forward from 2020/21

As set out in the table above, we reported a significant weakness in the Trust's arrangements for 2020/21. Our commentary on the progress made against these actions is set out on page 23. No additional significant weaknesses were identified for 2021/22.

Performance Management

We have reviewed key reports issued by the Board and confirmed the Trust reports its performance in several different ways:

- an Integrated Performance Report and Finance Report to each Board meeting, with Sub-Committees providing detailed scrutiny and challenge to relevant sections; and
- the publication of the Annual Report, and Annual Governance Statement, which are reviewed by the Audit, Risk and Governance Committee before adoption by the Board.
- The annual Quality Report

The Trust has in place a Performance Framework, which outlines the approach to holding Divisions to account for delivery of objectives and improvements including those relating to governance and risk management. This includes monthly Performance Review Improvement meetings for the Clinical Divisions, chaired by the Chief Operating Officer and attended by other Executive Directors. The outcomes of the Performance Review Improvement meetings are presented to the Finance and Performance sub-committee of the Board for oversight.

Integrated Performance Reports are summarised in a format which shows performance against target and over time. Board members are also able to triangulate information from this report with the assurance summaries from each Sub-committee, where Committee chairs draw attention to assurances provided or matters escalated for the full Board's attention. Minutes demonstrate sufficient challenge from non-executive directors on the Trust's costs, performance and service delivery and the Board holds managers to account where performance improvements are required.

We have read and reviewed the Trust's Annual Report and Quality Report, which set out its performance against key indicators and how it evaluates and assesses performance and improvement opportunities.

Our review confirms, overall, that the Trust's reports are adequately laid out and sufficiently detailed to monitor performance and take corrective action where required, which may include updating the Board Assurance Framework.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria (continued)

Care Quality Commission (CQC Ratings

At the end of 2021/22, the Trust's overall quality rating by the CQC was 'Requires Improvement', with the domain scores from the latest published report shown in the table opposite. The inspection was carried out September 2019, with the report published February 2020. Ratings will not change until the next formal inspection by the CQC.

Theme	Rating
Northern Lincolnshire and Goole NHS Foundation Trust (Report Issued February 2020)	
Overall rating	Requires improvement
Are services safe?	Inadequate
Are services effective?	Requires Improvement?
Are services caring?	Good
Are services responsive?	Requires Improvement
Are services well-led?	Requires improvement
Use of resources	Requires improvement

We have reviewed the Trust's Annual Report which sets out the steps being taken to continue to engage with the CQC, including monthly relationship meetings and the escalation of risks and concerns in respect of patient safety or quality if required.

The Annual Report confirms that the Trust is in the Single Operating Framework level 4 of the Recovery Support Programme (formerly 'Special Measures') for quality and continues to benefit from the support package put in place by NHSE/I; specifically support from an NHSE/I Improvement Director to implement and embed the required improvements.

Detailed Divisional improvement plans are in place in response to all CQC findings with oversight and reporting arrangements including regular reports on progress to Performance Review and Improvement Meetings, the relevant Trust Board Sub-committees and the Trust Board. The Trust's Quality Board (chaired by NHS/I) continues to be in place with relevant stakeholders supporting the Trust in the delivery of its improvement plan, and providing oversight of delivery of the required improvements. Whilst the Trust is in the Single Operating Framework level 4 of the Recovery Support Programme for quality it has no conditions on its registration, and is fully compliant with the registration requirements of the CQC.

We recognise the continuing impact of Covid-19 during the year, but the Trust has remained within financial and quality special measures and the Recovery Support Programme throughout 2021/22 and to the date of this report. We are unable to confirm though that the Trust has made sufficient progress for the ratings to be changed and the judgement on the effectiveness of arrangements is subject to any future inspection findings from the CQC.

3. VFM arrangements – Improving Economy, Efficiency and Effectiveness

Overall commentary on the Improving Economy, Efficiency and Effectiveness reporting criteria (continued)

Partnership working

The Trust's strategic objectives include 'to work more collaboratively', recognising the importance of working with others to provide effective and sustainable services and meet patients' needs. Our review of board minutes and discussions with management confirms the Trust continues to be committed to partnership working and these arrangements have become more established over the year.

The Trust works in close partnership with other Health and Social Care organisations in the area, through its participation in the Humber and North Yorkshire Health and Care Partnership (the ICS). The Trust's priorities include playing an active role in the ICS. The Trust has continued to work closely with partner organisations across the ICS to deliver a financial position within the allocated system envelope. Key priorities for the Trust in securing sustainability for the Trust and local services are progressing through the Humber Acute Services Review and its work with Hull University Teaching Hospitals NHS Trust to complete the Interim Clinical Plan to support strategy development and capital investment across both organisations. The Trust reports a number of positive developments in the governance, programme management and progress against milestones in these challenging areas.

Procurement

We read the Trust's Standing Financial Instructions and confirm these adequately set out the procedures, controls and the authorisation sign offs that are required for the commission or procurement of services. There is a professional procurement team in place with a specification process used to ensure that the selected option and supplier gives best value for money. Legally compliant Framework Agreements are used where appropriate and there are instructions in place regarding the levels for delegated approval of expenditure. The Trust has policies in place regarding expected standards of business conduct, and gifts and hospitality, to mitigate the risk of conflicts of interests arising. Our review of Board and Committee minutes confirms these are published on a regular basis. Our attendance at the Audit, Risk and Governance Committee confirms it receives regular reports on any waiving of Standing Orders and Losses and Compensation. The Committee's reviews provide assurance to the Trust Board that the Trust is working in accordance with relevant legislation, professional standards and internal policies.

3. VFM arrangements

Identified significant weaknesses in arrangements and our recommendations

3. VFM arrangements – Prior year recommendations

Progress against significant weaknesses and recommendations made in the prior year

As part of our 2020/21 audit work, we identified the following significant weaknesses, and made recommendations for improvement in the Trust's arrangements to secure economy, efficiency and effectiveness it its use of resources. These identified weaknesses have been outlined in the table below, along with our view on the Trust's progress against the recommendations made, including whether the significant weakness is still relevant in the 2021/22 year.

Previously identified significant weakness in arrangements	Reporting criteria	Recommendation for improvement	Our views on the actions taken to date	Overall conclusions
The Trust's arrangements for Quality The overall outcome from the most recent Care Quality Commission (CQC) inspection in 2019 was a combined rating of 'requires improvement', and the Trust continues to operate under the Quality Special Measures introduced in April 2017. The detailed assessment included a negative change in the rating in the 'Safe' domain (to 'inadequate') and an improvement in the rating in the 'well led' domain (to 'requires improvement'). Ratings will not change until the next formal inspection by the CQC. NHS England and Improvement (NHSE/I) continues to meet with the Trust for performance review meetings. The Trust also continues to be under the Financial Special Measures introduced in 2017. Under the Single Oversight Framework (SOF), which is designed to help NHS providers attain, and maintain, CQC ratings of 'Good' or 'Outstanding', The Trust's public score for 2020/21is "4", defined as: *Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues*. The public score is changed only once providers have been informed by their regional lead and there is a move between segments. We recognise the continuing impact of Covid-19 during the year, and acknowledge the steps being taken to engage with CQC and NHSE/I to address the areas of concern highlighted in inspection reports and secure financial sustainability. The Trust has though remained in financial and quality special measures throughout 2021/22 and there is insufficient evidence to demonstrate the Trust has made sufficient progress for conditions to be lifted by regulators. As a result, there is a significant weakness in the Trust's arrangements that exposes it to a risk of significant overspending and can be reasonably expected to lead to a significant impact on the quality or effectiveness of service and the Trust's reputation.	Improving Economy, Efficiency and Effectiveness	In order to ensure systems, processes and training are in place to manage the risks relating to the health, safety, and welfare of service users, the Trust must ensure it embeds and sustains the action plans that it has put in place Trust-wide to address the patient care issues identified by the CQC. In particular, it needs to ensure that robust monitoring and reporting processes are maintained, and that challenge, scrutiny and escalation arrangements drive the required improvements for patients and sustain the progress made to-date in implementing the actions to address the issues raised by the CQC.	We have considered the Trust's arrangements in relation to these VFM criteria and taken into account the Trust's frameworks in place to address the CQC and NHSE/I recommendations. We have confirmed that there have been no subsequent CQC inspection and Regulators' current ratings on the Trust are unchanged from the previous year. The Trust has continued to work towards improving overall arrangements in response to being placed in special measures and now under the Recovery Support Programme (RSP). However the Trust has remained within the RSP for Quality and Finance throughout 2021/22. There is insufficient evidence to demonstrate that the Trust has addressed all the issues raised to the point at which the Trust's regulators have concluded that sufficient progress has been made for the Trust to exit the RSP.	As a result, in our view, there remains a significant weakness in the Trust's arrangements regarding the improving economy, efficiency and effectiveness criteria.

