Northern Lincolnshire and Goole NHS Foundation Trust

Agenda

Council of Governors Business Meeting

Thursday, 13th July 2023
To be held in the Main Boardroom, Diana, Princess of Wales Hospital, Grimsby
14:00 – 16:45 hours

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.	**BUSINESS ITEMS**		14:00
1.1	**CHAIRS OPENING REMARKS** Sean Lyons, Trust Chair		Verbal
1.2	**APOLOGIES FOR ABSENCE*** Sean Lyons, Trust Chair		Verbal
1.3	**DECLARATIONS OF INTEREST** Sean Lyons, Trust Chair		Verbal
1.4	**TO APPROVE THE MINUTES OF THE PREVIOUS MEETINGS** Sean Lyons, Trust Chair		
	1.4.1	13th April 2023 Council of Governors' Business Meeting Minutes	Attached
	1.4.2	22nd June 2023 Council of Governors' Annual Review Meeting (ARM) Minutes	Attached
1.5	**MATTERS ARISING** Sean Lyons, Trust Chair		Verbal
1.6	**REVIEW OF ACTION LOG** Sean Lyons, Trust Chair		Attached
2.	**REPORTS AND UPDATES**		14:20
2.1	**Chair's Update** Sean Lyons, Trust Chair		Attached
2.2	**Chief Executive's Update** Shaun Stacey, Interim Chief Executive		Attached

2.3	**Lead Governor's Update** Ian Reekie, Lead Governor	Attached	
3.	**COG BRIEFINGS**		14:50
3.1	**Trust Priorities 2022/23 – End of Year Performance Report** Shaun Stacey, Interim Chief Executive	Attached	
3.2	**Role of the Medical Examiner and Patient Story** Gordon McAdam, Medical Examiner Carolyn Phillips, Lead Medical Examiner Officer	Attached	
4.	**ITEMS FOR APPROVAL**		15:50
4.1	**Council of Governors and Trust Board Engagement Policy (DCP231)** Alison Hurley, Assistant Trust Secretary	Attached	
5.	**ITEMS FOR NOTING**		15:55
5.1	**Annual Quality Account 2022/2023**	Attached	
6.	**QUESTIONS FROM GOVERNORS** Sean Lyons, Trust Chair	Verbal	16:00
7.	**QUESTIONS FROM THE PUBLIC** Sean Lyons, Trust Chair	Verbal	16:10
8.	**ITEMS FOR INFORMATION** (see separate **Appendix A**) Sean Lyons, Trust Chair	To Note	16:20
9.	**ANY OTHER URGENT BUSINESS** Sean Lyons, Trust Chair	Verbal	16:25
10.	**MATTERS TO BE ESCALATED TO THE TRUST BOARD** Sean Lyons, Trust Chair	Verbal	16:30
11.	**COUNCIL PERFORMANCE AND REFLECTION** Sean Lyons, Trust Chair	Verbal	16:35
12.	**DATE AND TIME OF THE NEXT MEETING** Sean Lyons, Trust Chair	Verbal	16:40

COUNCIL OF GOVERNORS' BUSINESS MEETING – PUBLIC

Date: 12th October 2023
Time: 14:00 - 17:00 hours
Venue: TBC

APPENDIX A

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

The Council has previously agreed that these items will be included within the CoG papers for information.

8.	**Items for Information**		
8.1	Finance Update	Lee Bond Chief Financial Officer	Attached
8.2	Board Assurance Framework	Helen Harris Director of Corporate Governance	Attached
8.3	Acronyms & Glossary of Terms	Alison Hurley, Assistant Trust Secretary	Attached

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests -** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. Source: NHSE - Managing Conflicts of Interest in the NHS
- 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 Chair'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 Chair.
- 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.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Minutes

PUBLIC COUNCIL OF GOVERNORS MEETING
Minutes of the Meeting held on Wednesday, 13 April 2023, from 14:00 to 17:00 hours
Held virtually via Microsoft Teams

Present:

Sean Lyons	Chair	David Cuckson	Public Governor
Linda Jackson	Vice Chair	Karen Green	Public Governor
Ahmed Aftab	Staff Governor	Emma Mundey	Stakeholder Governor
Diana Barnes	Public Governor	Ian Reekie	Lead Governor
Jeremy Baskett	Public Governor	Liz Stones	Public Governor
Mike Bateson	Public Governor		

In Attendance:

Lee Bond	Chief Financial Officer
Karina Ellis	Director of Corporate Affairs, NHS Humber & North Yorkshire ICB
Helen Harris	Director of Corporate Governance
Jug Johal	Director of Estates and Facilities
Sue Liburd	Non-Executive Director
Dr Peter Reading	Chief Executive
Suzanne Maclennan	Corporate Governance Officer (minutes)

Members of the Public: Paul Grinell

1. BUSINESS ITEMS

1.1 CHAIRS OPENING REMARKS

Sean Lyons opened and welcomed everyone present to the meeting and explained due to logistical reasons the meeting had been held virtually and not face to face as originally planned.

Sean Lyons drew Governor's attention to the Finance Report and Board Assurance Framework (BAF) both items for information and requested any questions to be raised before the end of the meeting.

1.2 APOLOGIES FOR ABSENCE

Helen Harris provided apologies for absence as detailed below:

Ade Beddow	Associate Director of Communications & Engagement
Kevin Allen	Public Governor
Tony Burndred	Public Governor
Alison Hurley	Assistant Trust Secretary
Tim Mawson	Staff Governor
Ivan McConnell	Director of Strategic Development

Shauna McMahon	Group Chief Information Officer
Shiv Nand	Public Governor
Fiona Osborne	Non-Executive Director
Simon Parkes	Non-Executive Director
Rob Pickersgill	Deputy Lead Governor
Gill Ponder	Non-Executive Director
Shaun Stacey	Chief Operating Officer
Kate Truscott	Associate Non-Executive Director
Dr Kate Wood	Chief Medical Officer

1.3 DECLARATION OF INTERESTS

Sean Lyons requested members of the Council of Governors (CoG) to raise any declarations of interest relating to specific agenda items. None were received.

1.4 TO APPROVE THE DRAFT MINUTES OF THE MEETING HELD ON 11 JANUARY 2023

Sean Lyons invited members to approve the minutes of the CoG Business Meeting held on 11th January 2023. The content of the minutes was accepted as a true and accurate record.

Council Decision: The Council received and approved the minutes from CoG Business Meeting

1.5 MATTERS ARISING

Sean Lyons requested any matters arising for discussion within the group. None were received.

1.6 REVIEW OF ACTION LOG

The Action Log following the January 2023 CoG meeting was reviewed.

Helen Harris provided an update on open action COG (23)02 explaining the difficulty in obtaining mutually convenient diary time for attendees. Sean Lyons requested the first meeting be held in June at the latest and if required, diaries would have to be moderated.

Lee Bond provided an update on the external audit position which despite continued efforts of advertising and requests to Mazaars, the previous external audit company, there was no confirmed audit company. The Trust was in the difficult position of relying on NHS England (NHSE) to establish connections with potential audit companies.

The other outstanding action was a further Health Inequalities update due in October 2023.

Council Decision: The Council received and agreed updates to the CoG Action Log

2. REPORTS AND UPDATES

2.1 CHAIR'S UPDATE

The Chair's report was taken as read and Sean Lyons drew the Councils attention to particular items.

Sean Lyons expressed joy in attending the opening of the new Emergency Department (ED) at Scunthorpe General Hospital (SGH) where great support had been received from all involved including Governors and volunteers.

Sean Lyons referenced the letter received by Governors outlining the timings for the recruitment of the Group Chief Executive with a selection date of 16 May. The process would include a full stakeholder engagement event with invited participants.

Jug Johal joined the meeting at 14:15

Following a query Sean Lyons explained there would be no imbalance within the joint working between Hull University Teaching Hospitals (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). The appointment of the Group Chief Executive would be vital to maintain the balance, optimise resources and any decisions would be transparent and open to Governor oversight and scrutiny.

Linda Jackson provided assurance that HUTH and NLaG would each have their own Non-Executive Directors (NEDs) who would protect the interests of their own trust. Each trust would still retain their own trust board and represent their own communities with the concept of the group to work together in achieving goals.

Sean Lyons confirmed that decisions regarding executive structures below the Group Chief Executive had not been decided and various models for group governance were being examined.

David Cuckson queried the role of Ivan McConnell as Interim Joint Director of Strategy and what the implications were for the Trust to have a shared role particularly in relation to shared costs. As the line manager of Ivan McConnell, Dr Peter Reading confirmed the costs would be shared 50/50 between NLaG and HUTH. Similarly, the roles of the Joint Chair, Joint Chief Financial Officer and Joint Chief Information Officer were full time positions with the ability to support at the next tier. Dr Peter Reading suggested the need to identify capacity in the role as areas of the former HUTH Director of Strategy role had been shared between other HUTH executives. It was highlighted as the two Trusts would be working collaboratively there would be a limited degree of duplication.

Sean Lyons invited Lee Bond to outline the significant financial pressures the NHS would be facing across the region and Integrated Care System (ICS). Lee Bond confirmed the 2023-2024 Operational and Financial Plan was nearing finalisation and the Integrated Care Board (ICB) in which NLaG sits was declaring a deficit position for the year of just under £100 million. Understandably, NHSE had not viewed this as acceptable resulting in a series of further submissions required for the financial plan. It was

confirmed that external inspections of acute organisations within the ICS had been conducted although NLaG had not been included due to regular visits from the financial special measures team in recent years.

Sean Lyons drew the Councils attention to the renaming of special measures to single oversight framework (SOF) 4.

Sean Lyons thanked the group for the questions and challenges.

Council Decision: The Council received the Chair's update

2.2 CHIEF EXECUTIVE'S UPDATE

Sean Lyons welcomed Dr Peter Reading to the meeting and highlighted there had been no written report submitted due to fast paced change of updates.

Dr Peter Reading confirmed last month a recommendation was taken by the Regional Director to NHSE Quality and Performance Committee outlining NLaG should exit SOF4 subject to an agreed financial plan which satisfied the region. The national committee would not require any further discussion and the decision had been delegated to the regional executive team. It was confirmed any decision regarding exiting SOF4 had been delayed until 4 May 2023 as a system and Trust financial plan must be agreed.

Following a query Dr Peter Reading explained the Trust previously had an Improvement Director, Elaine Criddle who had a positive impact in relation to quality for the last three years, supporting developments and programmes and additionally provided access to substantial sums of money. It was confirmed if the Trust exited SOF4 it would receive some financial assistance for another year to allow for improvements to become embedded with an estimated figure of around £300k. The Trust had not received financial intervention or support for around three years although scrutiny from the regional and national NHS had continued. Dr Peter Reading had felt the intention was for the regional team to exit the Trust from SOF4.

Dr Peter Reading emphasised to the Governors that any budget issues were an ICS budget issue of which NLaG could have a more adverse plan than neighbouring trusts. It was highlighted within a thirty year career only two other years had been as difficult as this year in relation to a trust level budget resulting in difficult decisions over the coming year.

Dr Peter Reading confirmed the Trust had achieved no 78-week waiters by the deadline of 31st March 2023, although there had been nine who had been HUTH transfers and credit was paid to the surgical teams. It was confirmed that an average of 60% had been achieved in relation to the four-hour target with one in ten patients having stayed in Emergency Departments (ED) longer than 12 hours.

Dr Peter Reading drew the Councils attention to the Summary Hospital-level Mortality Indicator (SHMI) which had moved above the median point for all trusts which had meant NLaG had the lowest ever SHMI.

Dr Peter Reading confirmed there had been modest improvements in cancer waiting times which varied between specialties.

Dr Peter Reading confirmed that during the three days in March for the junior doctor strikes the Trust had postponed 1057 outpatient appointments and 57 elective appointments. It was highlighted that during the current junior doctors strike the number of postponed outpatient appointments was just over 1000 and the elective cancellations had been 27 to date. Dr Peter Reading expressed gratitude to the senior medical staff during the periods of industrial action which had allowed the Trust to continue to provide a safe service.

Karen Green raised a query regarding the uplift in pay for bank staff which had not resulted in the reduction in agency spend and whether this had meant safer staffing level on the wards. In response Dr Peter Reading confirmed the introduction of a £250 bonus per member of staff in each of two six-week periods if they had worked extra shifts. It was confirmed that more bank shifts had been filled despite no reduction in agency spend due to seasonal and monthly variations on demand. It had been agreed that there had not been sufficient impact for the substantial cost which resulted in the discontinuation of the bonuses.

Sean Lyons thanked Dr Peter Reading for the update.

Council Decision: The Council received the Chief Executive's update

2.2.1 Trust Priorities 2023/24

Dr Peter Reading confirmed the Trust Board (TB) had agreed a series of priorities, a similar process for the last six years.

The report was taken as read with a two of the priorities highlighted, Our People and the Humber Acute Services Review.

Ian Reekie queried the nine priorities and sixty sub priorities and whether this amount was far too many for one organisation to focus on. In response Dr Peter Reading agreed that an expectation of priorities would be a small number although the TB had agreed none of the priorities could be removed.

In response to a query Lee Bond confirmed there had been funds secured to open the Urgent Care Service (UCS) 24/7 as part of the contract settlement for the year. The funds had not been formally signed off due to the £100 million deficit across the system.
Ian Reekie queried the ambitions of the Trust in relation to Priority Four which highlighted prioritising women from Black, Asian Minority Ethnics (BAME) backgrounds and why the focus had been limited to maternity services. Dr Peter Reading highlighted that work within the NHS particularly hospitals with regards to health inequalities was in a very early stage with major data issues being worked through. Jug Johal confirmed the Trust had very little variation in patients from BAME backgrounds on the waiting lists. Maternity services had remained a priority having gained some resource from work led by Jane Warner, Associate Chief Nurse

Midwifery. Jug Johal confirmed health inequalities was a huge agenda which required work at Place level and not just an acute level. Ahmed Aftab added that health inequalities were not only related to ethnicity but equally economic and social due to the amount of social deprivation in our area. The work should include equal pathways for north and south bank patients.