3. VFM arrangements – Prior year recommendations

Progress against significant weaknesses and recommendations made in the prior year (continued)

Previously identified significant weakness in arrangements	Reporting criteria	Recommendation for improvement	Our views on the actions taken to date	Overall conclusions
The Trust's financial sustainability As reported in the audited financial statements, the Group financial outturn was £7m deficit in 2020/21 and a £22m deficit in 2019/20, both an improvement from the £59m deficit in 2018/19. The Group financial statements also show the financial performance as measured on a control total basis by NHSE/I as: £0.1m surplus in 2020/21 and £25m deficit in 2019/20, with the deficit being £58m in 2018/19. The cumulative Income and Expenditure deficit at 31 March 2021 is significant, at £208m. The Trust has been in Financial Special Measures since 2017 and continues to face significant financial challenges. The Trust has engaged with NHS England and Improvement (NHSE/I) regarding the current criteria for exiting from Financial Special Measures In 2021/22. These are focused on the Trust and the Integrated Care System achieving the first 6 months financial plan, restructuring of the Finance team, delivering planned savings and developing a robust long term financial plan with emphasis on reducing Covid expenditure and the underlying run rate. The Trust's long term financial sustainability is dependent, amongst other things, on the resolution of long-standing issues in relation to the local configuration of services and workforce, which is the focus of the ongoing Humber Acute Services Review and also of the work with Hull University Teaching Hospitals NHS Trust to complete the Interim Clinical Plan. It is also dependent on the national funding structures yet to be determined. These long-standing issues, alongside the need to respond and adapt to Covid-19, have prevented the Trust from improving arrangements to secure financial sustainability during 2020/21. Overall, therefore, we have concluded that there is an ongoing significant weakness in arrangements to secure financial sustainability.	Financial Sustainability	Within the context of revisions to NHS financing and the 2021/22 Planning Guidance, the Trust should ensure that it delivers the action plans that have been developed by management, and that monitoring and reporting, challenge and scrutiny and escalation arrangements are in place to drive the required improvements for patients and sustain the improvements that are made.	We have considered the Trust's arrangements in relation to these VFM criteria and taken into account the Trust's 2021/22 financial outturn and 2022/23 financial plan. We have confirmed that the Regulators' current ratings on the Trust are unchanged from the previous year. The Trust has remained in Financial Special Measures, and now the RSP, for Finance throughout 2021/22. The Trust has continued to engage with NHSE/I regarding its improvement priorities and worked with local partners on workforce and service matters, including through the development and agreement of a 2022/23 plan. However, the Trust's regulator has determined that it is not yet satisfied sufficient progress has been made for it to exit the RSP. In our view, there is therefore insufficient evidence to demonstrate that sufficient and sustainable progress has been made to the Trust's underlying arrangements to address the significant weakness previously identified.	As a result, in our view, there remains a significant weakness in the Trust's arrangements regarding the Financial Sustainability criteria.

04

Section 04:

Other reporting responsibilities

4. Other reporting responsibilities

Matters we report by exception

The NHS Act 2006 provides auditors with specific powers where matters come to our attention that, in their judgement, require specific reporting action to be taken. Auditors have the power to:

- issue a report in the public interest; and
- make a referral to the regulator.

We have not exercised any of these statutory reporting powers.

We are also required to report if, in our opinion, the governance statement does not comply with relevant guidance or is inconsistent with our knowledge and understanding of the Trust. We did not identify any matters to report in this regard.

Reporting to the NAO in respect of consolidation data

The NAO, as group auditor, requires us to report to them whether consolidation data that the Trust has submitted is consistent with the audited financial statements. We have concluded and reported that the consolidation data is consistent with the audited financial statements.

Mark Surridge

Mazars
2 Chamberlain Square
Birmingham
B3 3AX

Mazars is an internationally integrated partnership, specialising in audit, accountancy, advisory, tax and legal services*. Operating in over 90 countries and territories around the world, we draw on the expertise of 40,400 professionals – 24,400 in Mazars' integrated partnership and 16,000 via the Mazars North America Alliance – to assist clients of all sizes at every stage in their development.

*where permitted under applicable country laws.

mazars

Humber and North Yorkshire
Health and Care Partnership

Understanding our Operating Model

Humber and North Yorkshire
Health and Care Partnership

Humber and North Yorkshire Health and Care Partnership comprises of NHS organisations, local councils, health and care providers and voluntary, community and social enterprise (VCSE) organisations. We are one of 42 Integrated Care Systems (ICSs), established across England, to:

- Improve outcomes
- Tackle Inequalities
- Enhance quality and productivity
- Support social and economic recovery

Our collective mission is to improve the lives of the people who live and work in the Humber and North Yorkshire

Our Integrated Care System: HNY

Humber and North Yorkshire Health and Care Partnership

4 acute hospital trusts (operating across 9 sites)

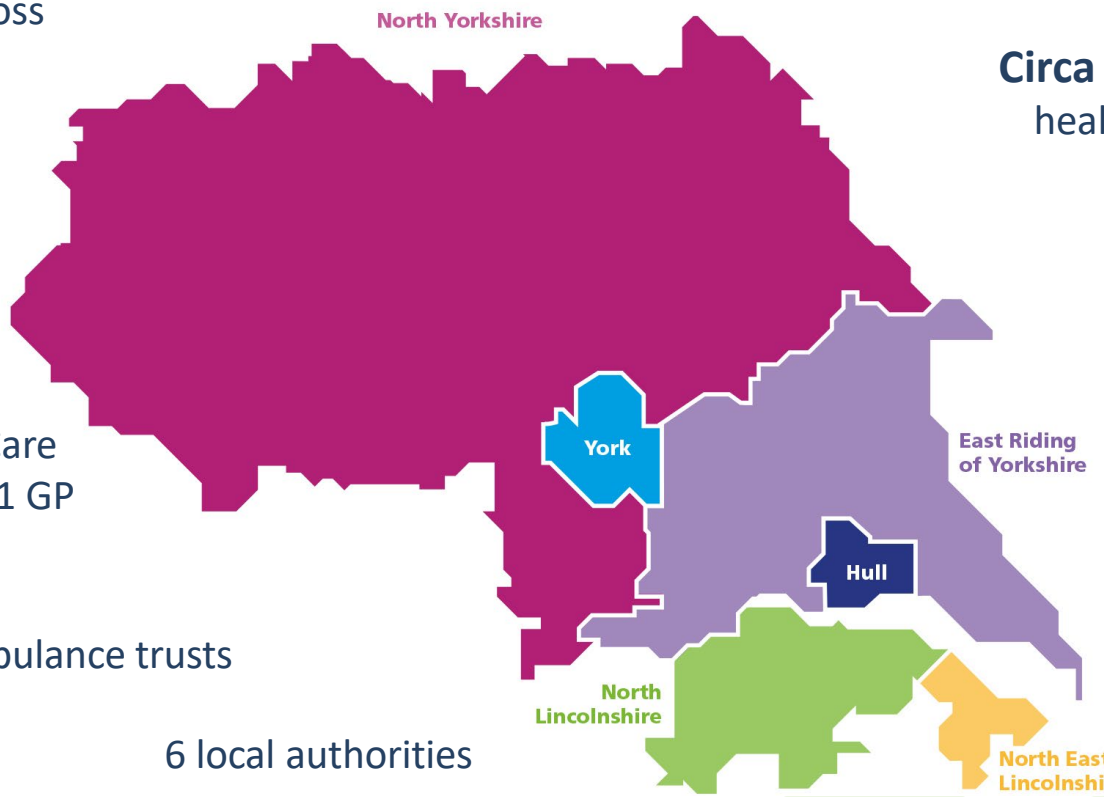
3 mental health trusts

4 community / not for profit providers

42 Primary Care Networks (181 GP Practices)

2 ambulance trusts

6 local authorities



1.7 million people

Circa 50,000 staff across health and adult social care

Total budget of approx. £3.5bn

550 care homes

180 home care companies

10 hospices

1000s of voluntary and community sector organisations

Our **vision** is to ensure that all our people:

- Start life well
- Live Well
- Age Well
- End Life Well

Humber and North Yorkshire
Health and Care Partnership

We will achieve this by:

Establishing a **collaborative culture** based on **trust**

Empowering **place based and provider collaboratives**

Ensuring an **honest public narrative**

Being **transformative** with a clear appetite for **innovation**

Placing a **greater emphasis on prevention** and demand management

Using **shared data and intelligence** to support decision making

Influencing national and regional **policy**

Learning by doing

The following describes the four core elements of an **Integrated Care System**:

Place

Arrangements between local authorities, the NHS and providers of health and care will be left to local areas to arrange. The statutory ICB will work to support places to integrate services and improve outcomes. **Health and Wellbeing Boards** will continue to have an important role in local places. **NHS provider organisations** will remain separate statutory bodies and retain their current structures and governance but will be expected to work collaboratively with partners.

Integrated Care Board

Directly accountable for NHS spend and performance within the system. As a minimum, the ICB board must include a chair and 2 non-executives, the ICB Chief Executive and clinical and professional leaders, and representatives from NHS trusts, primary care and local authorities.
ICB board - 2 statutory committees – **Audit** and **Remuneration**. It also need to establish other committees to focus on oversight and assurance and provide the board with assurance on the delivery of key functions including system quality and finance.

Integrated Care Partnership

The ICP is a standalone statutory committee between the ICB and Local Government. It will develop an **integrated care strategy** to address the health, social care and public health needs of their system. The membership and detailed functions of the ICP is up to local areas to decide. Focus on the **wider connections between health and wider issues including socio-economic development, housing, employment and environment**. It should take a **collective approach to decision-making and support mutual accountability** across the ICS.

Sector Collaboratives

Arrangements to ensure **each provider is part of a collaborative** to deliver specific objectives with one or more ICB, to contribute to the delivery of that system's strategic priorities. The members of the collaborative will agree together how this contribution will be achieved. The ICB and sector collaboratives should define their working relationship, including participation in committees via partner members and any supporting local arrangements, to facilitate the contribution of the sector collaborative to agreed ICB objectives.

This summarises the progress in developing **our Integrated Care System**

Humber and North Yorkshire Health and Care Partnership

HNY Integrated Care Partnership (ICP)

Membership of the Humber and North Yorkshire Integrated Care Partnership (ICP) will be established throughout the summer 2022 and meet formally for the first time in October 2022. This will be a statutory committee to represent the wider ICS partnership, including NHS, public health, social care, and VCSE sector organisations.