Jeremy Baskett raised a query in relation to hydration and how it would remain a focus across the Trust. Dr Peter Reading confirmed the data was included within the Integrated Performance Report (IPR) which would be viewed by the TB and committees on a routine basis. The Place report had recently marked the Trust within the middle of the rankings for nutrition and hydration and whilst there must be no complacency the Quality & Safety Committee (Q&SC) would be reviewing the scores. Jug Johal provided assurance that as the board lead for nutrition and hydration reporting any progress through the board sub-committees would ensure the Trust meets all the new national standards.

Council Decision: The Council received the Trust Priorities 2023/24

2.3 LEAD GOVERNOR'S UPDATE (to include highlights from the Governor Assurance Group (GAG) and Appointments & Remuneration Committee (ARC) meetings)

Ian Reekie provided an overview of the Lead Governors' report which covered updates on the following:

- An additional Governor briefing on 25th April for the 2023/24 Operational and Financial Plan
- The GAG piloted a deep dive into the Workforce Committee and would continue the process for each assurance committee on a rotational basis to hold NED colleagues to account for the performance of the TB.

Ian Reekie requested the group note the CoG virtually ratified the extension of Gill Ponder 's term of office as a NED and Senior Independent Director (SID) for three years.

Sean Lyons thanked Ian Reekie for his report.

Council Decisions: The Council received the Lead Governor's update.

2.3.1 – Appointments & Remuneration Committee Terms of Reference

Ian Reekie requested the Council approve the revised ARC Terms of Reference (ToR).

Council Decisions: The Council approved the ARC ToR

3. COG BRIEFINGS

3.1 Humber & North Yorkshire Health and Care Strategy

Sean Lyons welcomed Karina Ellis, Director of Corporate Affairs, Humber and North Yorkshire Integrated Care Board. Karina Ellis introduced herself to the group, outlined responsibilities within the role and delivered a comprehensive presentation.

Ian Reekie raised a query regarding the expertise and resources available which would ensure Place engagement is levelled up to provide the best engagement practice. Karina Ellis confirmed the ICB had developed a Working with People and Communities Engagement Strategy which had been approved on 1st July 2022. The strategy had been developed alongside Healthwatch as the ICS was wider than the ICB and the six Places. In addition, Healthwatch were represented on the ICB and Integrated Care Partnership (ICP). Karina Ellis agreed to share the strategy with the group and could be found on the ICB website.

Ian Reekie wondered whether there would be any intention to hold Place meetings in public as previously Clinical Commissioning Groups (CCG's) had been held in public which allowed for transparent decision making. Karina Ellis confirmed that each Place committee meetings were not held in public as they were committees of the ICB. Decisions made at Place were in line with their framework of governance and in accordance with the scheme of reservation and delegation. An operating model was being developed as the organisation matured incorporating local authority arrangements and NLaG representatives would be able to share discussions which happened at Place.

Jeremy Baskett questioned the communication links to areas outside of the ICB patch as a Public Governor representing East and West Lindsey. In response Karins Ellis confirmed it had been recognised in the development of the strategy and built in through Place. The necessary work and conversations had been pulled together by the six Places. Dr Peter Reading highlighted that the northern part of East Lindsey had some of the most dependant population in the country which impacted demand on services at DPoW. It was confirmed that Helen Kenyon, North East Lincolnshire Place Director worked very closely to manage these relationships.

Sean Lyons thanked Karina Ellis for the presentation and welcomed any further questions. None were received.

Council Decision: The Council received an update on the Humber & North Yorkshire Health and Care Strategy

Action: Karena Ellis to provide the Corporate Governance Office with the Working with People and Communities Engagement Strategy for sharing

Post Meeting Note: Karina Ellis shared the Working with People and Communities Engagement Strategy in the Teams chat area for the meeting - Working with People and Communities - Engagement Strategy 2022-23

Karina Ellis left the meeting at 15:27

Sean Lyons requested any further questions for Dr Peter Reading before leaving the meeting. None were received.

3.2 Capital Investment and Strategic Capital Overview

Jug Johal delivered the presentation to the Council which provided context to some of the large numbers contained within it. Jug Johal welcomed any questions.

David Cuckson raised a concern regarding aerated concrete and whether any of NLaGs building contained it due to a history of the concrete failing. In response Jug Johal highlighted hospitals which did have aerated concrete were known as reinforced autoclaved aerated concrete (RAAC) hospitals. Following a survey requested by the Department of Health it had been confirmed that NLaG did not have any RAAC across the sites including community settings and accommodation.

Dr Peter Reading left the meeting at 15:43

Jug Johal highlighted some trusts around the country had crumbling buildings due to RAAC. It had been noted that floors within the Acute Assessment Units were crumbling due to age and nothing else.

Ian Reekie requested further information regarding the Scunthorpe Community Diagnostic Centres (CDC) and whether it would be operational by the end of March 2024. In response Jug Johal confirmed the criteria had been set for the first patient though the door on 1st April 2024 and the equipment available would include two x MRI, three x CT, three x ultrasound rooms and two x-ray suites. Emma Mundey confirmed it would be a phased opening and not all equipment would be available on 1st April 2024. Lee Bond outlined the agreed £700-800k to support the pre recruitment costs for the CDC.

Paul Grinell joined the meeting at 15:47

Lee Bond confirmed there had been a national group reviewing the funding for CDC schemes with the intention for them to be fully funded for the first year. The tariffs proposed for certain modalities were not sufficient to cover the costs and work was ongoing. Jug Johal confirmed a number of partners working on the project and added the schemes would provide significant economic regeneration for Scunthorpe and Grimsby.

Sean Lyons thanked Jug Johal for the presentation and no further questions were received.

Council Decision: The Council received an update on the Capital Investment and Strategic Capital Overview

4. QUESTIONS FROM GOVERNORS

Sean Lyons invited questions from Governors.

David Cuckson suggested CoG meetings could have more public attendees if they were held in the evening as working people are unable to attend during the day. A discussion ensued regarding whether the meeting had moved from the evening to the afternoon. Linda Jackson confirmed that NLaG had never previously held CoG meetings in the evening. Sean Lyons suggested a discussion at the CoG Annual Review Meeting (ARM) in June.

5. QUESTIONS FROM THE PUBLIC

Sean Lyons invited questions from members of the public.

Paul Grinell raised a concern regarding the level of publication for the CoG meetings and previous similar conversations had established the only publicity had been on the Trust website and Facebook. It was understood a piece of work around engagement should include improved lines of communication with the public.

Sean Lyons requested this item to be added to the agenda for the CoG ARM in June.

6. ITEMS FOR INFORMATION

Sean Lyons drew the CoG's attention to the items for information contained within appendix A of the agenda which included the following documents:

6.1 Finance Update
6.2 Board Assurance Framework (BAF)
6.3 Acronyms and Glossary of Terms

Mike Bateson requested assurance from the Trust regarding item 3095 on the High Level Risk Register which related to out of date servers and software for Path Links. Mike Bateson was concerned by the impact it would have on Lincolnshire, North East Lincolnshire and radiology should the system fail. Helen Harris agreed to take an action to investigate further with Michael Chomyn, Path Links General Manager.

Action: Helen Harris to provide an update on High Level Risk Register Item 3095

Post Meeting note: Following consultation with key NLaG representatives Shauna McMahon, Group Chief Information Officer, provided a response shared by email to the CoG on 18 April 2023.

7. ANY OTHER URGENT BUSINESS

There were no further items of urgent business raised.

8. MATTERS FOR ESCALATION TO THE TRUST BOARD

Sean Lyons invited Governors to raise any matters for escalation to the Trust Board. None were received.

9. COUNCIL PERFORMANCE AND REFLECTION

Sean Lyons invited suggestions for future meetings. No suggestions were received.

10. DATE AND TIME OF THE NEXT FORMAL BUSINESS MEETING

Sean Lyons requested notification of the venue for the July Business meeting once confirmed.

COUNCIL OF GOVERNORS' ANNUAL REVIEW MEETING

Date: 22nd June 2023
Time: 14:00 – 16:00 hours
Venue: Main Boardroom, DPoW

COUNCIL OF GOVERNORS' BUSINESS MEETING - PUBLIC

Date: 13th July 2023
Time: 14:00 – 17:00 hours
Venue: TBC

Please notify the Membership Office of any apologies for this event.

Sean Lyons thanked members for their attendance and contributions and the meeting closed at 16:01 hours.

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 Trust Chair's Office in writing at least **10 clear days prior to the meeting at which it was to be considered.** Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Trust Chair.
- 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.

ANNUAL ATTENDANCE DETAILS

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Ahmed Aftab	1	1	Eddie McCabe	1	0
Kevin Allen	1	0	Tim Mawson	1	0
Diana Barnes	1	1	Emma Mundey	1	1
Jeremy Baskett	1	1	Shiv Nand	1	1
Mike Bateson	1	1	Anthonia Nwafor	1	0
Tony Burndred	1	0	Rob Pickersgill	1	0
Nick Coultish	1	0	Stephen Price	1	0
David Cuckson	1	1	Ian Reekie	1	1
Karen Green	1	1	Liz Stones	1	1

ANNUAL NON-EXECUTIVE DIRECTOR ATTENDANCE DETAILS

Attendee Name	Possible	Actual	Attendee Name	Possible	Actual
Sean Lyons	1	1	Fiona Osborne	1	0
Linda Jackson	1	1	Simon Parkes	1	0
Stuart Hall	1	0	Gillian Ponder	1	0
Sue Liburd	1	1	Kate Truscott	1	0

Minutes

COUNCIL OF GOVERNORS' ANNUAL REVIEW MEETING

Minutes of the Meeting held on Thursday, 22nd June 2023,
from 14:30 to 16:30 hours in the Main Boardroom, DPoW

Present:			
Sean Lyons	Chair	Karen Green	Public Governor
Kevin Allen	Public Governor	Tim Mawson	Staff Governor
Diana Barnes	Public Governor	Shiv Nand	Public Governor
Mike Bateson	Public Governor	Rob Pickersgill	Deputy Lead Governor
David Cuckson	Public Governor	Ian Reekie	Lead Governor

In Attendance:

Helen Harris	Director of Corporate Governance
Alison Hurley	Assistant Trust Secretary
Linda Jackson	Vice Chair / Non-Executive Director
Fiona Osborne	Non-Executive Director
Shaun Stacey	Interim Chief Executive
Suzanne Maclennan	Corporate Governance Officer (minutes)

1. BUSINESS ITEMS

1.1 CHAIR'S OPENING REMARKS

Sean Lyons opened the meeting by welcoming everyone to the Annual Review Meeting (ARM) of the Council of Governors (CoG).

1.2 APOLOGIES FOR ABSENCE

Alison Hurley provided apologies for absence as detailed below:

Apologies were received from Ahmed Aftab – Staff Governor, Jeremy Baskett – Public Governor, Tony Burndred – Public Governor, Stuart Hall, Associate Non-Executive Director, Sue Liburd – Non-Executive Director, Eddie McCabe – Stakeholder Governor, Emma Mundey – Stakeholder Governor, Anthonia Nwafor – Staff Governor, Simon Parkes – Non-Executive Director, Gill Ponder – Non-Executive Director, Stephen Price – Public Governor, Liz Stones – Public Governor and Kate Truscott, Associate Non-Executive Director.

1.3 TO RECIEVE THE MINUTES FROM THE PREVIOUS MEETING HELD ON 13TH OCTOBER 2022

Sean Lyons invited members to receive the minutes of the CoG ARM held on 13th October 2022. The minutes were approved at the CoG Business meeting held on 11 January 2023 as a true and accurate record.

Council Decision: The Council received the minutes

1.4 TO RECEIVE THE ACTION LOG FROM THE PREVIOUS MEETING HELD ON 13th OCTOBER 2022

Sean Lyons highlighted the action log and confirmed there were no outstanding actions and all had been completed.

Council Decision: The Council received the CoG ARM action log

2. REVIEW OF OPERATION AND PERFORMANCE

A brief overview of the low response rate was provided by Alison Hurley which outlined only six of the seventeen Governors had completed the framework review document. The Council progressed through framework as below.

2.1 ROLE OF GOVERNORS

2.1 (a) Do you fully understand the role of the Governor and CoG as a whole, and is the operation of the CoG influenced by the needs of the local community?

A positive response was provided by 83% of the Governors who responded that they understood their Governor Role, the CoG as a whole, and the operation of the CoG.

Alison Hurley highlighted that a key area throughout the review which required further consideration was engagement.

2.1 (b) Is the CoG satisfied with the level of attendance and engagement with the Trust Board (Executive Directors, NEDs and the Senior Independent Director (SID)), and do Governors have sufficient opportunity to question Directors? And do you feel your concerns are taken seriously and feedback given where agreed?

Alison Hurley reported that 100% of Governors were satisfied with the level of attendance and engagement with the Trust Board.

One Governor response was noted which stated the Governor Assurance Group (GAG) significantly enhanced the ability to hold Non-Executive Directors (NEDs) to account who attended to present the committee highlight reports.

2.1 (c) Do Governors feel the Trust Chair keeps CoG members informed about the key activities and risks concerning the Board of Directors?

Alison Hurley reported a positive response by 100% of Governors to this question. One response raised a potential action in relation to the need for more regular briefings on the Trust's contribution to system working through, for example, the Acute Collaborative to enable the CoG to hold Non-Executive Directors' (NEDs) to account for the Board's commitment to a system approach.