HNY Integrated Care Board (ICB)

The NHS Humber and North Yorkshire Integrated Care Board (ICB) is a statutory organisation accountable for NHS spend and performance for 1.7million people across a region of 1500 square miles.

It was formally established on 1 July 2022 as part of plans set out in the Health and Care Act 2022 to place Integrated Care Systems (ICSs) on a statutory footing.

Further details page 10

Sector Collaboratives

Our five sector collaboratives bring providers from across Humber and North Yorkshire together, to work across the ICS with a shared purpose, set of priorities and effective decision-making arrangements.

These collaboratives are an important part of ICS, working across a range of programmes and assist providers to work together to plan, deliver and transform services.

Further details page 18

Working at Place

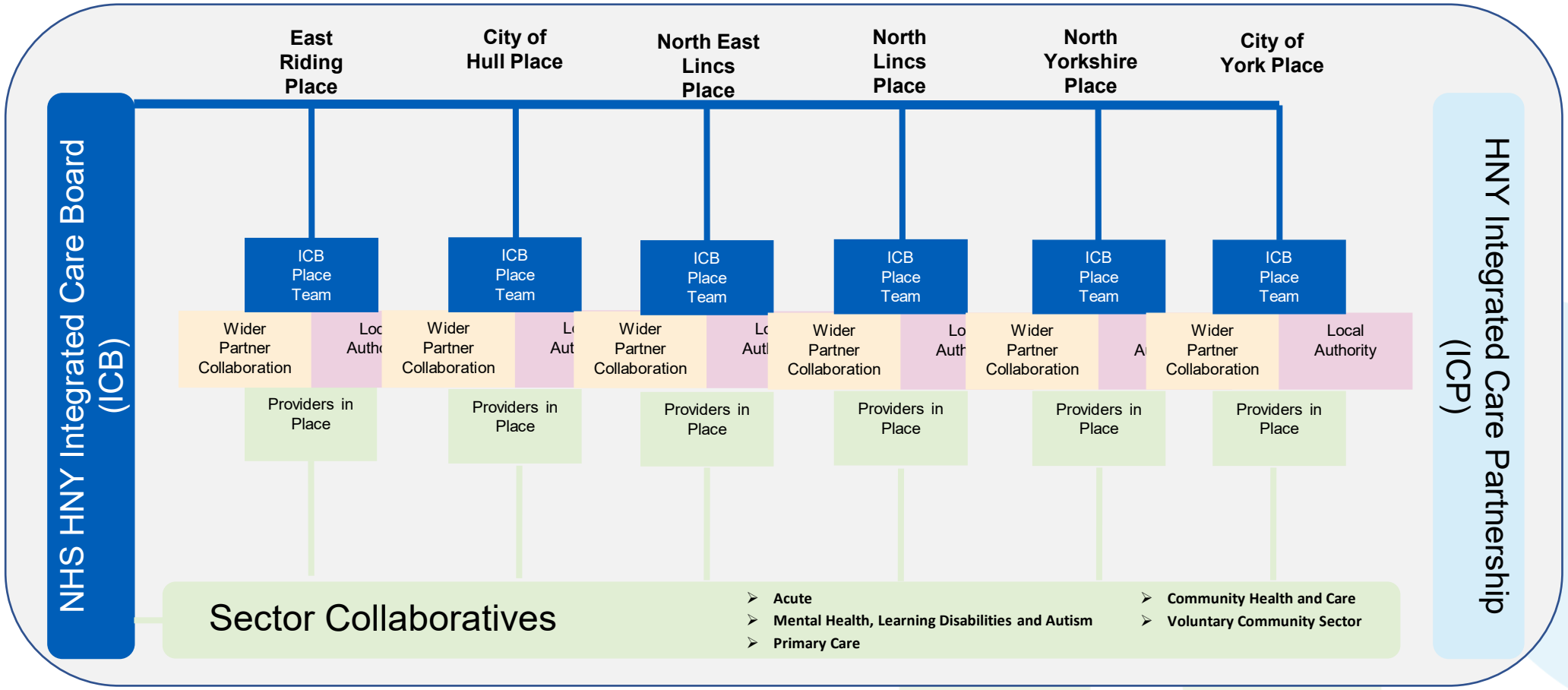
Place Committees are being developed for each of the six places in our region to enable increased autonomy and delegation of local decision-making to a formal joint committee

Further details page 14

And in practice, this is our Operating Model

Humber and North Yorkshire Health and Care Partnership

We have consistently emphasised the importance of place-based partnerships and our whole system operating model has been developed with Place at the core.



The ICB is the employer for the former CCG and Partnership Staff. The majority of staff will continue to work in Place. Some will continue to undertake similar roles and some will undertake functions wider than Place where that is appropriate.

Providers of health and care working in collaboration and as sector collaboratives both in Place and across the system to ensure health and care needs are met for the the population at Place and across the system.

Local Authorities working jointly with the NHS and with other partners in Place on population health and addressing health inequalities, community engagement and co-production, supporting local integration, provider collaboration and service transformation.

The ICP will enable the system partners to address the broader population health, socio-economic outcomes and inequalities. Working in partnership with the whole system (communities, public and private sector etc.) will be mutually accountable for the delivery of the agreed strategy.

Humber and North Yorkshire: Functions and Decisions Map

Humber and North Yorkshire Health and Care Partnership

Integrated Care Partnership (ICP)

Key role and responsibilities are to:

- Develop and agree an **integrated care strategy (Dec 22)** across Humber and North Yorkshire
- Make recommendations to the ICB on delivery of integrated care strategy
- Have **oversight** of delivery of the integrated care strategy
- Work effectively, collaboratively with partners and to have **shared accountability**.

Membership: ICB Independent Chair, Representatives from the ICB, Local Authorities, Healthwatch, and other partner organisations.

Strategy

Health and Wellbeing Boards (HWBB)

Key role and responsibilities are to:

- Agree the **Joint Strategic Needs Assessment** and the Joint Health and Wellbeing Strategy for their Place
- Encourage the organisations that are responsible for commissioning health or social care services to work together and to work closely with the Board;

A partnership between each Local Authority and 'place': York, East Riding, Hull, North Lincs, North East Lincs and North Yorkshire.

Strategy

Integrated Care Board (ICB)

Key role and responsibilities are to:

- Develop and agree a **5 year delivery plan (Spring 23)** that reflect the integrated care strategy
- Discharge the functions of an ICB including the accountability for **NHS spend and performance**
- Hold the executive to account for financial and operational objectives delivery
- Create an environment and conditions for **effective partnership working**

Membership: Independent Chair, Chief Executive, Executive Directors, Non-Executive Directors, and members selected from nominations made by Trusts, Local Authorities and General Practice, VCSE and HealthWatch

Delegation

Accountability

Place Arrangements

Key role and responsibilities are to:

- Deliver integration and service transformation in line with Place priorities and as required to deliver outcomes for the population
- Address health inequalities at a Place level

Membership: Place Chief Executive Lead, NHS Place based directors, NHS, public health, social care, local health and care providers, VCSE, HealthWatch

Delegation

Assurance

Agreements

Integrated Care Board Committees

Provide the Integrated Care Board with assurance about specific functions e.g. Audit, Risk, Remuneration, Quality, Performance, Finance For further details, see page 10

Place committees (as required)

Provide the Place Committee with assurance about place delegated functions e.g. Quality, Finance if required

Agreements

Sector Collaboratives

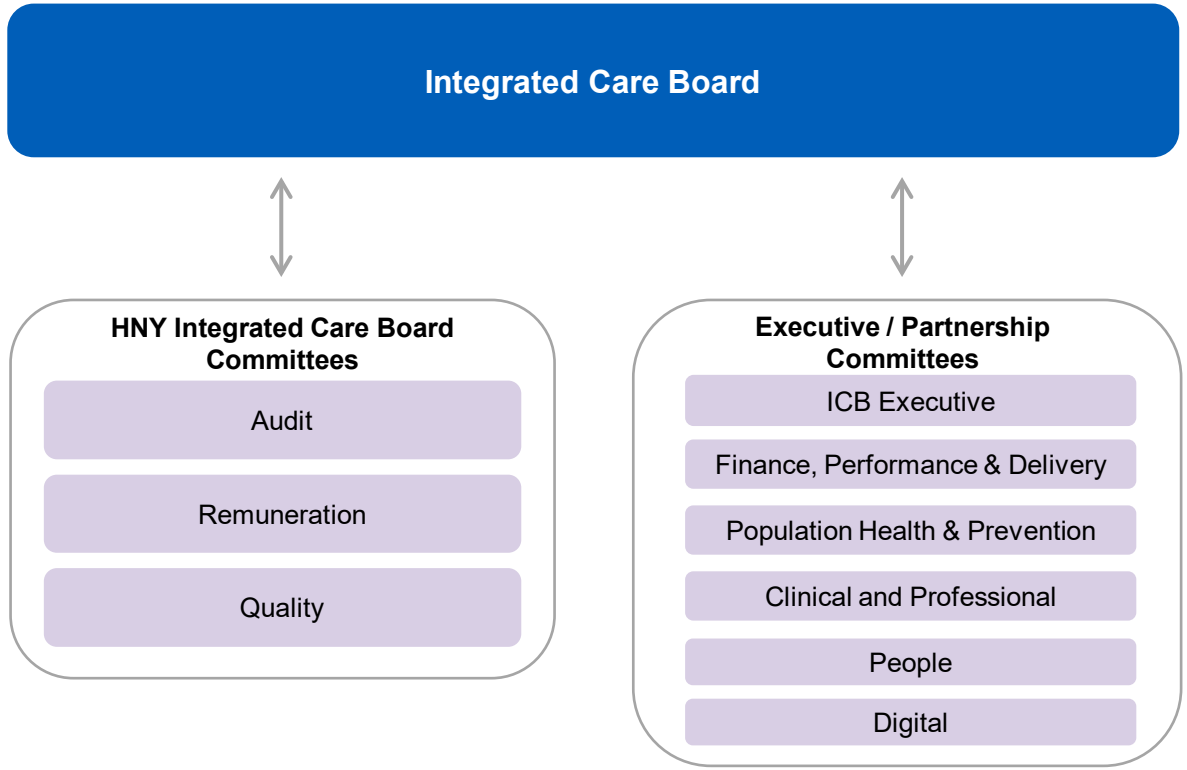
Sector Collaboratives will deliver key responsibilities agreed with the ICB where it makes sense to work together across Humber and North Yorkshire to meet the needs of the population.

Provider Partnerships

Provider Partnerships will collaborate to deliver plans that transform services to meet the needs of the population in a specific place

Integrated Care Board – Principles and Functions

Humber and North Yorkshire Health and Care Partnership

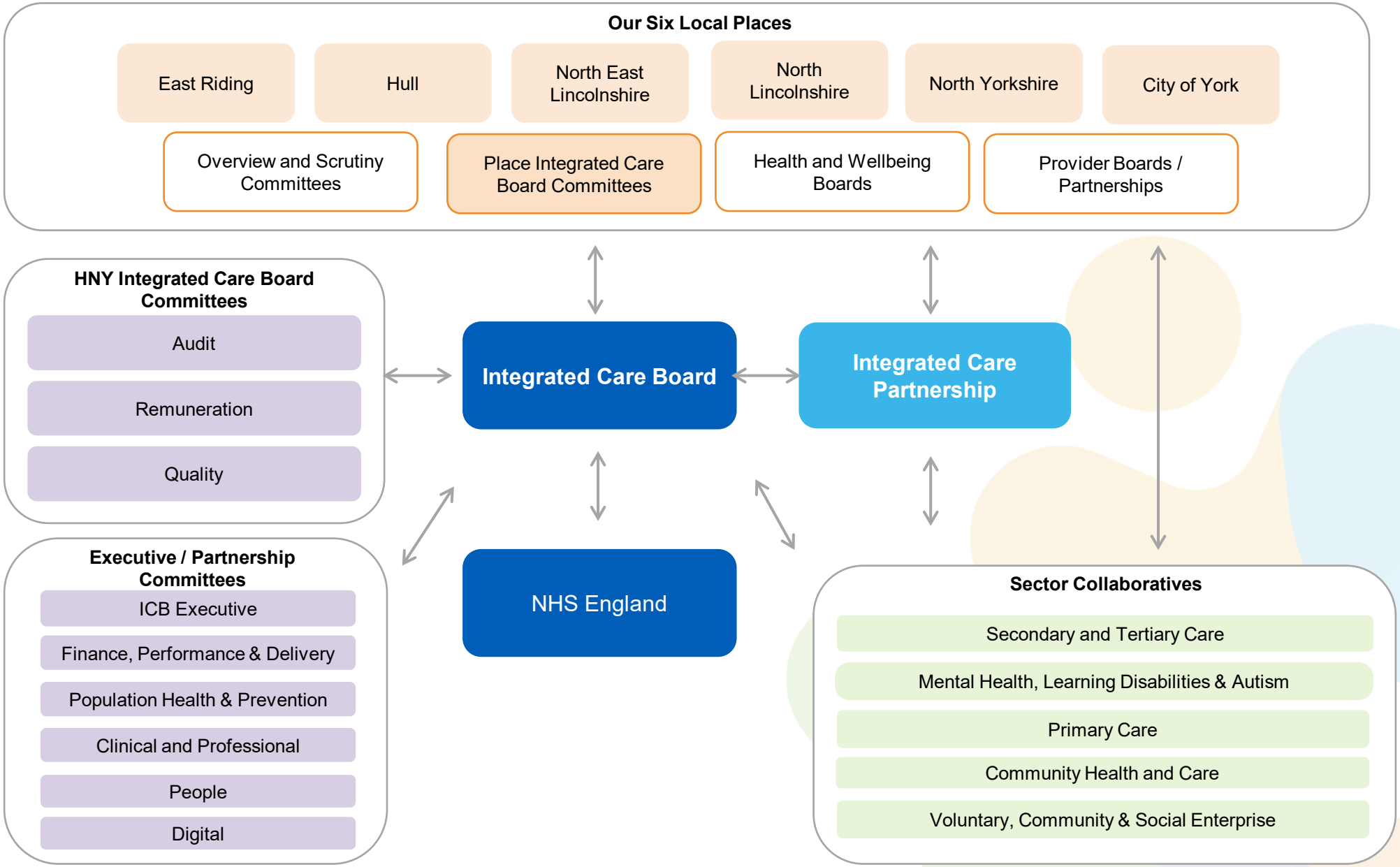


Functions of the Integrated Care Board:

1. Developing a plan to meet the health and healthcare needs of the population, having regard to the ICP strategy.
2. Allocating resources to deliver the plan. Establishing joint working arrangements with partners that embed collaboration as the basis for delivery within the plan.
3. Establishing joint working arrangement with partners to deliver the plan.
4. Establishing governance arrangements to support collective accountability between partner organisations for whole-system delivery and performance, underpinned by the statutory and contractual accountabilities of individual organisations
5. Arranging for the provision of health services in line with the allocated resources
6. Leading system implementation of people priorities including delivery of the People Plan and People Promise
7. Leading system-wide action on data and digital
8. Using joined-up data and digital capabilities to understand local priorities, track delivery of plans, monitor and address unwarranted variation, health inequalities and drive continuous improvement in performance and outcomes.
9. Through joint working between health, social care and other partners including police, education, housing, safeguarding partnerships, employment and welfare services, ensuring that the NHS plays a full part in achieving wider goals of social and economic development and environmental sustainability.
10. Driving joint work on estates, procurement, supply chain and commercial strategies to maximise value for money across the system
11. Planning for, responding to and leading recovery from incidents (EPRR)
12. Functions to be delegated by NHS England and NHS Improvement include commissioning of primary care and appropriate specialised services.

Humber and North Yorkshire: Governance & Accountability

Humber and North Yorkshire Health and Care Partnership



Integrated Care Board – Roles, Membership & key documents

Humber and North Yorkshire Health and Care Partnership

Integrated Care Board		
	Name	**Role**
Non-Executives	Sue Symington	Chair
	Stuart Watson	Non-Executive Director (audit)
	Mark Chamberlain	Non-Executive Director (remuneration & quality)
Ordinary / Partner Members	Simon Morritt	Provider Partner Member
	Dr Bushra Ali	Primary Care Partner Member
	Cllr Jonathan Owen	Local Authority Partner Member
Executive Members	Stephen Eames	Chief Executive
	Amanda Bloor	Chief Operating Officer
	Dr Nigel Wells	Exec Director of Clinical & Professional
	Teresa Fenech	Exec Director of Nursing & Quality
	Jane Hazelgrave	Exec Director of Finance
Executive Participants	Jayne Adamson	Exec Director of People
	Karina Ellis	Exec Director of Corporate Affairs
	Anja Hazebroek	Exec Director of Communications
Partner Participants	TBC	Local Authority
	TBC	Local Authority
	Louise Wallace	Director of Public Health
	Jason Stamp	Voluntary and Community Sector
	Andrew Burnell	Community Interest Companies
	Michele Moran	Mental Health, Learning Disability and Autism
	Helen Grimwood	Healthwatch
	Shaun Jones	NHSE/I attendee

Key documentation

- **Integrated Care Board Constitution and Standing Orders**
- **Standards of Business Conduct Policy**
- **Functions and Decision Map**
- **Conflicts of Interest Policy**
- **Scheme of Reservation and Delegation**
- **Governance Handbook**
- **Terms of Reference**
  - Remuneration,
  - Audit,
  - Quality Committees