Action: Consideration for appropriate system working briefings

2.1 (d) Do the Lead/Deputy Lead Governors keep you informed of developments of interest to governors between meetings and effectively represent the interests of governors in discussions with the Trust Chair/Deputy Chair and Director of Corporate Governance/Assistant Trust Secretary?

Alison Hurley confirmed a positive response was received and extended congratulations to Ian Reekie and Rob Pickersgill on the feedback.

Ian Reekie requested Governors provide their thoughts on how the Governor Assurance Group (GAG) had worked, particularly since the revised format of one NED chair providing a deep dive into the work of their committee.

Sean Lyons confirmed the GAG had been highlighted as a useful and efficient device to other Foundation Trusts which enabled connections with committee chairs providing discussion and responding to challenge as required. Alison Hurley highlighted that any Governor could attend the GAG as an observer in addition to the members of the group.

Sean Lyons queried the Governor attendance level at the GAG meetings and in response Alison Hurley confirmed it had been generally good. Any attendance issues had been addressed and Governors supported where necessary. Alison Hurley reminded Governors that expressions of interest had been sought for one vacant seat on the GAG and none had been received to date.

Ian Reekie expressed gratitude to the NEDs for attending the bi-monthly GAG meetings given their extensive commitments. Sean Lyons concurred with the appreciative sentiments.

Following a query Ian Reekie confirmed that all Governors had been invited to join the WhatsApp group and the majority of Governors had accepted.

2.2 ENGAGEMENT WITH MEMBERS AND STAKEHOLDERS

2.2 (a) How do you as a Governor feel opinions are canvassed and represented on the interests of Trust staff and public members and the general public, and are these effectively feedback to the Board of Directors for inclusion in the governance of the Trust?

Alison Hurley highlighted there had been a mixed response to this question with some Governors fully engaged and proactive compared to others who had been less so. It was confirmed there would be more formalised engagement with support from the Trust which had been discussed by the Member Engagement Working Group and through the formal consultation for the Humber Acute Services (HAS).

Alison Hurley reminded Governors of their individual statutory duties regarding engagement within their communities. Examples for individual Governor engagement were raised such as local friends, family,

neighbours and community groups, Healthwatch, Patient Participation Groups (PPGs), neighbourhood groups, Men in Shed's, knit and natter, golf and other sports or special interest groups, volunteering roles etc. These opportunities were available to engage, provide feedback to the Trust and update the constituents. Further suggestions for sharing with all Governors were welcomed.

David Cuckson queried whether the Trust would support Governors with any outside engagement opportunities, perhaps at a local club. Alison Hurley confirmed the Trust had previously produced a presentation which could be adapted for each Governor's specific needs and the Corporate Governance team would be happy to support this work.

Kevin Allen suggested approaching schools to engage with the teachers and school Governors.

A discussion ensued regarding engagement opportunities and it was agreed a survey would be circulated to Governors to ascertain what engagement was currently being undertaken. Sean Lyons encouraged Governors to participate in the survey and reminded Governors of their responsibility to represent their communities.

Action: Corporate Governance team to create and circulate public engagement survey to Governors

2.2 (b) How do you feel Governors communicate about the Trust, its vision and performance to members, the public and stakeholder organisations who elected or appointed you?

There was a mixed response to this question and Alison Hurley suggested the engagement element had been captured in the previous question. It was confirmed the channels of communication currently in place were member newsletters, Facebook, Twitter, the Trust's website, e-mails to members and Governor election voting packs utilised for additional messages where appropriate.

Alison Hurley sought suggestions for further channels of communication which could be utilised. None were received.

2.2.1 Member Engagement Working Group Report

Ian Reekie outlined that the Member Engagement Working Group had been created following an action at the previous CoG ARM held on 13 October 2022 due to recognition of poor member engagement, particularly since COVID-19. It was confirmed a survey had been distributed to members which had received a response rate of only 4.5%. An overview of the report was the provided.

Sean Lyons commended the report to the Governors with a view to assessing the outcome of the HAS consultation later in the year.

Governor drop-in sessions were suggested at each Trust site and Alison Hurley requested Governor support for these once they were organised.

A discussion ensued regarding the importance of the drop-in sessions and where Governors could possibly be stationed at each site to enable useful interactions with the public. It was confirmed the drop-in sessions at Goole District Hospital (GDH) had been successful pre COVID-19, although were never well attended post COVID-19 and as a result were eventually discontinued.

Sean Lyons highlighted Place and Place Directors as a potential route to channelling Trust orientated patient views.

Shaun Stacey suggested Governor stations in each of the Outpatient departments or front entrances with the option to of a private room for more detailed or personal conversations. Engagement opportunities through primary care areas was suggested and Shaun Stacey would be happy to facilitate through primary care direct contacts. Shaun Stacey proposed Governors or Volunteers are positioned outside supermarkets for a couple of hours during busy weekend times potentially with incentives available.

Action: Corporate Governance team to re-instate Governor and Member Drop-in sessions at each Trust site, publicise them and seek Governor commitment

2.3 ACCOUNTABILITY

2.3 (a) Do Governors use their voting rights as a CoG to effectively hold Non-Executive Directors (NEDs) individually and collectively to account for the performance of the Board of Directors?

100% of Governors provided a positive response and there were no further points to be highlighted.

2.3 (b) Are Governors confident that the Audit, Risk and Governance Committee criteria for appointing, re-appointing and removing external auditors is effective?

Alison Hurley highlighted the lack of providers for the external audit contract which had presented a challenge although the criteria had been rated effective.

2.3 (c) Do the CoG receive and consider appropriate information to enable it to discharge its duties?

Alison Hurley confirmed that 100% of Governor responses were positive and referred to the overuse of jargon and acronyms in reports and presentations which was being addressed by the Trust. It was confirmed that top tips for report writing had been circulated via the Wednesday

Weekly News e-mail to all staff and further details were linked to the Trust's Hub to assist with this issue.

Fiona Osborne confirmed all acronyms would be removed from the Quality & Safety Committee (Q&SC) highlight reports going forward.

David Cuckson requested speakers to explain acronyms once in full during presentations. Sean Lyons agreed this point should be addressed at each meeting and was good practice.

2.4 CONDUCT OF MEETINGS

2.4 (a) Does the membership and size of the CoG remain fit for purpose?

Alison Hurley confirmed a mixed response to this question although all Governors agreed the CoG composition was fit for purpose, concerns were raised about engagement levels and vacancies for stakeholder Governors.

2.4 (b) Are there sufficient meetings to address the workload of the CoG and is the balance between the work undertaken at the CoG and at sub-groups correct?

Alison Hurley reported that a positive response was received highlighting the work of the of the GAG, the Appointments and Remuneration Committee (ARC) and more recently the task and finish Member Engagement Working Group.

2.4 (c) Are the agenda, minutes and supporting documents circulated in good time for meetings. Are Governors satisfied that you are provided with the key information on the performance of the Trust to be able to discharge your duties as a governor?

A positive response was provided by all Governors to this question and it was confirmed that meeting papers were provided in a reasonable time.

2.5 PERSONAL DEVELOPMENT

2.5 (a) Are governors satisfied that the mechanisms in place are appropriate to identify and meet Governor training needs?

100% of Governors reported being satisfied with the training mechanisms in place. Alison Hurley highlighted the recent Governor briefings delivered by Anthonia Nwafor and Jeremy Baskett following attendance on NHS Providers courses. It had been a positive way to maximise the cost of the training sessions and they had been well received by all Governors and NEDs who had attended. It was confirmed the sessions were recorded for viewing via Microsoft Teams at a convenient time for those unable to attend.

Alison Hurley welcomed any request to participate in other courses which could be presented to all the Governors in a similar way. It was confirmed that Ian Reekie had attended the Member and Public

Engagement course delivered by NHS Providers and Alison Hurley would provide assistance in delivering a briefing on this subject.

Action:

- **Corporate Governance team to schedule and assist Ian Reekie with Governor briefing on Member and Public Engagement**

2.5 (b) Do Governors feel that they have received sufficient induction and training to fulfil their role?

Alison Hurley confirmed there had been a 100% positive response to this question which contained links to the previous question.

2.6 SHAPING THE FUTURE

2.6 (a) Do Governors feel that they make a useful contribution and have had the opportunity to be sufficiently involved in activities within the Trust that influence the future of either clinical services or the Foundation Trust as a whole?

Alison Hurley reported that a mixed response and feedback had been received. There had been requests both previously and recently regarding holding 15 Step Reviews in the evening or weekends. It had been confirmed by Melanie Sharp, Deputy Chief Nurse that in addition the 15 Step Reviews, there were Place assessments, Infection and Prevention team audits, Ward and Matron Assessment tool and the Patient Experience team capturing feedback. It was agreed at this time it would not be appropriate to add other assurances which could potentially disturb clinical patient time.

2.6 (b) Is there sufficient dialogue on the Trust's forward plan?

Alison Hurley confirmed the responses were all positive scores and requested suggestions on how improvements could be made if necessary.

2.7 STANDARD OF CONDUCT

2.7(a) Are Governors satisfied about the agreed process to remove any Governor from the Council who consistently and unjustifiability fails to attend the meetings of the CoG, has an actual or potential conflict of interest which prevents the proper exercise of their duties or whose behaviours or actions as a Governor or group of Governors may be incompatible with the values and behaviours of the Trust?

Governors provided a 100% positive response to this question.

2.7(b) Are Governors aware of the ability of the CoG to exercise its power to remove the Trust Chair or any NEDs after exhausting all means of engagement with the Board of Directors?

All Governors who had responded were aware of this power.

Sean Lyons thanked Alison Hurley for reporting the findings of the responses received from Governors and requested a significant improvement in the response rate for the next CoG ARM.

3. REFLECTION OF FORMAT FOR FUTURE REVIEW MEETING

Sean Lyons welcomed any feedback regarding the format of the CoG ARM and whether Governors were satisfied with the agenda, documentation and level of discussion.

Alison Hurley advised of slight changes next year due to the new Code of Governance.

Mike Bateson queried what the opinion of the NEDs in relation to the Governors and whether there was more Governors could do to help. In response Sean Lyons felt that discussions relating to engagement with members, patients and their families was the area Governors were required to focus on as a fundamental part of their role.

Helen Harris reminded Governors of the opportunity to participate in an annual Governor Development Review which was a confidential conversation to raise any areas of concern.

Linda Jackson confirmed it was a pleasure to work with the Governors who provided necessary challenge at times and equally there was mutual respect.

Sean Lyons confirmed the input received from Governors was valued and that relationships were to be maintained and enhanced.

4. ANY OTHER BUSINESS

Sean Lyons requested any other items of business and none were received.

7. DATE AND TIME OF NEXT COUNCIL OF GOVERNORS' MEETINGS

Council of Governors' Business Meeting
Date: 13th July 2023
Time: 14:00 - 17:00 hours
Venue: Main Boardroom, DPoW

Sean Lyons thanked members for their attendance and contributions. The meeting closed at 15:29 hours.

Northern Lincolnshire and Goole NHS Foundation Trust

COUNCIL OF GOVERNORS

ACTION LOG & TRACKER

(Public)

2019-2023

(updated July 2023)

ACTION LOG & TRACKER

Council of Governors (CoG) Meeting

Northern Lincolnshire and Goole NHS Foundation Trust

Minute Reference	Date of Meeting	Action Reference	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored
COG(23)10	13/04/2023	6	Provide an update on High Level Risk Register Item 3095	Helen Harris	Apr-23	Shauna McMahon provided a response folllowing consultation with NLaG representatives - Emailed to Governors on 18th April 2023	**Completed**	Emails	yes
COG(23)09	13/04/2023	5	Publicity of CoG meetings	Corporate Governance Office	Apr-23	Comms team emailed on 2nd May regarding members with no access to social media platforms and a request for further publicity of CoG meetings	**Completed**	Emails	yes
COG(23)08	13/04/2023	3.1	Share the Working with People and Communities Engagement Strategy	Corporate Governance Office	Apr-23	Karina Ellis shared the link in the chat function of Teams during the April CoG and included in the minutes	**Completed**	Link in chat & minutes	yes
COG(23)02	11/01/2023	2.4	Reinstate Staff Governor meetings with Trust Chair, Chief Executive, Interim Director of People & Lead Governor	Corporate Governance Office	Apr-23	Diary invites issued for 28th June - Cancelled Sean Lyons requested the meetings be reinstated once Jonathan Lofthouse commenced in post		Diary invites & emails	yes
COG(23)01	11/01/2023	2.3	Update the CoG on external auditor position	Lee Bond	Apr-23	Lee Bond provided a verbal update at the April CoG	**Completed**	Minutes	yes
COG(22)25	13/10/2022	3.2	Deliver Health Inequalities update in 12 months time	Jug Johal	Oct-23	Report to October CoG			