Documents can be found here

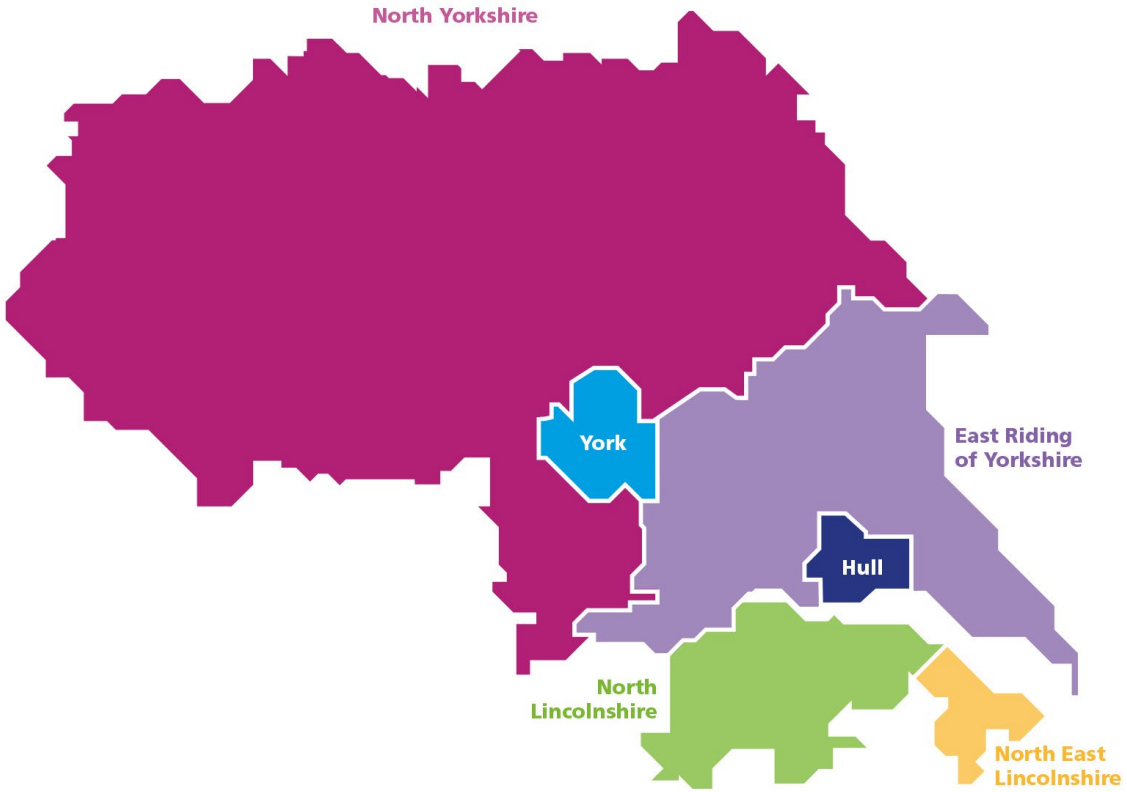
ICB Executive Portfolios

Humber and North Yorkshire Health and Care Partnership

Chief Operating Officer Amanda Bloor	Finance and Investment Jane Hazelgrave	Nursing & Quality Teresa Fenech	Clinical & Professional Development Nigel Wells	People Jayne Adamson	Corporate Affairs Karina Ellis	Communication, Marketing & PR Anja Hazebroek
• Primary Care Strategy • Population Health & Health Inequalities • COVID 19 & Vaccination • Commissioning • Operating Model framework with Place • Transformation programmes with Place and Provider Collabs • Operational planning (annual and longer) • Interpretation & implementation of the LTP, NICE quality standards and other national strategic priorities • Performance & assurance • Emergency planning	• Statutory ICB financial & investment activities • Financial strategy & planning • Budget devt. & allocation • Productivity & Value for money Programmes • ICS Capital programme • Financial governance, policy, & best practice standards • Financial Audit & Assurance • Sustainability & Net Zero strategies • ICS Estates function • Provider Selection Regime/ Procurement/ Contract Management	• Quality & safety assurance and governance incl clinical risk • Safeguarding • Infection prev & control • Nursing Workforce, leadership & development • Midwifery and AHPs • Mental Health, Learning Disabilities & SEND • Children and Young People • Maternity • End of Life • Continuing Health Care • Regulatory process, support, improvement & compliance • Safer just culture, safe systems & safe care	• Clinical & Professional strategy • Clinical pathway devt. • Clinical leadership devt. • Pharmacy & Meds Mx • Medical & Dental leadership and development • Clinical & Professional education • Innovation, research & development • Clinical effectiveness • Digital • Clinical & professional workforce strategy & performance • Freedom to Speak Up Guardian • Caldicott Guardian • Individual Funding Requests	• People strategy and plan • Workforce planning • OD, talent management & succession planning • Education & training • Recruitment & retention • People change management • Staff health & wellbeing • Diversity & inclusion • Trade Union relationships • Workforce/ employee engagement • Voluntary and Community Sector	• Governance incl. information governance and risk management • Corporate Services incl. Legal and Regulatory • System Development Plan • Strategy Development incl. Partnerships with wider system leaders & stakeholders • Co-ordination of ICS / ICB activities on behalf of Chair & CEO e.g. Anchor Networks • Portfolio / Programme Management • Patient & Public Insight incl complaints, PALs • Link with regulators & coordination of inspections • Business Intelligence & Analytics • Business Continuity	• Marketing • Communication and engagement strategy • Development of multimedia channels • Stakeholder mapping and research exercises • Design and co-ordination of high-profile campaigns • Link with NHSE National and Regional comms • Communications delivery • Media enquiries • Disseminating information to the public and stakeholders • Stakeholder engagement

Our Places

We have six Place based arrangements that are broadly the same as the Local Authority boundaries (except Craven in North Yorkshire which is part of a neighbouring ICB).



- East Riding of Yorkshire (Pop. 343,000)
- Hull (Pop. 260,000)
- North East Lincolnshire (Pop. 165,000)
- North Lincolnshire (Pop. 170,000)
- North Yorkshire (Pop. 605,000)
- York (Pop. 208,000)

Our Places, Our Partnership, Our Approach

We start by looking and the local population needs and priorities in each of our six **Places**.

Most of our work will take place in each one of these six Places.

Where it makes sense to do so, **we will join up across more than one Place** to plan, improve and deliver services.

There are some areas where we can make bigger and faster improvements by working together across a larger area – **across our full system** or beyond.

Our guiding principles for Place

Humber and North Yorkshire Health and Care Partnership

- Consistency, not Conformity
- Safe and Prudent
- Evolution, not Revolution
- Delegation & subsidiarity, where appropriate
- Local Autonomy
- Partnership
- Shared Vision, Values and Objectives

Place

Our places will:

- Calibrate local priority setting (LA) and delivery of national priorities (NHS).
- Undertake collaborative decision-making at Place with Local Authority, VCSE and other bodies to improve local services and outcomes and tackle inequalities, using evidence such as practice level / ward level population profiles.
- Target operational capability to support their PCNs, General Practices, GP Federations and wider primary care provider partners to enable primary care to fully participate at all levels.
- Mobilise operational capability across local providers to integrate care for their populations, underpinned by documented place provider partnership arrangements.
- Align local JSNA with the ICP Strategy to align views on local needs and where at-scale working is needed to fully address those needs.

Overview of Place

Humber and North Yorkshire Health and Care Partnership

The Place arrangements are supported by a minimum leadership arrangement of an NHS Place Director (ICB) ,a Place Chief Executive Lead a Place Clinical & Professional Lead, a Place based Nursing lead , a Place based Finance lead and a Place based VCSE lead. The appointments to date are set out below.

Place based directors will also take on ICS wide responsibilities as appropriate.

Each Place has completed a maturity assessment against a common framework and have a development plan and roadmap to support their journey and growth.

In the first year (22/23) the resources will be delegated to the NHS Place Director to be discharged through the Place Committee/Board arrangement which include a wide range of health and care partners relevant to their local place and in accordance with the Scheme of Reservation and Delegation and the Operational Scheme of Delegation.

The ICB and each place will agree a responsibility agreement identifying joint objectives and delivery plans for 2022/3

It is the intention of each Place to work towards the development of joint committee arrangements by April 2023 at the latest.

Place Leadership

East Riding • Place Director – Simon Cox • Place Chief Executive Lead – Caroline Lacey	Hull • Place Director – Erica Daley • Place Chief Executive Lead - Matt Jukes
North East Lincolnshire • Place Director – Helen Kenyon • Place Chief Executive Lead – Rob Walsh (NB joint arrangement with ICB)	North Lincolnshire • Place Director – Alex Seale • Place Chief Executive Lead – Peter Thorpe
North Yorkshire • Place Director – Wendy Balmain • Place Chief Executive Lead – Richard Flinton	York • Place Director – to be confirmed covered by Chief Operating Officer • Place Chief Executive Lead – Ian Floyd

Overview of Sector Collaboratives

Humber and North Yorkshire Health and Care Partnership

We have established five sector collaboratives which work both in Place and across the system:

- Collaborative of Acute Providers (CAP),
- Mental Health, Learning Disability and Autism, Collaborative,
- Primary Care Collaborative,
- Community Health and Care collaborative, and
- VCSE Collaborative.

A set of priorities for 2022/23 is being agreed with each collaborative and assurance of delivery will be through the Finance, Performance and Delivery Executive Committee these will be enshrined in a responsibility agreement identifying joint objectives and delivery plans for 2022/3.

We are working with each of the sector collaborative on their development plan to support leadership to deliver collective action to address quality and risk and also how they establish Clinical and Quality leadership arrangements.

During 2022/23 we are hoping to work with the Acute, Mental Health, Community and Primary Care collaboratives to support their development and maturity to lead collective action on system quality issues.

Sector Collaborative Leadership

CAP • Chair / Chief Executive Lead – Chris Long • Director – Interim Wendy Scott	Mental Health, LD & Autism • Chair / Chief Executive Lead – Brent Kilmurray • Director – Alison Flack
Primary Care • Chair / Chief Executive Lead – Faisel Baig • Director - TBC	Community • Chair / Chief Executive Lead – Andrew Burnell • Director – Yvonne Elliott
VCSE • Chair / Chief Executive Lead – Jason Stamp • Programme Director – Gary Sainty	


Humber and North Yorkshire
Health and Care Partnership
Thank You

GOVERNOR ELECTIONS - NOVEMBER 2022

Timetable:

Nominations open	26 September 2022
Deadline for receipt of nominations	11 October 2022
Voting opens	28 October 2022
Voting closes	18 November 2022
results declared	21 November 2022

Nominations are invited for the following seats:

CONSTITUENCIES	SEATS AVAILABLE
East & West Lindsey	1
North East Lincolnshire	3
North Lincolnshire	2
Staff	1
TOTAL	7

Agenda Number: CoG (09/22) Item: 6.1

Name of the Meeting	**Council of Governors Annual Members' Meeting**	
Date of the Meeting	29 September 2022	
Director Lead	Alison Hurley, Assistant Trust Secretary	
Contact Officer/Author	As above	
Title of the Report	**Acronyms and Glossary of Terms**	
Purpose of the Report and Executive Summary (to include recommendations)	A reference guide for any words, phrases or acronyms used during the meeting.	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Click here to enter text.
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ☐ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ✓ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	N/A	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

ACRONYMS & GLOSSARY OF TERMS

Sept 2022 – v8.1

2WW - Two week wait

A&E – Accident and Emergency: A walk-in facility at hospitals that provides urgent treatment for serious injuries and conditions