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

Minute reference	Date/Month of Meeting	Action Reference (if Different)	Action Point	Lead Officer	Due Date	Progress	Status	Evidence	Evidence Stored
COG(23)07	11/01/2023	4.3	Forward approved Governor Assurance Group ToR to Document Control for processing	Corporate Governance Office		Formatted ToR (DCT092) and extract of approving minutes sent to DC for processing 12/01/23	**Completed**	Email & DC Library	yes
COG(23)06	11/01/2023	4.1	Forward updated and approved Trust Constitution to Document Control for processing	Corporate Governance Office		Formatted Trust Constitution (DCM001) and extract of approving minutes sent to DC for processing 12/01/23	**Completed**	Email & DC Library	yses
COG(23)05	11/01/2023	3.2	Request staff C19 & flu vaccine uptake figures	Helen Harris		Figures requested from Paul Bunyan and results emailed to Governors 12/01/23	**Completed**	Emails	yes
COG(23)04	11/01/2023	3.1	Membership Office to arrange End of Life briefing with Kate Wood, Jan Haxby & Donna Smith	Corporate Governance Office	Mar-23	Briefing delivered on 8th March 2023 at 17:00 - 18:00 hours and diary invites issued	**Completed**	Email & diary invites	yes
COG(23)03	11/01/2023	2.4	Forward approved Member Engagement Working Group ToR to Document Control for processing	Corporate Governance Office		Formatted ToR (DCT274) and extract of approving minutes sent to DC for processing 12/01/23	**Completed**	Email & DC Library	yes
COG(22)24	13/10/2022	3.2	Provide details of success measures for Tobacco and Alcohol Dependency Programmes	Jug Johal		Update provided on 17th October 2022 and emailed to Governors	Complete	Email	Yes
COG(22)23	13/10/2022	3.2	Remove Out of Hours GP signage at SGH	Jug Johal		Confirmation of signage removed on 14th October 2022	Complete	Email	Yes
COG(22)22	13/10/2022	3.1	Provide Governors with the Wellbeing Directory	Christine Brereton		Financial Wellbeing Directory emailed to Governors on 13th October 2022	Complete	Email	Yes
COG(22)11	13/04/2022	1.6	Membership Office to arrange briefing with Lee Bond on Cost Improvement Programme (CIP)	Membership Office / Helen Harris	Jan-23	Lee Bond invited to present within the 20th July CoG. Brian Shipley delivered the update. Brian Shipley to provide Summary of CIP following July CoG. Brain Shipley provided the CIP Summary and MO emailed to Governors 28th November 2022	Complete	Agenda & Document	Yes
COG(22)21	20/07/2022	4.1	Jeremy Baskett DOI requires updating - form sent to MO via post	Membership Office		Updated Governor Register of Interests and ROI system	Complete	Emails & DOI Form	Yes
COG(22)20	20/07/2022	2.3	Extend the term of office for Fiona Osborne as Associate NED until NED appointment commences	Helen Harris			Complete		Yes
COG(22)19	20/07/2022	2.3	Cancel Governor and NED Briefings in September and November - further briefing to be arranged as required	Membership Office	Jul-22	All Governors and NEDs emailed and diary invites cancelled	Complete	Emails	Yes
COG(22)18	20/07/2022	1.6	Membership Office to update the Action Log	Membership Office		Action Log updated	Complete	Action log	Yes
COG(22)17	20/07/2022	1.4	Membership Office to amend the 13th April minutes	Membership Office		Page 4 amended following correction from Kevin Allen	Complete	Minutes	Yes
COG(22)15	13/04/2022	3.1	Membership Office to rearrange the briefing on Integrated Care Systems (ICS) Development	Membership Office	Jul-22	Ivan McConnell to present at the 26th July Governor and NED Briefing	Complete	Agenda	Yes
COG(22)04	18/01/2022	2.1	Membership Office to arrange for Alison Dubbins to provide a future briefing on culture, equality, diversity, inclusion, and freedom to speak up at a future CoG	Membership Office	Apr-22	Christine Brereton to deliver update within the 20th July CoG	Complete	Email	Yes
COG(22)01	18/01/2022	3.1	Membership Office to contact Rob Pickersgill regarding his question to Lee Bond	Membership Off	Sep-22	Rob Pickersgill contacted by email on 27.01.22 regarding query on Financial Special Measures briefing. Chased on 23.02.2 & 28.03.22. Request for CIP briefing within the 20th July CoG.	Complete	Email & Minutes	Yes

COG(22)16	13/04/2022	6	Membership Office to email public members regarding a link to the virtual meetings, which was the approach taken by the Trust	Membership Office	Jul-22	Zoe Hinsley emailed Charlie Grinhaff regarding this approach. Serena Mumby previously recommenced the media bulletin for the CoG meetings in line with that of the Trust Board. Internet site updated	Complete	Emails	Yes
COG(22)14	13/04/2022	2.3	Membership Office to investigate options regarding the emergency department walkaround at DPoW prior to it opening to the public	Membership Office	Jul-22	Original walkaround cancelled by Zoe Hinsley. Rearranged for 11th May 2022	Complete	Emails	Yes
COG(22)13	13/04/2022	2.2	Dr Peter Reading would address the signage issues regarding the termination of the park and ride service	Dr Peter Reading	Jul-22	Peter Reading confirmed this had been picked up with Sally Yates and Keith Fowler	Complete	Email	Yes
COG(22)12	13/04/2022	1.6	Membership Office to update the Action Log	Membership Office	Jul-22	Action log updated	Complete	Action log	Yes
COG(22)10	13/04/2022	1.4	Membership Office to amend the previous minutes	Membership Office	Jul-22	Minutes amended	Complete	Minutes	Yes
COG(22)06	18/01/2022	3.2	Membership Office to contact Shaun Stacey to return to a future CoG to provide an update on the planning position and the operational plan	Membership Office	Apr-22	Shaun Stacey to provide update at the 12th May Governor & NED Briefing (presented by Ashy Shankar)	Complete	Agenda	Yes
COG(21)12	20/04/2021	3.2	Membership Office to arrange for a North Lincolnshire Community Services update within six to 12 months	Membership Office	Apr-22	Briefing added to 6th January 2022 Pre GAG Briefing - briefing stood down due to anticipated service pressures. Scheduled for 10.03.22 - briefing stood down due to anticipated service pressures. Update confirmed to be delivered with 12th May Governor & NED Briefing	Complete	Email	Yes
COG(22)09	18/01/2022	7	Membership Office to reintroduce questions from the public on future agendas	Membership Office	Apr-22	Membership will add to future agendas	Complete	Agenda	Yes
COG(22)08	18/01/2022	4.1	Shiv Nand to send through a new declaration of interests to include his employment details to the Membership Office	Shiv Nand	Jan-22	Declaration requested and received	Complete	Email	Yes
COG(22)07	18/01/2022	3.2	Shaun Stacey to send a briefing note to the Membership Office on the Trust's Planning Position for distribution	Shaun Stacey	Jan-22	Briefing note on Trust's planning position distributed on 19.01.22	Complete	Email	Yes
COG(22)05	18/01/2022	2.3	Membership Office to seek expressions of interest for the two vacant seats on the ARC	Membership Office	Apr-22	Email sent to Governors requesting expressions of interest on 19.01.22	Complete	Email	Yes
COG(22)03	18/01/2022	1.6	Membership Office to update the Action Log	Membership Office	Apr-22	Action log updated	Complete	Action log	Yes
COG(22)02	18/01/2022	1.4.2	Membership Office to update the attendance records on the minutes from the October and November minutes	Membership Office	Apr-22	Governor and NED attendance has been updated on all three sets of minutes.	Complete	Minutes	Yes
COG(21)22	19/10/2021		Adolfazl Abdi to provide an update within the January 2022 CoG on elective recovery, A&E attendances and performance levels	Adolfazl Abdi	Jan-22	Update provided within Jan 2022 CoG by Shaun Stacey	Complete	Minutes	Yes
COG(21)21	19/10/2021		Adolfazl Abdi to investigate issues around the early morning discharge of patients	Adolfazl Abdi	Jan-22	Adolfazl Abdi investigated issues around the early morning discharge of patients and the outcome was emailed to Governors by the Membership Office.	Complete	Email	Yes
COG(21)20	19/10/2021	1.6	Organise a briefing with Lee Bond or Shaun Stacey on changes and provide information to Governors on changes to elective care and the ICS.	Membership Office	Jan-22	Update provided within Jan 2022 CoG by Shaun Stacey	Complete	Minutes	Yes
COG AMM(21)19	13/09/2021	6	Membership Office to use the feedback to improve proceedings at the next CoG AMM (AMM)	Membership Office	Sep-22	CoG AMM review and planning meeting arranged for 01.12.21. Feedback report produced in readiness.	Complete	AMM review and planning meeting held 01.12.21.	Yes
COG AMM(21)18	13/09/2021	5	Membership Office to contact individuals raising queries by email regarding responses to the queries raised in advance of the CoG AMM meeting (AMM)	Membership Office	Oct-21	Responses to questions raised were distributed following the CoG AMM meeting	Complete	Emails saved with CoG AMM papers	Yes
COG AMM(21)17	13/09/2021	3.1.1	Membership Office to distribute the audit report to all attendees following the meeting (AMM)	Membership Office	Oct-21	Distributed to attendees following the CoG AMM meeting	Complete	Emails saved with CoG AMM papers	Yes

COG(21)16	20/07/2021	10	Discuss Council Reflection at next GAG meeting	Membership Office	Nov-21	Added to GAG agenda for the meeting on 02.09.21	Complete	Added to GAG Agenda	Yes
COG(21)15	20/07/2021	3.1	Lee Bond or Shaun Stacey to provide information to Governors on changes to elective care and the ICS.	Membership Office	Oct-21	Briefing included within 19.10.21 CoG meeting	Complete	CoG agenda and following minutes	Yes
COG(21)14	20/07/2021	2.2	Request for communications team to raise the importance of wearing face masks and PPE as required	Infection Contro	Oct-21	Directed to the IPC team and a request to comms to raise the importance of wearing face masks and PPE as required	Complete	Emails within CoG meeting actions	Yes
COG(21)13	20/07/2021	1.2	Governors gratitude and best wishes to be conveyed to Terry Moran CB	Alison Hurley	Oct-21	Lead Governor to forward gratitude and best wishes on behalf of the Governors	Complete	Letter sent	Yes
COG(21)11	20/04/2021	3.2	Membership Office to distribute the North Lincolnshire Community Services presentation following the meeting	Membership Office	Apr-21	Alison Hurley distributed Community Services presenation following the April CoG	Complete	Presenation distriubted following April CoG	Yes
COG(21)10	20/04/2021	5	Infection Control to produce a written briefing on nosocomial infections, numbers experienced in the Trust in comparison to regional and national data for circulation to the Governors	Membership Office	Jul-21		Complete	Update provided within the 1st July Governor & NED Briefing session	Yes
COG(21)9	20/04/2021	5	Membership Office to invite Jackie France to provide an update on digital appointment letters at the Governor and NED briefing scheduled for 27th May 2021	Membership Office	Apr-21	Jackie France provided update at 27th Governor & NED Briefing	Complete		Yes
COG(21)8	20/04/2021	5	Jackie France to liaise with Kevin Allen about digital letters and patient support	Membership Office	Jul-21	Kev Allen contacting by Dr Peter Reading, Jackie France and Zoe Hinsley - awaiting confirmon from Kevin action now closed	Complete	Virtual meeting between Kev Allen and Jackie France held on 5th May 2021	Yes
COG(21)7	20/04/2021	**4.1**	Membership Office to update the Governors' Register of Interests with Jeremy Baskett amendment	Membership Off	Jul-21	Jeremy Baskett's updated Declaration of Interests received and added to Register of Interest for approval at July CoG	Complete	Presented at July CoG	Yes
COG(21)6	20/04/2021	2.3	Membership Office arranged CoG Annual Review Meeting, 23rd to be held of site, at Sansview Stadium, Scunthorpe	Membership Office	Jun-21	Off site venue arranged for CoG AMM - virtual meeting arranged in line with COVID-19 guidance	Complete	Off site venue arranged for CoG AMM	Yes
COG(21)6	20/04/2021	1.6	Membership Office to update action log	Membership Office	Apr-21	Action log updated	Complete	Action log updated	Yes
COG(21)5	20/04/2021	1.4	Membership Office to amend 19th January 2021 CoG minutes as discussed	Membership Office	Apr-21	Minutes amended as agreed	Complete	Minutes amended as agreed	Yes
COG(21)4	19/01/2021	6	Alison Hurley to seek and collate votes for NHS Providers' Governor Advisory Committee	Alison Hurley	Mar-21	Voting information was distributed on 19th January 2021. NHS Providers' Governor Advisory Committee votes were cast on behalf of the CoG as agreed.	Complete	E-mail	Yes
COG(21)3	19/01/2021	4.2	Membership Office to distribute 15th October Private CoG minutes	Membership Office	Apr-21	Distributed to governors on 19th January 2021	Complete	E-mail	Yes
COG(21)2	19/01/2021	2.2.1	Chief Information Officer to consider increasing IT accessibility for staff to access staff updates	Shauna McMahon	Apr-21	Shauna MacMahanon provided update within 9th March Briefing held prior to the GAG	Complete	Briefing	Yes
COG(21)1	19/01/2021	2.2.1	Membership Office to distribute COVID-19 presentation	Membership Office	Apr-21	Distributed to governors on 19th January 2021	Complete	E-mail	Yes
COG(20)254	22/07/2020	3.2	Virtual Governor waiting list briefing to be organised	Membership Office	Nov-20	Governors received update at January 2021 CoG	Complete	Minutes	Yes
COG(20)253	14/01/2020	1.7.1	Health Tree Foundation briefing for Governors to be organised	Membership Office	Nov-20	On hold until the COVID-19 restrictions are lifted and normal business resumes - possible agenda item at April coG	Complete	E-mail	Yes
CoG(20)259		6	Membership Office to distribute questionnaire to CoG members for Council Reflection	Membership		Distributed	Completed		
COG(20)259	15/10/2020	9.2	Membership Office to amend the Governor Attendance at Briefings Document	Membership Office	Jan-21	Governor Attendance at Briefings Document amended	Complete	Governor attendance document	Yes
CoG(20)258		2	Membership Office to electronically circulate the proposal document following this meeting	Membership		Distributed	Completed		
COG(20)258	15/10/2020	4.3.1	Lee Bond to investigate and provide an update at the January CoG meeting on any short term Trust investments	Lee Bond	Jan-21	Verbal update to be provided at April CoG	Completed	Update provided within April CoG	Yes
CoG(20)257		1.8	Membership Office to distribute the Oncology Stakeholder briefing to Governors	Membership		Briefing document circulated 23.01.2020	Completed		

COG(20)257	15/10/2020	3.2	The significant transactions element of the Trust Constitution to be circulated to CoG members	Membership Office	Oct-20	The significant transactions element of the Trust Constitution circulated to CoG members	Complete	E-mail	Yes
CoG(20)256		7.1	Membership Office to send Mr Garrington a copy of the most recent staff survey results	Membership		Staff survey results sent to Mr Garrington 21.01.2020	Completed		
COG(20)256	22/07/2020	13	Alison Hurley, Linda Jackson and Helen Harris to discuss public attendance at CoG meetings outside of the meeting	Alison Hurley	Oct-20	Considered and addressed via a virtual meeting which also considered general Governor engagement	Complete	E-mail	Yes
CoG(20)255		5.1	Mr Karvot to contact Mrs Jackson outside of the CoG to discuss the antibiotic service for DPoW	Mr Karvot		Mr Karvot contacted Mrs Jackson regarding the antibiotic s	Completed		
COG(20)255	22/07/2020	7.1	Claire Low to provide an update on the incidents of potential inappropriate access to WebV	Claire Low	Oct-20	Addressed in the all staff e-mail shared with Governors on 6th October 2020	Complete	E-mail	Yes
CoG(20)254		5.1	Membership Office to add 5-year forecasting to the February Governor & NED Bi-annual Briefing	Membership		Discussed at 11.02.20 Bi-annual Governor and NED Briefin	Completed		
CoG(20)252		1.7.1	Membership Office to add Health Tree Foundation Highlights Report to future CoG agendas	Membership		Actioned	Completed		
CoG(20)251		1.7.2	Dr Wood to contact NLCCG regarding the use of Everlight Radiology services	Dr Kate Wood		This was addressed within the May CoG	Completed		
COG(20)249	04/07/2019	9	Mrs Hurley to investigate potential sponsorship for IT tablets for Governors	Alison Hurley	Oct-19	Oversight will be maintained at the Governor Assurance Group meeting	Completed	GAG Agenda	Yes
CoG(20)245		1.6	Membership Office to add Women and Children Services to Sheffield Hospital to a future CoG Agenda	Membership		Addressed within October CoG	Completed		
CoG(20)244		1.5.1	Membership Office to invite Mrs Farquharson to provide a Pride & Respect briefing	Membership		Addressed within November Bi-annual Briefing	Completed		
CoG(20)242		1.3	Add Smoking Shelter Update to the next CoG Agenda	Membership		Addressed within October CoG	Completed		
CoG(19)240		8	Membership Office to liaise with Mr Bramley to arrange a Governor & NED briefing on Quality and Service Improvement Report (QSIR) later in the year	Membership		To be addressed within QRG & QSC agenda	Completed		
CoG(19)237		5.1	Membership Office to circulate papers from the NHS Providers Regional Workshop for information	Membership		Completed 02/05/2019	Completed		
CoG(19)236		3.1	Membership Office to invite Mr Stacey to discuss Winter Planning at a future CoG meeting	Membership		Added to July CoG agenda	Completed		
CoG(19)235		2.1	Membership Office to add IT Security to a future CoG agenda for Mr Johal to speak to	Membership		Added to July CoG agenda	Completed		
COG(20)234	16/04/2019	4.2	Membership Office to invite Mrs Plant to provide a briefing on planned initiatives for improving financial and operating targets	Membership Office	Jul-19	Discussed within July CoG briefing	Completed	July CoG briefing agenda	Yes
CoG(19)233		4.1	Dr Reading to discuss externally procured coding with Mr Johal outside of the meeting to ascertain backlog and sustainability status	Dr Reading		Completed 23/05/2019	Completed		
CoG(19)232		1.6.1	Membership Office to organise an urgent treatment centres briefing	Membership		Addressed within November 2019 Bi-annual Briefing	Completed		
CoG(19)231		1.6	Membership Office to organise a radiology and pathology briefing at the next Governor & NED Briefing session	Membership		Addressed within November 2019 Bi-annual Briefing	Completed		
CoG(19)230		1.6	Dr Reading to provide Mrs Jeffreys with feedback regarding the biometric machine for ophthalmology at GDH	Dr Reading		Completed 23/05/2019	Completed		
CoG(19)229		1.4	Membership Office to update the Action Log including the archiving of completed actions	Membership		Completed 17/04/2019	Completed		
CoG(19)228		10.5	Membership Office to add Terms of Reference for the ARC to the April CoG agenda	Membership		Agenda item 7.4 on April 2019 CoG agenda	Completed		
CoG(19)227		10.4	Trust Constitution to be added to the April CoG agenda	Membership		Agenda item 7.3 on April 2019 CoG agenda	Completed		
CoG(19)226		10.3.1	Mrs Adamson to circulate updated action plan from the National Guardian's Office	Mrs Adamson		No newer version available at present. This will be added to a future CoG agenda when available	Completed		
CoG(19)225		8.1.1	Mrs Capitani to forward names of Goole patients experiencing problmens regarding attendance to Mrs Hurley	Mrs Capitani		Mrs Capitani provided the membership office with the patient details and this action was resolved on 06.02.19	Completed		

CoG(19)224		8.1.1	Mr Jefferys to forward query regarding Goole patient receiving ophthalmology treatment to the Membership Office	Mrs Jeffreys		Mrs Jeffreys provided the membership office with the patient details and this action was resolved on 31.01.19	Completed		
CoG(19)223		9.4	Dr Reading to contact Mr Reekie regarding timescales of coding issues	Membership		Mr Reekie was updated on the 22.03.19	Completed		
CoG(19)222		4	Membership Office to update the CoG action log	Membership		Membership Office updated the action log	Completed		
CoG(19)221		11.2	Trust Constitution Updates to be presented to the Governor Assurance Group	Mrs Booth		Update to be provided at the January 2019 CoG meeting at 11.1 of the agenda	Completed		
CoG(19)220		10.1 & 12.3.1	Mrs Farquharson to provide a Pride & Respect Programme update to the December Governor and NED briefing	Mrs Farquharson		To be delivered at the Governor and NED Briefing in February 2019 (as above at item 200)	Completed		
CoG(19)219		9.4.1	Mrs France to provide a Patient Administration Progress update at the December Governor and NED briefing	Mrs France		Delivered at the December briefing	Completed		
CoG(19)218		4	Membership Office to update the Action Log, and completed actions will be moved and archived	Membership		Action log amended	Completed		
CoG(19)217		3	Amend Item 4.1 in the Annual Review Meeting minutes from 12th June 2018	Membership		Minutes amended	Completed		
CoG(19)216		6	Mr Stacey to provide an update at the next meeting on the Pain Management Service and use of St Hugh's Hospital in Grimsby and InHealth services at Scunthorpe	Mr Stacey		Agenda item 9.3.2 on January 2019 CoG agenda	Completed		
CoG(19)214		4	Membership Office to amend previous minutes to state Dr Reading throughout.	Membership		Membership Office amended minutes	Completed		
CoG(19)213		13.3.1	Membership Office to ensure the National Guardians report on NLaG Procedures is on the next CoG agenda	Membership		Item 12.3.1 on the January CoG agenda	Completed		
CoG(19)212		13.3	Membership Office to ensure the National NLaG Freedom to Speak Up Report is on the next CoG agenda	Membership		Item 12.3 on the January CoG agenda	Completed		
CoG(19)211		13.2	Membership Office to update the totals column on the Attendance at Governor Briefings and Training and Development Opportunities document to reflect the rolling 12 month period	Membership		Membership Office updated document	Completed		
CoG(19)210		13.1	Membership Office to update the totals column on the Governor Attendance at CoG and Sub-groups document to reflect the rolling 12 month period	Membership		Totals column on spreadsheet amended	Completed		
CoG(19)209		9.1	Membership Office to ensure BAF is added to the next CoG agenda.	Membership		Item 9.1 on the January CoG agenda	Completed		
CoG(19)208		8.4	The ARC are to amend the NED remuneration to reflect the NHS cost of living increase of 3% effective from 1st April 2018	ARC		Referred to ARC Meeting to address	Completed		
CoG(19)207		7	Membership Office to invite Mr Stacey to provide updates at future CoG meetings	Membership		Update provided at the October CoG meeting	Completed		
CoG(19)206		6	Update on restructuring and nursing due at the October CoG meeting	Membership		Update provided at the October CoG meeting	Completed		
CoG(19)205		9.4.2	Mr Stacey agreed to establish whether local patients were presenting with early or late stage cancer	Mr Stacey		Update provided at the October CoG meeting	Completed		
CoG(19)204		10.2	Membership Office to distribute update to be provided by Mrs Clipson	Membership		Update provided at the October Pre-CoG briefing	Completed		
CoG(19)203		10.2	Membership Office to ensure Humber Acute Services Review update is on the next CoG agenda	Membership		Update provided at the October Pre-CoG briefing	Completed		
CoG(19)202		10.1	Membership Office to distribute update to be provided by Mrs Clipson	Membership		Update provided at the October Pre-CoG briefing	Completed		
CoG(19)201		10.1	Membership Office to ensure STP update is on the next CoG agenda	Membership		Update provided at the October Pre-CoG briefing	Completed		
CoG(19)200		11.1	Membership Office to ensure Pride and Respect is added to the agenda quarterly	Mrs Farquharson		To be delivered at the Governor and NED Briefing in February 2019 - Deliverd at the February Governor & NED Briefing sessioin	Completed		

CoG(19)199		9.4.1	To invite Mrs France to the October CoG meeting for a further Patient Administration Progress update	Membership		Update provided at the December briefing	Completed		
CoG(19)198		9.2	The Membership Office to ensure that the Improving Together Programme briefing is on the agenda for the November briefing session.	Membership		Added to the November briefing	Completed		
CoG(19)197		4	Membership Office to update the Action Log.	Membership		Membership Office updated	Completed		
CoG(19)196		3	Membership Office to add 'during the day' to clarify item 7 on page 5 of the minutes.	Membership		Membership Office amended minutes	Completed		
CoG(19)195		6.2.1	Governors to receive an STP update covering Trust representatives on all of the various work-streams	Membership		October CoG	Completed		
CoG(19)194		6.2.1	Membership Office to seek timelines for the release of the embargoed Annual Report and Account for the Governor Assurance Group	Membership		Annual Report circulated to Govenors before AMM	Completed		
CoG(19)193		6.2.1	Mrs Hurley to add a simplified criteria column to the framework documents	Mrs Hurley		Completed for 2019	Completed		
CoG(19)192		6.1.1	Membership Office to move the CQC update briefing session to the CoG agenda and replace by a meet and greet session with the Chief Executive and Executive Directors.	Membership		July CoG	Completed		
CoG(19)191		13.3	Membership Office to invite Mr Hemadri to present the National Guardians Report at the July CoG	Membership		Mr Hemadri invited to the July CoG to provide update on National Guardians Report	CLOSED		
CoG(19)191		4.2	Mrs Hurley to discuss raising awareness of the SID role with Mrs Booth	Mrs Hurley		To be incorporated within the review of the Trust Board sub-committees	Completed		
CoG(19)190		9.4	Mrs Jackson suggested Mrs Louise Glover could provide clarity around the clinical harm process for Mr Baskett	Membership		Mrs Lousie Glover liaised with Mr Baskett around the clinical harm process	Completed		
CoG(19)189		9.3	Membership Office to arrange a briefing for Governors on Capital Funding	Membership		Delivered at the November Gov & NED Briefing	Completed		
CoG(19)188		9.1	Membership Office to invite Mr Daws to the next QRG Meeting	Membership		This has been completed. Mr Daws attended June QRG Meeting.	CLOSED		
CoG(19)187		11.3	Membership Office to invite governors on behalf of Mr Currie, to attend the Compassionate Leadership Confiernce on 17th May 2018	Membership		This has been completed. Mrs Bett attended conference.	CLOSED		
CoG(19)186		11.3	Membership Office to invite Mr Currie to return in the autumn for a further progress report.	Mrs Hurley		Mrs Claire Low confirmed for providing an update at the July CoG.	CLOSED		
CoG(19)185		4	Membership Office to update Action Log	Membership		This has been completed.	CLOSED		
CoG(19)184		17	Membership Office to invite Mrs Graves to the Quality Review Meeting in February to discuss the Ward Reviews.	Mrs Hurley		Mrs Filby attended the February QRG meeting and provided an update on the new ward review/SQAT process	CLOSED		
CoG(19)183		14.3	Mrs Shaw to address the potential conflict of interest outside of the meeting.	Mrs Shaw		This was addressed and resolved	CLOSED		
CoG(19)182		8.5	Membership Office to distribute the Staff Governor Working Group terms of reference electronically for comments.	Mrs Hurley		Completed and added to the April CoG agenda for full CoG ratification	CLOSED		
CoG(19)181		8.4	Mr Grinell to take appraisals of the Non-Executive Directors (NED) and the Trust Chair back to ARC agenda for further consideration.	Mr Grinell		This will be discussed within the ARC meetings. A response wil lbe provided at the July CoG.	CLOSED		
CoG(19)180		8.3	Mrs Hurley to contact IT and the communications team regarding the feasibility of recording short You-tube clips for the Trust website	Mrs Hurley		Communications team to consider utilisng You-tube for positive promotion of the Trust and its' services	CLOSED		
CoG(19)179		8.3	MWG to liaise with Mrs Clipson to discuss linking the group with service strategy.	Mrs Hurley		Mrs Sandra Hills now aligned with the MWG as the NED lead for service strategy.	CLOSED		
CoG(19)178		8.2	Membership Office to add RTT to the next QRG agenda for further discussion.	Mrs Hurley		RTT has been added to the May QRG agenda.	CLOSED		
CoG(19)177		8	Membership Office to amend the agenda for April CoG meeting to incorporate the Trust Board sub-committee highlight reports in to the CoG sub-group highlight reports.	Mrs Hurley		This has been completed.	CLOSED		