A4C – Agenda for Change. NHS system of pay that is linked to the job content, and the skills and knowledge staff apply to perform jobs

Acute - Used to describe a disorder or symptom that comes on suddenly and needs urgent treatment

AAU – Acute Assessment Unit

Acute Hospital Trust - Hospitals in England are managed by acute trusts (Foundation Trusts). Acute trusts ensure hospitals provide high-quality healthcare and check that they spend their money efficiently. They also decide how a hospital will develop, so that services improve

Admission - A term used to describe when someone requires a stay in hospital, and admitted to a ward

Adult Social Care - Provide personal and practical support to help people live their lives by supporting individuals to maintain their independence and dignity, and to make sure they have choice and control. These services are provided through the local authorities

Advocate - An advocate is someone who supports people, at times acting on behalf of the individual

AGC – Audit & Governance Committee

AGM – Annual General Meeting

AHP – Allied Health Professional

ALOS – Average Length of Stay

AMM – Annual Members' Meeting

AO – Accountable Officer

AOMRC – Association of Medial Royal Colleges

AOP – Annual Operating Plan

ARC – the governor Appointments & Remuneration Committee has delegated authority to consider the appointment and remuneration of the Chair, Deputy Chair and Non-Executive Directors on behalf of the Council of Governors, and provide advice and recommendations to the full Council in respect of these matters

ARM – Annual Review Meeting for CoG

Audit Committee - A Trust's own committee, monitoring its performance, probity and accountability

ARGC – Audit Risk & Governance Committee

Auditor - The internal auditor helps organisations (particularly boards of directors) to achieve their objectives by systematically evaluating and proposing improvements relating to the effectiveness of their risk management, internal controls and governance processes. The external auditor gives a professional opinion on the quality of the financial statements and report on issues that have arisen during the annual audit

BAF - Board Assurance Framework

Benchmarking - Comparing performance or measures to best standards or practices or averages

BLS – Basic Life Support

BMA – British Medical Association

BME – Black and Minority Ethnic: Defined by ONS as including White Irish, White other (including White asylum seekers and refugees and Gypsies and Travellers), mixed (White & Black Caribbean, White & Black African, White & Asian, any other mixed background), Asian or Asian British (Indian, Pakistani, Bangladeshi, any other Asian background), Black or Black British (Caribbean, African or any other Black background), Chinese, and any other ethnic group

Board of Directors (BoD) - A Board of Directors is the executive body responsible for the operational management and conduct of an NHS Foundation Trust. It is includes a non-executive Chairman, non-executive directors, the Chief Executive and other Executive Directors. The Chairman and non-executive directors are in the majority on the Board

Caldicott Guardian - The person with responsibility for the policies that safeguard the confidentiality of patient information

CAMHS - Child and Adolescent Mental Health Services work with children and young people experiencing mental health problems

Care Plan - A signed written agreement setting out how care will be provided. A care plan may be written in a letter or using a special form

CCG – Clinical Commissioning Groups were introduced by the Health & Social Care 2012 Act. Following the abolition of Primary Care Trusts (PCTs), they are formed by GP practices and are responsible for commissioning the majority of local health care services

CFC – Charitable Funds Committee

C Diff - Clostridium difficile is a type of bacteria. Clostridium difficile infection usually causes diarrhoea and abdominal pain, but it can be more serious

CE/CEO – Chief Executive Officer

CF – Cash Flow

Choose and Book - When a patient has been referred by your GP for an appointment with a healthcare provider, they may be able to book your appointment with Choose and Book. Most services are available via Choose and Book. Patients

can choose the date and time of their appointment their GP may be able to book their appointment there and then. However, the patient has the right to think about their choices, compare different options and book their appointment at a later stage

CIP – the Cost Improvement Programme is a vital part of Trust finances. Every year a number of schemes/projects are identified. The Trust have an agreed CIP process which has been influenced by feedback from auditors and signed off at the CIP & Transformation Programme Board

Clinical Audit - Regular measurement and evaluation by health professionals of the clinical standards they are achieving

Clinical Governance - A system of steps and procedures through which NHS organisations are accountable for improving quality and safeguarding high standards

Code of Governance - The NHS Foundation Trust Code of Governance is a document published by Monitor which gives best practice advice on governance. NHS Foundation Trusts are required to explain, in their annual reports, any non-compliance with the code

CoG - Council of Governors. Each NHS Foundation Trust is required to establish a Board of Governors. A group of Governors who are either elected by Members (Public Members elect Public Governors and Staff Members elect Staff Governors) or are nominated by partner organisations. The Council of Governors is the Trust's direct link to the local community and the community's voice in relation to its forward planning. It is ultimately accountable for the proper use of resources in the Trust and therefore has important powers including the appointment and removal of the Chairman

Commissioners - Commissioners specify in detail the delivery and performance requirements of providers such as NHS Foundation Trusts, and the responsibilities of each party, through legally binding contracts. NHS Foundation Trusts are required to meet their obligations to commissioners under their contracts. Any disputes about contract performance should be resolved in discussion between commissioners and NHS Foundation Trusts, or through their dispute resolution procedures

Committee - A small group intended to remain subordinate to the board it reports to

Co-morbidity - The presence of one or more disorders in addition to a primary disorder, for example, dementia and diabetes

Compliance Framework - Monitor's Compliance Framework serves as guidance as to how Monitor will assess governance and financial risk at NHS Foundation Trusts, as reflected by compliance with the Continuity of Services and governance conditions in the provider licence. NHS Foundation Trusts are required by their licence to have regard to this guidance. It was superseded by the Risk Assessment Framework in 2013/14

Constituency - Membership of each NHS Foundation Trust is divided into constituencies that are defined in each trust's constitution. An NHS Foundation Trust must have a public constituency and a staff constituency, and may also have a patient, carer and/or service users' constituency. Within the public constituency, an NHS Foundation Trust may have a "rest of England" constituency. Members of the various constituencies vote to elect Governors and can also stand for election themselves

Constitution - A set of rules that define the operating principles for each NHS Foundation Trust. It defines the structure, principles, powers and duties of the trust

COO – Chief Operating Officer

CoP – Code of Practice

CPA – Care Programme Approach

CPD – Continuing Professional Development. It refers to the process of tracking and documenting the skills, knowledge and experience that is gained both formally and informally at work, beyond any initial training. It's a record of what is experienced, learned and then applied

CPN – Community Psychiatric Nurse

CPIS - Child Protection Information Sharing

CQC - Care Quality Commission - is the independent regulator of health and social care in England, aiming to make sure better care is provided for everyone in hospitals, care homes and people's own homes. Their responsibilities include registration, review and inspection of services; their primary aim is to ensure that quality and safety are met on behalf of patients

CQUIN – Commissioning for Quality and Innovation are measures which determine whether we achieve quality goals or an element of the quality goal. These achievements are on the basis of which CQUIN payments are made. The CQUIN payments framework encourages care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. For the patient – this means better experience, involvement and outcomes

CSU – Commissioning Support Unit support clinical commissioning groups by providing business intelligence, health and clinical procurement services, as well as back-office administrative functions, including contract management

Datix - is the patient safety web-based incident reporting and risk management software, widely used by NHS staff to report clinical incidents

DBS – Disclosure & Barring Service (replaces CRB (Criminal Records Bureau)

DCA – Director of Corporate Affairs

DD – Due Diligence

Depreciation – A reduction in the value of a fixed asset over its useful life as opposed to recording the cost as a single entry in the income and expenditure account.

DGH – District General Hospitals

DH or DoH – Department of Health – A Government Department that aims to improve the health and well-being of people in England

DHSC - Department of Health and Social Care is a government department responsible for government policy on health and adult social care matters in England and oversees the NHS

DN - District Nurse, a nurse who visits and treats patients in their homes, operating in a specific area or in association with a particular general practice surgery or health centre

DNA - Did not attend: when a patient misses a health or social care appointment without prior notice. The appointment is wasted and therefore a cost incurred

DNR - Do not resuscitate

DoF – Director of Finance

DOI - Declarations of Interest

DOLS - Deprivation of Liberty Safeguards

DOSA – Day of Surgery Admission

DPA - Data Protection Act

DPH - Director of Public Health

DPoW - Diana, Princess of Wales hospital

DTOCs – Delayed Transfers of Care

EBITDA - Earnings Before Interest, Taxes, Depreciation and Amortisation. An approximate measure of a company's operating cash flow based on data from the company's income statement

ECC - Emergency Care Centre

ED – Executive Directors or Emergency Department

HER – Electronic Health Record

EIA - Equality Impact Assessment

Elective admission - A patient admitted to hospital for a planned clinical intervention, involving at least an overnight stay

Emergency (non-elective) admission - An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available

EMG - Executive Management Group – assists the Chief Executive in the performance of his duties, including recommending strategy, implementing operational plans and budgets, managing risk, and prioritising and allocating resources

ENT – Ear, nose and throat treatment. An ENT specialist is a physician trained in the medical and surgical treatment of the ears, nose throat, and related structures of the head and neck

EoL – End of Life

EPR - Electronic Patient Record

ERoY – East Riding of Yorkshire for Council and CCG etc

ESR - Electronic Staff Record

Executive Directors - Board-level senior management employees of the NHS Foundation Trust who are accountable for carrying out the work of the organisation. For example the Chief Executive and Finance Director, of a NHS Foundation Trust who sit on the Board of Directors. Executive Directors have decision-making powers

and a defined set of responsibilities, thus playing a key role in the day to day running of the Trust.