CoG(19)176		11.2	Mrs Clipson to provide the governors with regular updates on the Humber Acute Service Progress Report.	Mrs Clipson		This is ongoing as a CoG agenda item.	CLOSED		
CoG(19)175		10.4.1	Membership Office to invite Mrs France to return in the autumn for a further progress report.	Mrs Hurley		Mrs France confirmed for providing an update at the July CoG.	CLOSED		
CoG(19)174		10.4.1	Membership Office to distribute late papers to attendees	Mrs Hurley		Papers distributed as actioned.	CLOSED		
CoG(19)172		10.3	Membership Office to add Draft Trust Strategy 2021 & Strategic Objectives to the January pre-CoG briefing	Mrs Hurley		This was delivered as part of the Governor and NED briefings held on 22nd February.	CLOSED		
CoG(19)170		6	Membership Office to involve Dr Reading in the November briefing for the Improving Together Programme	Mrs Hurley		This was delivered as part of the Governor and NED briefings held on 22nd February.	CLOSED		
CoG(19)168		7.3	Mrs Greenbeck to provide article ideas to the Membership Office	Mrs Greenbeck		Mrs Hurley and Mrs Greenbeck wrote an article with Mrs Dobson on dementia and improvements for dementia patients and new staff.	CLOSED		
CoG(19)166		9	Mrs Hurley to investigate the use of microphones for future CoG Meetings	Mrs Hurley		This is now closed. This will be reviewed dependant on the venue being used. Equipment to be sourced from the Smile Foundation. Mrs Hurley will contact the Health Tree Foundation as they are often able to bring equipment with them from Hull and return.	CLOSED		
CoG(19)154		5.1	Chairs of CoG Sub-Groups are to ensure their terms of reference reflect those of the Trust Board	CoG Sub-Group Chairs		CoG sub-groups are now aligned with TB sub-committeeswhich is reflected in their terms of reference.	CLOSED		
CoG(19)150		3.3	Mrs Hurley to seek a champion who can take the IT Tablets for Governors business case to the Charitable Funds Committee meeting on the 27th July 2017	Mrs Hurley		This is now closed. As this was an ongoing item requiring futher exploration. It was agreed to monitor this action through the Governor Assurance Group. Support has been received from the information team to produce specification for palmtops. Previous sponsorship plans have not come to fruition.	CLOSED		

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: CoG (07/23) Item: 2.1

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Sean Lyons, Trust Chair	
Contact Officer/Author	As above	
Title of the Report	**Chair's Update**	
Purpose of the Report and Executive Summary (to include recommendations)	Briefing for the Council of Governors on the key highlights from the recent Trust Board and current issues	
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

1. Chair's Update for Council of Governors (CoG) meeting 13 July 2023

A very busy and eventful period since the last CoG Business meeting, and as usual, I would like to commend the hard work of the staff to the CoG and ask that they show appreciation for this work under continuing pressure.

This would be particularly relevant as the NHS celebrates its 75th year on 5 July 2023.

2. Joint Chief Executive Officer (CEO) Appointment and Interim CEO Arrangements

Interviews were held for the position of Joint CEO for Hull University Teaching Hospitals NHS Trust (HUTH) & Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) on 16 May 2023.

Two very strong candidates went through a thorough process including Stakeholder Presentations, Board member discussions and Panel Interview.

Jonathan Lofthouse was successful on the day, and I am pleased to report that the CoG ratified this appointment on 18 May 2023. Jonathan starts his role on 14 August 2023 and he is very much looking forward to working with Governors.

Dr Peter Reading left the Trust at the end of May to take up the role of Interim CEO of Yorkshire Ambulance Trust, having guided the Trust through a very successful Care Quality Commission (CQC) inspection and the Trust exiting Segment 4 of the NHS Oversight Framework - also mentioned later.

I am sure Governors will join me in thanking Peter for his work with the Trust and we wish him every success in his new role.

In the period between Peter leaving and Jonathan starting, following an agreed internal application and interview process, Shaun Stacey, NLaG's Chief Operating Officer (COO) has been appointed Interim CEO and we wish him well in this position.

3. Exiting RSP (Special Measures)

On 7 March 2023, a paper was considered at the NHS England Quality and Performance Committee, and subsequently at North East and Yorkshire Regional Support Group on 15 May 2023, to recommend that the Trust transition from Segment 4 to Segment 3 of the NHS Oversight Framework. Both Committees agreed the recommendation and therefore the Trust no longer needs support of the Recovery Support Programme (RSP).

Formal notice of this was received in a letter from Sir David Sloman, COO of NHS England, on 17 May 2023. This means that the colloquial 'Special Measures' terminology no longer applies to the Trust - this is a significant moment and a cause for justifiable celebration.

4. CoG Annual Review

The CoG Annual Review Meeting (ARM) took place on 22 June 2023. A substantial input to this meeting is the review of an assessment questionnaire which should be used to inform further action and development. Whilst this did take place, it is disappointing to note that only 6 from a possible 17 responses were received and therefore we have some work to do to use this process effectively.

The Trust also looks forward to working with Governors to increase public and Trust Membership engagement.

I would like to thank Governors for their support over the last year.

5. Appointment of External Auditors
One of the CoG's formal duties is to appoint the Trust's External Auditors. After an extensive search, on 22 June 2023, Governors approved the appointment of the External Auditor which will now progress to the Audit, Risk and Governance Committee on 20th July 2023.

6. Group Governance Intentions
On 27 June 2023, Governors were briefed on the intended Group Governance arrangements following an extensive period of analysis and discussions between the Boards of HUTH and NLaG.

At the end of that briefing, the Lead Governor read out a pre-prepared statement in response, and also sent a letter to NLaG Board members containing that statement and mentioning other aspects of concern. The Trust is reviewing its response to that process and the content of this letter, and a response will be forthcoming in due course.

Sean Lyons, Trust Chair, July 2023

Agenda Number: CoG (07/23) Item: 2.2

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Shaun Stacey, Interim Chief Executive	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Chief Executive's Update**	
Purpose of the Report and Executive Summary (to include recommendations)	To provide a high level overview of work ongoing both across the Trust and wider health economy	
Background Information and/or Supporting Document(s) (if applicable)	Other Board documents provide more detailed information	
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

1. Delays with Mental Health Patients within our Emergency Departments

There has recently been an increase in patients attending our emergency department who require the support of our psychiatric providers where long delays have been identified to their assessment and treatment planning.

Navigo Grimsby (DPOW)
The delays have in the main been caused by Navigo streamlining their clinical team including the team being relocated at Harrison House. When an assessment is required, DPOW inform the Navigo team but due to reduced staffing, the time from referral to assessment is longer than previously seen. Should admission, or a treatment plan be required that is not able to be delivered at home then a further delay is incurred due to the poor availability of acute mental health beds in the UK at this time. Whilst we understand the complexity of this service and its needs in supporting local people, we have escalated the challenge to the Navigo Director, NEL ICS Place and a multiagency meeting took place a week ago at which agreement was reached around escalation and a more sustainable action to resolve the delays where possible.

RDASH Scunthorpe (SGH)
A similar theme is being experienced by patients waiting for mental health support from our partners in Rotherham, Doncaster and South Humber NHS Foundation Trust (RDASH). This includes a patient who waited in ED for three days whilst an acute mental health bed was identified due to poor availability of mental health beds. We have reported previously that RDASH has challenges regarding bed and workforce capacity. All mental health patients at SGH are being monitored closely and discussed at the regular site meetings with escalations to the partner senior team members to ensure a prompt response.

2. Cancer Backlog

In January 2023 NLaG had 213 (17.6% of the total Cancer PTL) patients waiting longer than 62 days, of which 40 had been waiting longer than 104 days – as at 25th June 2023 the trusts longer than 62 days backlog is 7.6%.The backlog percentage has been more than halved and reviewing the numbers on 30th June 2023, the trust are down to 153 patients over 62 days (131 x 2week wait pathways and 22 x screening and consultant upgrade pathways). Reducing the volume of patients waiting longer than 62 days by 30%.

As of 30th June 2023, 71% of the total Cancer PTL is day 0-28 – the focus has been on reducing and sustaining the reduction of the backlog by reviewing the suspected patients and getting faster clinical decision making to remove these patients from the PTL. The trust is now reviewing waits between 29-41 days to prevent further patient delays reaching over day 42+. The trust can report 25.4% of patients are seen within 2 working days, 57.8% are seen by day 7 and 96.1% by day 14 of referral to our services.

The transformation work program and improvements the divisions are making towards the Best Practice Timed Pathways (BPTP) in terms of timings for each step will deliver further benefits. However, there remains a risk related to the challenges around diagnostic/pathology demands with a potential impact on routine diagnostics. Straight to Test (STT) for Upper Gastrointestinal patients commenced on 5th June with the Colorectal cancer backlog significantly reduced since its introduction.

3. Junior Doctors Strike

Industrial action is planned to take place on the following dates:

- British Medical Association (BMA) and British Dental Association (BDA) – **Junior Doctors** – 07:00 on 13th July until 06:59 on 18th July 2023 (5 consecutive days)
- British Medical Association (BMA) – **Consultants** – 07:00 on 20th July until 06:59 on 22nd July 2023 (2 consecutive days)

Upon notification of these further strike dates, we are recommencing our Industrial Action Planning Group which will include planning for the Junior Doctors and Consultants strikes. The group is chaired by the Interim Chief Executive / Chief Operating Officer Shaun Stacey as Senior Responsible Officer for the strike incident. The planning group will take the same approach to the planning and mitigating risks to reduce the disruption to patients and services and ensure continued patient safety:

- Local engagement with unions including agreement on picket lines and welfare provision
- Divisional strike plans for services developed which detail activity plans, critical functions, workforce redeployments and mitigating actions
- All elective activity will be reviewed by Divisions with the focus to maintain activity wherever possible and keep rescheduling of appointments to a minimum. However, it is very likely that there will be a significant loss of activity during the consultant's industrial action
- Guidance and communication for managers and medical staff with FAQs on industrial action and cover arrangements
- Situation reporting process to ensure accurate information can be accessed and used to support decision making during the industrial action

The Trust will again operate a virtual Incident Coordination Centre (ICC) function 24 hours a day throughout the period of industrial action The ICC will have a Strategic Health Commander who will lead the response in conjunction with a lead from Chief Medical Officer's Office and Chief Nurse's Office. There will also be Emergency Preparedness, Resilience and Response (EPRR) support within the ICC who will be linking with neighbouring Trusts and ICB preparedness and response.

While the planning and preparation for the upcoming industrial action is providing confidence that critical services will be covered and maintained during the period using lessons learned from the recent industrial action, the change in these upcoming dates of a longer period of Junior Doctor action and the first Consultant action providing only Christmas Day service will require additional assessment and mitigation of risks through the planning group.

4. RCN Ballot

The recent RCN ballot did not meet the required threshold of a 50% postal response. Therefore, no further strike action will take place at this time.

5. HUTH & NLAG Electronic Patient Record

Over the last three years, Hull University Teaching Hospitals (HUTH) and NLaG have

been working together as part of the Humber Acute Services Review to identify how to better provide services for the benefit of our patients. HUTH and NLaG continue to consolidate clinical and operational services through the Humber Clinical Collaboration Program. This is being hindered by inefficiencies in clinical and patient processes that the current disparate EPR solutions cannot resolve. Patient digital information is held on two systems, which are not integrated meaning that paper processes are having to be implemented to bridge the gap in digital capabilities. Similarly, patients are experiencing potential delays in treatment through the use of paper processes for investigation requests and medication prescriptions and results. HUTH and NLaG have consistently set a clear direction for a joint single Enterprise ePR for the two Trusts either through a joint two Trust procurement or wider procurement with partner Trusts within the ICS.

We received an email from the ICB CEO raising concerns about delays to the process of procuring a system and the potential impact this would have on our organisations. We have responded jointly to the ICB CEO stating that several factors have led to the delay with the principles being:

- We started later than York/Harrogate and until we had some funding allocated for the work, we're doing it in house. Our two digital teams are also dealing with significant work in creating one team; delivering a robust data warehouse in NLaG and delivering the digital transformation to allow the ten Humber-wide services to integrate.
- We and the North Yorkshire Trusts are looking at different solutions.
- We are doing a lot of work to align the pathways and ways of working across the two trusts and this involves a lot of "hearts and minds" with all involved. This work is essential if we are to build a sufficiently robust Outline Business Case and have clinical support to enable implementation.
- We have a significantly smaller funding envelope than that available to York and Harrogate.
- NHSE have confirmed our delayed timeline (i.e. Board approval in Oct) would present them with no problems. We are waiting a response from the ICB CEO which we hope will be positive.

6. Death of Dr Kevin Speed

It is with regret that I announce that Dr Kevin Speed, the clinical lead for Haematology and the lead for the clinical Haematology network has passed away. Dr Speed worked for the trust for 40 years as consultant in Haematology and single handedly for many years developed the Chemotherapy Service for Children and Adults for leukemia and other Haematological disorders. He was prominent in the training of medical students. Dr Speed was also a key person in the trusts hospital cricket team. Our condolences have been sent to his family.

7. Pathlinks

I wish to announce formally the retirement of Mick Chomyn, the associate director of Pathlinks, and I am pleased to say that we have successfully recruited James McClean, currently the Pathology Manager at Kettering General Hospital.