FD – Finance Director

F&PC – Finance & Performance Committee

FFT - Friends and Family Test: is an important opportunity for patients to provide feedback on the services that provided care and treatment. This feedback will help NHS England to improve services for everyone

FIP – Finance & Performance Committee

FOI - Freedom of information. The FOI Act 2000 is an Act of Parliament of the United Kingdom that creates a public "right of access" to information.

FPC – Finance & Performance Committee

FRC – Financial Risk Rating

FT – Foundation Trust. NHS foundation trusts are public benefit corporations authorised under the NHS 2006 Act, to provide goods and services for the purposes of the health service in England. They are part of the NHS and provide over half of all NHS hospital, mental health and ambulance services. NHS foundation trusts were created to devolve decision making from central government to local organisations and communities. They are different from NHS trusts as they: have greater freedom to decide, with their governors and members, their own strategy and the way services are run; can retain their surpluses and borrow to invest in new and improved services for patients and service users; and are accountable to, among others, their local communities through their members and governors

FTE – Full Time Equivalent

FTGA – Foundation Trust Governors' Association

FTN – Foundation Trust Network

FTSUG - Freedom to Speak Up Guardians help to protect patient safety and the quality of care, whilst improving the experience of workers

FY – Financial Year

GAG – the Governor Assurance Group has oversight of areas of Trust governance and assurance frameworks in order to provide added levels of assurance to the work of the Council of Governors*

GDH – Goole District Hospital

GDP – Gross Domestic Product

GDPR – General Data Protection Regulations

GMC - General Medical Council: the organisation that licenses doctors to practice medicine in the UK

GP - General Practitioner - a doctor who does not specialise in any particular area of medicine, but who has a medical practice in which he or she treats all types of illness (family doctor)

Governance - This refers to the "rules" that govern the internal conduct of an organisation by defining the roles and responsibilities of groups (e.g. Board of

Directors, Council of Governors) and individuals (e.g. Chairman, Chief Executive Officer, Finance Director) and the relationships between them. The governance arrangements of NHS Foundation Trusts are set out in the constitution and enshrined in the Licence

Governors - Elected or appointed individuals who represent Foundation Trust Members or stakeholders through a Council of Governors

GUM - Genito Urinary Medicine: usually used as the name of a clinic treating sexually transmitted disease

H1 - First Half (financial or calendar year)

H2 - Second Half (financial or calendar year)

HAS - Humber Acute Services

HASR - Humber Acute Services Review

HCA - a Health Care Assistant is someone employed to support other health care professions

HCAI - Healthcare Acquired Infections or Healthcare Associated Infections, are those acquired as a result of health care

HDU - Some hospitals have High Dependency Units (HDUs), also called step-down, progressive and intermediate care units. HDUs are wards for people who need more intensive observation, treatment and nursing care than is possible in a general ward but slightly less than that given in intensive care

Health inequalities - Variations in health identified by indicators such as infant mortality rate, life expectancy which are associated with socio-economic status and other determinants

HEE – Health Education England

HES - Hospital Episode Statistics – the national statistical data warehouse for England of the care provided by the NHS. It is the data source for a wide range of healthcare analysis for the NHS, government and many other organisations and individuals

HOBS - High Observations Beds

HOSC - Health Overview and Scrutiny Committee. Committee that looks at the work of the clinical commissioning groups, and National Health Service (NHS) trusts, and the local area team of NHS England. It acts as a 'critical friend' by suggesting ways that health related services might be improve

HR – Human Resources

HSCA – Health & Social Care Act 2012

HSMR - Hospital Standardised Mortality Ratio

HTF - Health Tree Foundation (Trust charity)

HTFTC - Health Tree Foundation Trustees' Committee

Human Resources (HR) - A term that refers to managing "human capital", the people of an organisation

HW – Healthwatch

HWB/HWBB – Health & Wellbeing Board

HWNL - Healthwatch North Lincolnshire

HWNEL - Healthwatch North East Lincolnshire

HWER - Healthwatch East Riding

Healthwatch England - Independent consumer champion for health and social care. It also provides a leadership and support role for the local Healthwatch network.

H&WB Board - Health and Wellbeing Board. A statutory forum where political, clinical, professional and community leaders from across the care and health system come together to improve the health and wellbeing of their local population and reduce health inequalities. The joint strategy developed for this Board is based on the Joint Strategic Needs Assessment. Each CCG has its own Health and Wellbeing Board.

IAPT – Improved Access to Psychological Therapies

IBP – Integrated Business Plan

I & E – Income and Expenditure. A record showing the amounts of money coming into and going out of an organisation, during a particular period.

ICS – Integrated Care Systems - Partnership between NHS organisations, local councils and others, who take collective responsibility for managing resources, delivering NHS standards, and improving the health of the population they serve. There are 44 ICS 'footprint' areas. The size of a system is typically a population of 1-3 million.

ICU – Intensive Care Unit

IG – Information Governance

Integrated Care - Joined up care across local councils, the NHS, and other partners. It is about giving people the support they need, joined up across local councils, the NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. The aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time.

IP – Inpatient

IPC - Infection Prevention & Control

IPR – Integrated Performance Report

IT – Information Technology

ITU – Intensive Therapy Unit

JAG – Joint Advisory Group accreditation

Joint committees - In a joint committee, each organisation can nominate one or more representative member(s). The joint committee has delegated authority to make binding decisions on behalf of each member organisation without further reference back to their board.

JSNA – Joint Strategic Needs Assessment

KPI – Key Performance Indicator. Targets that are agreed between the provider and commissioner of each service, which performance can be tracked against

KSF – Knowledge and Skills Framework- This defines and describes the knowledge and skills which NHS staff (except doctors and dentists) need to apply in their work in order to deliver quality services

LA – NHS Leadership Academy

LATs – Local Area Teams

LD – Learning Difficulties

Lead Governor - Governors will generally communicate with Monitor through the trust's chair. However, there may be instances where it would not be appropriate for the chair to contact Monitor, or for Monitor to contact the chair (for example, in relation to the appointment of the chair). In such situations, we advise that the lead Governor should communicate with Monitor. The role of lead Governor is set out in The NHS Foundation Trust Code of Governance

LETB – Local Education and Training Board

LGBTQ+ – Lesbian, gay, bisexual, transgender, questioning, queer, intersex, pansexual, two-spirit (2S), androgynous and asexual.

LHE – Local Health Economy

LHW – Local Healthwatch

LiA – Listening into Action

Licence - The NHS provider licence contains obligations for providers of NHS services that will allow Monitor to fulfil its new duties in relation to: setting prices for NHS-funded care in partnership with NHS England; enabling integrated care; preventing anti-competitive behaviour which is against the interests of patients; supporting commissioners in maintaining service continuity; and enabling Monitor to continue to oversee the way that NHS Foundation Trusts are governed. It replaces the Terms of Authorisation

LMC – the Local Medical Council is the local representative committee of NHS GPs which represents individual GPs and GP practices as a whole in their localities

Local Health Economy - This term refers to the different parts of the NHS working together within a geographical area. It includes GP practices and other primary care contractors (e.g. pharmacies, optometrists, dentists), mental health and learning disabilities services, hospital services, ambulance services, primary care trusts (England) and local health boards (Wales). It also includes the other partners who contribute to the health and well-being of local people – including local authorities, community and voluntary organisations and independent sectors bodies involving in commissioning, developing or providing health services

LOS - length of stay for patients is the duration of a single episode of hospitalisation

LTC - Long Term Condition

M&A – Mergers & Acquisitions

MCA - Mental Capacity Act

MDT - Multi-disciplinary Team

Members - As part of the application process to become an NHS Foundation Trust, NHS trusts are required to set out detailed proposals for the minimum size and composition of their membership. Anyone who lives in the area, works for the trust, or has been a patient or service user there, can become a Member of an NHS Foundation Trust, subject to the provisions of the trust's constitution. Members can: receive information about the NHS Foundation Trust and be consulted on plans for future development of the trust and its services; elect representatives to serve on the Council of Governors; and stand for election to the Council of Governors

MHA – Mental Health Act

MI – Major Incident

MIU – Major Incident Unit

MLU - Midwifery led unit

Monitor - Monitor was the sector regulator of health care services in England, now replaced by NHS Improvement as of April 2016 (which has since merged with NHS England)

MPEG – the governor Membership & Patient Engagement Group has been established to produce and implement the detailed Membership Strategy and provides oversight and scrutiny of the Trust Vision and Values and engagement with patients and carers*

MRI – Magnetic Resonance Imaging

MRSA – Metacillin Resistant Staphylococcus Aureus is a common type of bacteria that lives harmlessly in the nose or on the skin

MSA – Mixed Sex Accommodation

National Tariff - This payment system covers national prices, national currencies, national variations, and the rules, principles and methods for local payment arrangements

NED – Non-Executive Director

Neighbourhoods - Areas typically covering a population of 30-50,000, where groups of GPs and community-based services work together to coordinate care, support and prevention and wellbeing initiatives. Primary care networks and multidisciplinary community teams form at this level.

Neonatal – Relates to newborn babies, up to the age of four weeks

Nephrology - The early detection and diagnosis of renal (kidney) disease and the long-term management of its complications.

Neurology - Study and treatment of nerve systems.

NEWS - National Early Warning Score

Never Event - Serious, largely preventable patient safety incidents that should not occur if the available preventable measures have been implemented

NEL - North East Lincolnshire for Council and CCG etc

NGO - National Guardians Office for the Freedom to Speak Up Guardian

NHS - National Health Service

NHS 111 - NHS 111 makes it easier to access local NHS healthcare services in England. You can call 111 when you need medical help fast but it's not a 999 emergency. NHS 111 is a fast and easy way to get the right help, whatever the time

NHSP - NHS Professionals

NHS Confederation - is the membership body which represents both NHS commissioning and provider organisations

NHS ICS Body - Will be a new legal entity under Government White Paper with responsibility for the day-to-day running of the ICS. Allocative functions of CCGs will be merged into the new ICS NHS body.

NHSE - NHS England. The NHS Commissioning Board, referred to as NHS England, was established as a statutory body from October 2012. From April 2013, it has taken on many of the functions of the former PCTs with regard to the commissioning of primary care health services, as well as some nationally based functions previously undertaken by the Department of Health

NHS Health and Care Partnership - a locally-determined coalition will bring together the NHS, local government and partners, including representatives from the wider public space, such as social care and housing.

NHSI - NHS Improvement: An umbrella organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning Systems, the Advancing Change Team and the Intensive Support Teams. These companies came together on the 1st April 2019 to act as a single organisation to better support the NHS and help improve care for patients. The NHSI ensures that it receives sufficient timely information, including monitoring activity against annual plans and maintaining oversight of key quality, governance, finance and sustainability standards, to enable it to assess the performance of each provider in order that it can give the Department a clear account of the quality of its implementation of its functions

NHSE/I - NHS England / Improvement

NHSLA - NHS Litigation Authority. Handles negligence claims and works to improve risk management practices in the NHS

NHS Providers - This is the membership organisation and trade association for all NHS provider trusts

NHSTDA – NHS Trust Development Authority

NICE - the National Institute for Health and Care Excellence is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health

NL - North Lincolnshire for Council and CCG etc

NLaG - Northern Lincolnshire & Goole Hospitals NHS Foundation Trust

NMC - Nursing & Midwifery Council

Non-Elective Admission (Emergency) - An unplanned admission to hospital at short notice because of clinical need or because alternative care is not available

NQB - National Quality Board

NSFs – National Service Frameworks

OBC - Outline Business Case

OFT – Office of Fair Trading

OLU - Obstetric led unit

OOH - Out of Hours

OP – Outpatients

Operational management - Operational management concerns the day-to-day organisation and coordination of services and resources; liaison with clinical and non-clinical staff; dealing with the public and managing complaints; anticipating and resolving service delivery issues; and planning and implementing change

OSCs – Overview and Scrutiny Committees

PALS - Patient Advice and Liaison Service. All NHS Trusts have a PALS team who are there to help patients navigate and deal with the NHS. PALS can advise and help with any non-clinical matter (eg accessing treatment, information about local services, resolving problems etc)

PADR - Personal Appraisal and Development Review - The aim of a Performance Appraisal Development Review is to confirm what is required of an individual within their role, feedback on how they are progressing, to identify any learning and development needs through the use of the and to agree a Personal Development Plan

PAU – Paediatric assessment unit

PbR - Payment by Results

PCN - Primary Care Network: Groups of GP practices, working with each other and with community, mental health, social care, pharmacy, hospital and voluntary services in their local areas. Led by a clinical director who may be a GP, general practice nurse, clinical pharmacist or other clinical profession working in general practice.

PCT – Primary Care Trust

PDC – Public Dividend Capital

PEWS - Paediatric Early Warning Score

PFI – Private Finance Initiative

PLACE - Patient Led Assessment of Controlled Environment are annual assessments of inpatient healthcare sites in England that have more than 10 beds. It is a benchmarking tool to ensure improvements are made in the non-clinical aspects of patient care, such as cleanliness, food and infection control

Place - Town or district within an ICS, which typically covers a population of 250,000 – 500,000 people. Often coterminous with a council or borough.

Place Based Working - enables NHS, councils and other organisations to collectively take responsibility for local resources and population health

POE - People & Organisational Effectiveness

Population Health Management (PHM) - A technique for using data to design new models of proactive care, delivering improvements in health and wellbeing which

make best use of the collective resources. Population health aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

PPE - Personal Protective Equipment

PPG - Patient Participation Group. The CCGs supports and encourages patients to get involved with the way their healthcare is planned by creating and joining Patient Participation Groups which are based in each Medical Practice. This is another term for GP Patient group

PPI – Patient and Public Involvement

PRIMM - Performance Review Improvement Management Meeting

PROMS – Patient Recorded Outcome Measures

Provider Collaborative - Arrangements between NHS organisations with similar missions (e.g., an acute collaborative). They can also be organised around a 'place', with acute, community and mental health providers forming one collaborative. It is expected that all NHS providers will need to be part of one or more provider collaborates, as part of the new legislation.

PSF - Provider Sustainability Fund

PTL – Patient Transfer List

PTS – Patient Transport Services

QA – Quality Accounts. A QA is a written report that providers of NHS services are required to submit to the Secretary of State and publish on the NHS Choices website each June summarising the quality of their services during the previous financial year **or** Quality Assurance

QGAF – Quality governance assurance framework

QI – Quality Improvement

QIA – Quality Impact Assessment

QIPP – Quality Innovation, Productivity and Prevention. QIPP Is a national, regional and local level programme designed to support clinical teams and NHS organisations to improve the quality of care they deliver while making efficiency savings that can be reinvested into the NHS

QOF – Quality and Outcomes Framework. The quality and outcomes framework (QOF) is part of the General Medical Services (GMS) contract for general practices and was introduced on 1 April 2004

QRG – the governor Quality Review Group gather robust information on the quality and safety of care provided or commissioned by the Trust and in particular gather information on patients' perceptions of service quality and safety*

QRP – Quality & Risk Profile

Q&SC – Quality & Safety Committee

QSIR – Quality & Service Improvement Report

R&D – Research & Development

RAG – Red, Amber, Green classifications

RCGP – Royal College of General Practitioners

RCN – Royal College of Nursing

RCP – Royal College of Physicians

RCPSYCH – Royal College of Psychiatrists

RCS – Royal College of Surgeons

RGN – Registered General Nurse

RIDDOR – Reporting of Injuries, Diseases, Dangerous Occurrences Regulation. Regulates the statutory obligation to report deaths, injuries, diseases and "dangerous occurrences", including near misses, that take place at work or in connection with work

Risk Assessment Framework – The Risk Assessment Framework replaced the Compliance Framework during 2013/14 in the areas of financial oversight of providers of key NHS services – not just NHS Foundation Trusts – and the governance of NHS Foundation Trusts

RoI – Return on Investment

RTT – Referrals to Treatment

SaLT - Speech and Language Therapy

SDEC – Same day emergency care

Secondary Care - NHS trusts and NHS Foundation Trusts are the organisations responsible for running hospitals and providing secondary care. Patients must first be referred into secondary care by a primary care provider, such as a GP

Serious Incident/event (**SI) -** An incident that occurred during NHS funded healthcare which resulted in serious harm, a never event, or another form of serious negative activity

Service User/s - People who need health and social care for mental health problems. They may live in their own home, stay in care, or be cared for in hospital

SGH – Scunthorpe General Hospital

SGWG – the Staff Governor Working Group provides a mechanism to monitor and assist as appropriate in staff engagement, recruitment and retention and staff morale*

SHMI - Summary Hospital-level Mortality Indicator

SI - Serious Incident: An out of the ordinary or unexpected event (not exclusively clinical issues) that occurs on NHS premises or in the provision of an NHS or a commissioned service, with the potential to cause serious harm

SIB - System Improvement Board

SID - Senior Independent Director - One of the non-executive directors should be appointed as the SID by the Board of Directors, in consultation with the Council of Governors. The SID should act as the point of contact with the Board of Directors if Governors have concerns which approaches through normal channels have failed to resolve or for which such normal approaches are inappropriate. The SID may also act as the point of contact with the Board of Directors for Governors when they

discuss, for example, the chair's performance appraisal and his or her remuneration and other allowances. More detail can be found in the Code of Governance

Single Oversight Framework - (SOF) sets out how the NHSI oversee NHS trusts and NHS foundation trusts, using one consistent approach in order to determine the type and level of support Trusts require to meet these requirements. The framework identifies NHS providers' support needs across five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability

SJR - Structured Judgement Review

SLA – Service Level Agreement

SLM/R – Service Line Management/Reporting

SNCT - Safer Nursing Care Tool

Social Care - This term refers to care services which are provided by local authorities to their residents

SPA – Single Point of Access

SoS – Secretary of State

SSA – Same Sex Accommodation

Strategic Management - Strategic management involves setting objectives for the organisation and managing people, resource and budgets towards reaching these goals

Statutory Requirement - A requirement prescribed by legislation

STP - Sustainability and Transformation Partnerships

SUI – Serious untoward incident/event: An incident that occurred during NHS funded healthcare which resulted in serious harm, a never event, or another form of serious negative activity

T&C – Terms and Conditions

Terms of Authorisation - Previously, when an NHS Foundation Trust was authorised, Monitor set out a number of terms with which the trust had to comply. The terms of authorisation have now been replaced by the NHS provider licence, and NHS Foundation Trusts must comply with the conditions of the licence

TMB - Trust Management Board

Third Sector - Also known as voluntary sector/ non-profit sector or "not-for-profit" sector. These organisations are non-governmental

ToR – Terms of Reference

Trauma - The effect on the body of a wound or violent impact

Triage - A system which sorts medical cases in order of urgency to determine how quickly patients receive treatment, for instance in accident and emergency departments

TTO – To Take Out

ULYSSES - Risk Management System to report Incidents and Risk (Replaces DATIX)

UTC - Urgent Treatment Centre

Voluntary Sector - Also known as third sector/non-profit sector or "not-for-profit" sector. These organisations are non-governmental

Vote of No Confidence - A motion put before the Board which, if passed, weakens the position of the individual concerned

VTE – Venous Thromboembolism

WRES - Workforce Race Equality Standards

WDES - Workforce Disability Equality Standards

WC - Workforce Committee

WTE - Whole time equivalent

YTD - Year to date