8. Interim Chief Executive Officer and Interim Chief Operating Officer

I am pleased to announce that Aswathi (Ashy) Shanker has successfully been recruited into the position of Interim Chief Operating Officer until the 13th August 2023. This comes after I have been successful in becoming Interim Chief Executive until the same date.

9. Cricket

We are pleased to report that the hospital cricket team won for the first time the hospital doctors versus GP cricket match, not at Lords, but at Heslam Park Scunthorpe on Sunday 25th June.

Shaun Stacey
Interim Chief Executive

Agenda Number: CoG (07/23) Item: 2.3

Name of the Meeting	**Council of Governors**
Date of the Meeting	13 July 2023
Director Lead	
Contact Officer/Author	Ian Reekie
Title of the Report	**Lead Governor's Update**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of this report is to update governors on highlights from Governor Assurance Group meetings held on 6 April and 12 June and an Appointments & Remuneration Committee meeting held on 15 June 2023. The Council of Governors is recommended to: • Note the content of the Lead Governor's Update report including highlights from Governor Assurance Group and Appointments & Remuneration Committee meetings. • Consider under agenda item 4.1 the Governor Assurance Group recommendation to approve revisions to the Council of Governors and Trust Board Engagement Policy • Consider the Appointments & Remuneration Committee recommendation to approve a 3% cost of living increase for Non-Executive Directors backdated to 1 April 2022 • Consider the Appointments & Remuneration Committee recommendation to approve the re-appointment of Linda Jackson as a Non-Executive Director and Vice Chair for a period of one year commencing 30 September 2023 • Consider the Appointments & Remuneration Committee recommendation to approve the re-appointment of Stuart Hall as an Associate Non-Executive Director for a period of one year commencing on 30 September 2023
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 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:**

	☐ 1 - 1.6 **To be a good employer:** ☐ 2	☐ 5 ✓ Not applicable
Financial implication(s) (if applicable)	None	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

1.	**To give great care**
1.1	To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards internationally. Risk to Strategic Objective: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by international comparison) of safety, clinical effectiveness and patient experience.
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

COUNCIL OF GOVERNORS

13 July 2023

Lead Governor's Update

GOVERNOR ASSURANCE GROUP (GAG) HIGHLIGHTS

At the GAG meeting held on Thursday 6 April governors considered the content of board assurance committee highlight reports presented by NED chairs. As GAG meetings are now programmed to closely follow Trust Board meetings the highlight reports are much more up to date. In an attempt to gain additional assurance the GAG meeting successfully piloted holding a deep dive into the work of one of the board committees with Sue Liburd leading a very helpful discussion on the workforce challenges the trust is facing. Other topics focused on included:

- Community diagnostic centres
- Achievement in hitting 2022/23 revenue control totals and capital spending targets
- Improvements in cancer performance
- Pharmacist vacancies at SGH
- Revisions to cardiology services
- Failure to appoint external auditor
- A first bi-annual review of the Integrated Performance Report
- A review of governor attendance and the concerning governor vacancy position

The GAG meeting held on Monday 12 June again considered the latest iterations of committee highlight reports with this time a deep dive led by Simon Parkes into the work of the Audit, Risk and Governance Committee. Other topics discussed included:

- Continuing growth in temporary staffing spend
- The wisdom of the Board decision to sign off a financial plan for 2023/23 incorporating a £35.7m Cost Improvement Programme plus £10m in unidentified savings
- Identification of 'unknown unknown' quality issues in the context of the failure to recognise paediatric audiology deficiencies
- Sickness absence rates
- Leadership programme/management training progress
- Identification of potential external auditor
- GAG evaluation assessment tool
- Governor election preparations

The 12 June GAG meeting also considered a comprehensive updating of the Council of Governors and Trust Board Engagement Policy and agreed to recommend CoG to approve the revised document (see agenda item 4.1).

APPOINTMENTS & REMUNERATION COMMITTEE (ARC) HIGHLIGHTS

A meeting of the Appointments & Remuneration Committee was held on Thursday 15 July when the following items were considered:

- **NED Appraisals** – ARC was advised that NHS England has this year adopted a revised performance scoring matrix for NED appraisals with four levels – Strong Performance/Fully Competent/Needs Development/Poor. It is pleasing to report that all NLaG NEDs and Associate NEDs were assessed as either exhibiting strong performance or as being fully competent.
- **NED Cost of Living Increase** – ARC agreed to recommend CoG to approve a 3% cost of living increase for NEDs and Associate NEDs backdated to 1 April 2022. This is identical to the pay award agreed for Very Senior Managers.
- **Re-appointment of Linda Jackson** – Linda Jackson's NED tenure is due to end on 29 September 2022 after serving what is normally the maximum three full terms of three years. In accordance with national guidance ARC subjected the possibility a further extension to particularly rigorous review and concluded that retaining Linda's services as a NED and Vice Chair for an additional 12 months is essential to facilitate the successful implementation of a revised group governance structure. ARC was advised that NHS England's Regional Director had approved this course of action.
- **Re-appointment of Stuart Hall** – Stuart Hall was appointed as an Associate NED on 1 April 2020 initially for two years which was subsequently extended until 30 September 2023 to coincide with his Vice Chair role at Hull University Teaching Hospitals. The intention of the respective Vice Chairs also serving as Associate NEDs was to ensure appropriate collaboration between the two separate trust boards in recognition of the need for ever closer partnership working. On this basis ARC agreed to recommend that CoG further extend Stuart Hall's Associate NED appointment for a period of one year commencing 30 September 2023.

Ian Reekie

Lead Governor

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: CoG (07/23) Item: 3.1

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Shaun Stacey, Interim Chief Executive Officer	
Contact Officer/Author	Richard Peasgood, Executive Assistant	
Title of the Report	**Trust Priorities 2022/23 – End of Year Report**	
Purpose of the Report and Executive Summary (to include recommendations)	This report updates the Council of Governors on the outcomes of the 2022/23 Trust Priorities.	
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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Trust Priorities 2022/23

End of Year Performance Report

1. Our People

- We have more substantive staff in post in March 2023 compared to April 2022. These include 100 more whole time equivalent (wte) registered nurses, 122 wte unregistered nurses, and 25 wte medics
- We have developed new roles including Registered Nurse apprenticeships, Medical Specialist, Medical Support Workers and apprenticeship roles introduced within AHP areas
- We are running Schwartz rounds for our staff to help with support and development
- We are focusing on our managers with a new induction programme, new individual assessments to highlight personalised development pathways, as well as access to leadership qualifications
- We have launched a disability policy to support disabled individuals within the workplace

2. Quality and Safety

- The number of people dying within 24 hours of admission has decreased year on year from 249 in 2020/21, 201 in 2021/22 and 193 in 2022/23
- We achieved our target for adult observations recorded on time with mean 90.55% and median 90.69%
- The percentage of patients admitted to IAAU with their weight recorded increased from 13.13% in April 2022 to 56% in March 2023
- We continued to see a reduction in medication omissions from 13% in August 2021 to 1.4% in March 2023
- 665 staff have been trained in Quality Improvement
- The Trust has maintained better than average performance across all alert organisms, with top quartile performance on C-difficile and zero cases of MRSA bacteraemia.

3. Restoring Services

- We discharged 122,942 patients in 2022/23, which is 11,319 higher than the previous year
- During 2022/23, there were 159,975 Outpatient New Appointments and 327,169 Outpatient Follow-Up Appointments carried out which is an increase from the 154,268 Outpatient New and 325,891 Outpatient Follow-Up Appointments in 2021/22
- We also treated 670 mutual aid patients
- Our community services have made great strides in their geographic coverage, as well as exceeding the 70% threshold of reaching patients within two hours. Their average is 95%
- We need to do further work around our cancer performance, reducing 12-hour waits for patients in ED and reducing delays in ambulance handovers.

4. Reducing Health Inequalities

- We now provide seven-day alcohol dependency services for patients in North East Lincolnshire
- We have introduced tobacco dependency treatment services to support patients who are admitted to our hospitals via wards and assessment centres, and we are piloting an enhanced staff offer for those wanting to quit
- We are also carrying out twice weekly vulnerabilities ward rounds to identify patients with learning disabilities or autism who haven't got a flag on WebV, to ensure all patients receive the appropriate care and adjustments. Complex patients coming in for elective procedures are referred to the learning disability liaison nurse to facilitate reasonable adjustments prior to admission, and ensure a smooth patient journey.

5. Collaborative and System Working

- We are continuing plans to further align our organisations and services with those of Hull University Teaching Hospital, including the Humber Acute Services Review
- We are also actively engaged across the North Yorkshire and Humber Integrated care Board (NYH ICB), as well as with both the regional and national GIRFT teams.

6. Strategic Service Development and Improvement

- Together with our partners in the Humber Acute Services Review, we have completed the Pre-Consultation Business Case (PCBC) which sets out new models of care for urgent and emergency care, maternity, neonates and paediatrics and planned care and diagnostics. However, the timescales for submission changed at the instigation of the HNY ICB.

7. Finance

- The Trust achieved its Financial Plan and we have exited Financial Special Measures (Recovery Support Programme).

8. Capital Investment

- New emergency departments
- Work has begun on our AAU/SDECs
- Refurbished ward 25 at SGH
- Replaced the fire alarm system at DPoW
- Refurbished theatres seven and eight at DPoW and theatre A at SGH
- Undertaken critical water infrastructure works at SGH
- Fire door replacement works at SGH
- Refurbishment and installation of new equipment into the fluoroscopy facility at SGH
- Completion of the final phase of oxygen replacement works at DPoW
- Installation of additional refrigerated body storage in the mortuaries at SGH and DPoW, along with replacement of floor finishes
- Installation of a fully accessible ‘Changing Places’ toilet facility at SGH
- Chiller replacement works at SGH and DPoW, including the replacement of the endoscopy chiller at SGH.

9. Digital

- Lorenzo PAS migration project is in full flight, with a planned completion date of September 2023
- Single Sign-On is being implemented
- Demographic data and discharges are now available on some shared system between Hull and us, which is improving the joint management of patient pathways.

10. The NHS Green Agenda

- Our shuttle service has avoided 375,660 miles of business mileage. This equates to a saving of 145tCO2e
- Our entire pool fleet will be 60% electric or hybrid by 2024, and our park and ride service will utilise full electric transport during 2023
- We have prevented £30k of replacement furniture costs by repairing and reusing items marked for disposal
- We have sent 11 tonnes of redundant medical consumables and equipment to charitable organisations.

2023/24 Trust Priorities

1. Our People
2. Quality and Safety of Care for Our Patients
3. Restoring and Developing Services for our Patients
4. Reducing Health Inequalities
5. Collaborative and System Working
6. Strategic Service and Estate Development and Improvement
7. Finance
8. Digital
9. The Green Agenda

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: CoG (04/23) Item: 3.1a

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Shaun Stacey, Interim Chief Executive	
Contact Officer/Author	Shaun Stacey, Interim Chief Executive	
Title of the Report	**Trust Priorities 2023/24**	
Purpose of the Report and Executive Summary (to include recommendations)	This paper has been developed by the Executive Team and their teams, and was presented and approved at the Trust Board Public Meeting on the 4 April 2023. These 'headline priorities' will be supported with more detailed metrics and implementation plans in the Trust's business plan and in the individual objectives of Executive Directors.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ☐ Other: Trust Board
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)	Applicable through the Trust's business planning processes.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Objectives to further equality, diversity and inclusion, and to reduce health inequalities are included.	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	☐ Information ☐ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Our promise to our staff and our stakeholders

What we will do in 2023-24

Delivering Today / Transforming Tomorrow

NLaG Trust Priorities 2023-24

Trust Priority 1 – Our People

- We will further develop how we seek to **attract and recruit** new staff by:
    - Developing **targeted** recruitment plans and practices at both a Place and ICS level to attract staff to a range of roles across the Trust, including hard to fill clinical roles, resulting in less reliance on bank and agency staff and associated premium spend. This will include targeted planning for specific clinical/medical roles and appropriate on-boarding for new starters.
    - Embedding **recruitment practices** that are fair, inclusive, responsive and provide a positive candidate experience.
    - Developing **workforce plans and initiatives** that tackle longer term workforce shortages. This will include the introduction of new roles, increasing the use of vocational programmes and greater support for veterans and reservists as we aim to widen participation.
    - Increasing the **reward and recognition** proposition for staff on appointment. This will include a greater access to benefits, flexible working practices and development opportunities.
    - Investing in educating and training future healthcare leaders, specialists, and general practitioners to attract and keep skilled employees in our organisation.

- We will **develop and care** for our own staff to **improve retention** by:
    - Developing **career pathways and training academies** that offer development opportunities for new and existing staff, utilising our apprenticeship levy wherever possible. This will include a particular focus on ACPs.
    - Continuing to invest in **values-based leadership development** with a view to creating caring and compassionate working environments.
    - Providing access to a range of benefits such as **flexible and hybrid working** and **retire and return** options that balance the needs of work and life.
    - Continuing to raise awareness of and expand access to responsive and preventative **health and wellbeing services.** This will include a specific focus on supporting colleagues with identified disabilities.
    - Forming alliances with other healthcare organisations to give our staff and trainees **networking opportunities and experience of varied work practices**.

- We will continue to improve our **culture and staff engagement** within the Trust by:
    - Developing annual culture objectives and metrics formed through staff feedback and the National Staff Survey. This will be overseen and monitored through the **Culture Transformation Board.**
    - Continuing to embed **Just and Learning Culture** practices into how we address adverse events that affect our staff.
    - Developing interventional **Organisational Development** programmes that support managers and teams to develop productive and vibrant working environments.
    - Strengthening our efforts to increase and celebrate the **diversity** of our workforce, developing strong staff networks to ensure an inclusive employee experience for all staff.

Trust Priority 2 – Quality and Safety of Care for our Patients

- We will **improve safety** on the following five **Trust Quality Priorities**:
    - **End of Life** – we will improve personalised palliative and end of life care to ensure patients are supported to have a good death.
    - **Deteriorating patient** – we will improve recognition and responding to the deteriorating patient in patients age 16+.
    - **Sepsis** – we will improve recognition and response to sepsis in patients.
    - **Medication safety** – we will the improve the safety of prescribing weight dependent medication to adults.
    - **Mental Capacity** - we will Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording.

- We will continue to implement and embed **actions flowing from our CQC inspection** in 2022.

- We will improve safety by **sharing key learning** through multiple routes to enable the messages to become embedded.

- We will work towards transitioning from the Serious Incident Framework to the Patient Safety Incident Response Framework (PSIRF) in 2023 culminating in the publication of a **Trust Patient Safety Incident Response Plan (PSIRP)**.

- We will continue to participate in **national audit** and act on national and outlier alerts, and ensure we keep our services up to date by reviewing and changing practice, based on best practice guidance from NICE.

- We will develop our new QI Strategy, implement our dosing model and strengthen the role of the QI council.

- We will work in collaboration with our LMNS (Local Maternity and Neonatal System) on improvement of Maternity Services based on national improvement plans and work towards completion of the Maternity Self Assessment Tool, and pursue exit from Maternity Support Programme.

- We will prepare the organisation for the changes to statutory **Liberty Protection Safeguards** (due summer 2022)

- We will continue to ensure compliance with **Safe Staffing** requirements in line with national workforce safeguards.

- We will continue to maintain the highest standards of **Infection Prevention and Control**.

[1] These are subject to confirmation through the Quality Account process.

Trust Priority 3 – Restoring and Developing Services for our Patient

- We will **increase the number of people we can diagnose, treat, and care for in a timely way** through doing things differently, accelerating partnerships, and making effective use of the resources available to us, across health and social care. This will include offering our facilities to provide 'mutual aid' to neighbouring trusts if their waiting times are longer than ours.

- By keeping our patients safe, offering the right care, at the right time and in the right setting, we will deliver **10% more activity** in 2023/24 when compared to levels of activity in 2019/20, including:

    - Significantly **reducing the backlog** of patients waiting for care in the Trust through implementation of our Outpatient Transformation Programme and discharging patients as per national clinical best practice pathways.
    - **Reducing long waits** for treatment by reducing the number of patients waiting above 65 weeks to zero by March 2024
    - By March 2024, increasing **Patient Initiated Follow-Ups** (PIFU) to 5% of all outpatient attendances, maintaining Advice and Guidance (A&G) services at 16% of first outpatient attendances, and supporting the reduction of unnecessary Follow Ups by a minimum of 25%, against 2019/20 activity levels.
    - Improving performance against **cancer waiting times** standards:
        - 62-day performance – ensuring that no more than 102 patients are waiting over 62 days by March 2024;
        - Delivering the Faster Diagnosis Standard of 75% by March 2024;
        - Increasing treatment volumes by 13%.
    - Ceasing having any **patients waiting for 12-hours** or more in our emergency departments by March 2024.
    - Significantly improving the number of patients waiting to be admitted to wards from the emergency department within one hour.
    - Maintaining utilisation of **Same Day Emergency Care** (SDEC) above national average and at 40%.
    - Significantly reducing the time **ambulances** wait in our current emergency departments to **handover** care to achieve the following:
        - 65% of handovers in under 15 minutes
        - 95% of handovers in under 30 minutes
        - No handovers waiting more than an hour
    - Opening our **new Integrated Acute Assessment Units** in DPOW and SGH during 2023, co-located with the new Emergency Departments opened during 2023/24.
    - Patients being seen more quickly in Emergency Departments: with the ambition to improve to 76% of patients being admitted, transferred or discharged within four hours by March 2024, with further improvement in 2024/25.
    - Supporting our ambulance service partners improve ambulance response times for Category 2 incidents to 30 minutes on average over 2023/24, with further improvement in 2024/25 towards pre-pandemic levels.
    - Improving the responsiveness and increasing the capacity of **community care** to support timely hospital discharge:
        - Achieving full geographic coverage urgent community response - 8am to 8pm, 7 days a week and cover all 9 clinical conditions or needs of the national 2-hour guidance;
        - Improving productivity so as to reach more patients in under 2 hours to exceed the minimum 70% threshold of people seen within 2 hours by December 2023;

- Completing the comprehensive development of virtual wards (including hospital at home) towards a national ambition of 40-50 virtual beds per 100,000 population by December 2023.

Trust Priority 4 – Reducing Health Inequalities

- We will work at system level to reduce pre-pandemic and pandemic related Health Inequalities, using related waiting list data that is embedded within performance frameworks to measure access, outcomes and experience for **BAME populations and those in the bottom 20% of IMD (Index of Multiple Deprivation)** scores.

- We will improve the length of stay for patients who have **alcohol dependency** from North East Lincolnshire (identified as an area of additional need) and provide support to manage and improve their health in the long term.

- We will provide additional support and treatment to **tobacco** dependent inpatients, high risk outpatients, and pregnant women under our care.

- Our **maternity services** will prioritise those women most likely to experience poorer outcomes, including women from BAME backgrounds and women from the most deprived areas.

- We will focus on ensuring that **patients with learning disabilities or autism** suffer no additional disadvantages when using or accessing our services, with a particular focus on waiting lists.

- We will strengthen our support to young people going through **transition** in their care to adult services.

Priority 5 – Collaborative and System Working

- Jointly with Hull University Teaching Hospitals (HUTH), we will implement Group executive leadership and associated governance collaborations.

- Jointly with HUTH, we will roll out to more specialties and further embed in those specialties already included, the Humber Clinical Collaboration Programme (formerly the Interim Clinical Plan.

- We will play a full part in the work of the **Humber and North Yorkshire Health and Care Partnership (Integrated Care Board)**, including the Collaborative of Acute Providers (CAP), the Community Collaborative, the three Place-based partnerships of North Lincolnshire, North East Lincolnshire, and the East Riding of Yorkshire, and associated clinical and professional networks.

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

- We will work together with partners across Humber and North Yorkshire to develop our approach to **population health management and prevention**.

Trust Priority 6 – Strategic Service and Estate Development and Improvement

- With partners in the **Humber Acute Services Review**, we will progress the Programme to Consultation in Q2 2023 with a view to having a Decision Making Business Case and Decision agreed by the end of Q4 2023/24.

- We will agree the approach that we will take to securing **Strategic Capital Investment** in our infrastructure with a focus on both DPoW and SGH. This will include identification of the potential capital investment and funding options and completion of Business Cases for agreement with the Trust Board and ICB.

- We will secure funding for the **Community Diagnostic Centre (CDC)** in Scunthorpe and design a procurement approach which allows the build to be complete by end of Q4 2023/2024; and we will develop an outline business case to support the procurement and build of a 'spoke' CDC scheme in Grimsby with a focus on ophthalmology by Q4 2023/2024.

- We will continue to invest **into our estates and equipment**, including new Same Day Emergency Care and Acute Assessment Units at both DPOW and SGH, and refurbishments of Theatres &7 & 8 at DPoW and A at SGH.

Trust Priority 7 - Finance

- We will achieve the **Trust's 2023/24 Financial Plan**.

- We will play our full part in the achievement of the 2023/24 Humber and North Yorkshire HCP **system financial control total**.

Trust Priority 8 – Digital

We will move towards a "smarter hospitals" environment while working within our current constraints, including by:

- Developing a consolidated Digital Strategy for NLaG and HUTH to enable joined-up working and to improve capacity to proactively engage with the business and clinicians to align Digital and IT Infrastructure to the wider organisation strategy.

- Completing the procurement for a single EPR for the four acute Trusts in the ICS, with a proposed implementation strategy to achieve HIMSS Level 5 Digital Maturity.

- Achieving final phase completion of shared PAS, new LMS at HUTH, single ICS Maternity Solution, Single Sign On, and Robotic Process Automation.

- Achieving approval for Enterprise Content/Document Management Systems. Digitising **Health Records** as a priority, followed by corporate paper processes to support paper-lite/paperless working.

- Creating a consolidated diagnostics plan including SharePlus (RIS), EIS, access and sharing between NLaG and HUTH and the wider ICS. This will include completion of the eye referral system from community to acute care.

- Expanding the tracking of RFID and Scan4Safety to enable real time collection of information.

- Reviewing and implementing a modern and combined network and hosting service to enhance security, capacity and deliver new and improved service levels 24/7 with capacity to support new digital innovations (i.e Artificial Intelligence, robotics).

- Reducing operational complexity through adopting best practice IT Service Management processes and accreditation to enable a high standard of performance excellence. Operate Sustainably through strong technology business management methods, capacity management, and programme prioritisation.

- Reviewing all applications in the estate against clinical and corporate priorities and the future view of the EPR systems to reduce complexity, reduce wasted cost and to enable infrastructure change.

- Continuing to develop digital skills and knowledge across the organisations engaging with end-users to foster a culture that embraces technology and leverages digital champions to support sustained digital transformation.

Trust Priority 9 – The NHS Green Agenda

- We will continue to promote, develop, and embed the **NHS Green agenda** into the Trust, specifically, procurement policies, staff energy champions, Net Zero Heroes, travel, waste, and recycling.

- Building on our success in eliminating single use plastic in all areas possible, we will increase the amount of waste we redirect for recycling, by reduce all waste streams and ensuring they are compliant with their routes for disposal

- At SGH, we will continue to explore all funding streams to provide **energy conservation** schemes to include a new energy centre. We are growing the use of electric and low emission fleet within the Trust vehicles with over 30% of the fleet now fully electric.

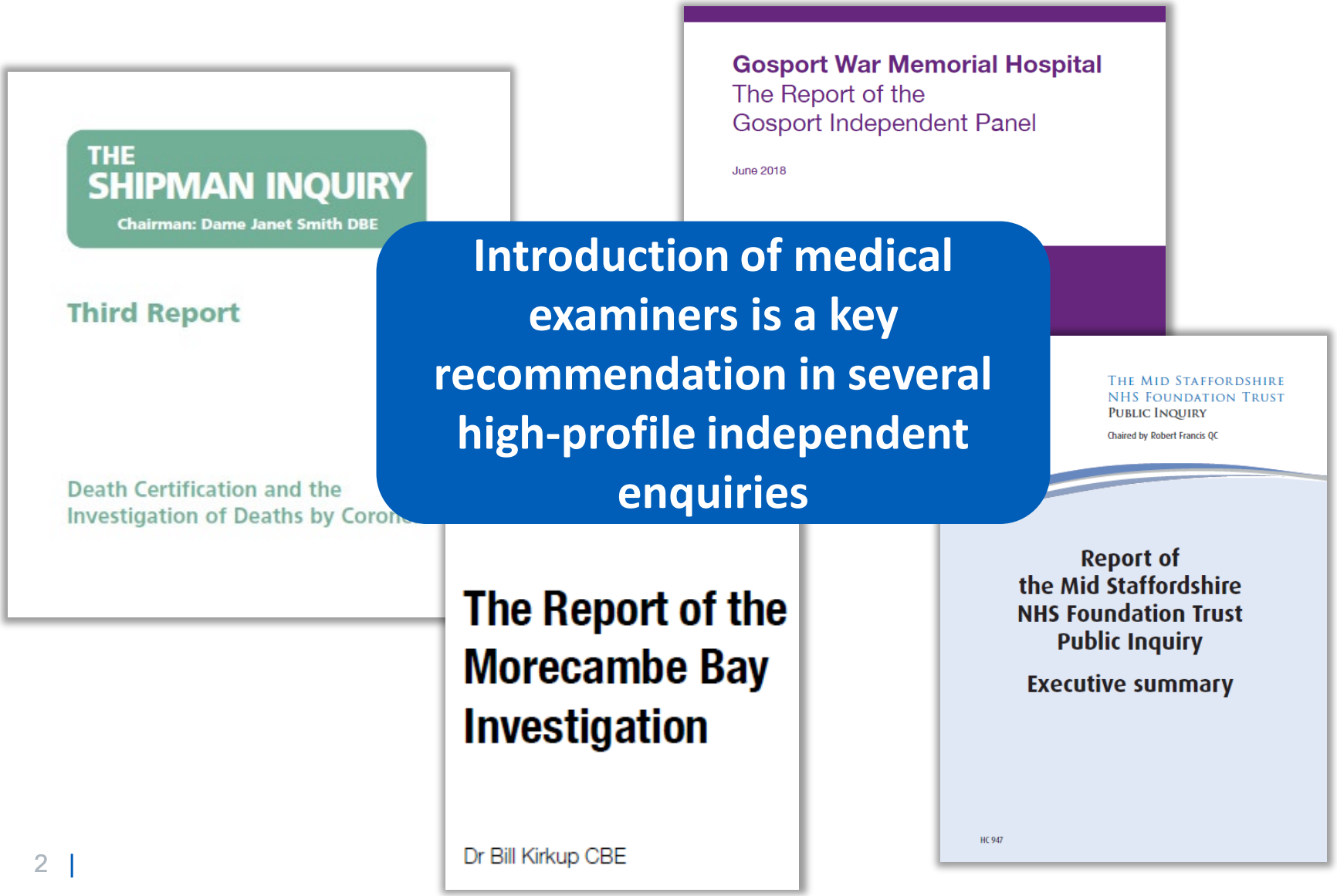
- At DPOW, we will continue to work with North East Lincolnshire Council to explore and develop a **district heating network** across the locality, including a new energy centre coupled with energy conservation measures such as LED lighting.

Medical Examiners: overview

Mr J G McAdam Lead Medical Examiner

Carolyn Phillips Lead Medical Examiner Officer

Why we need medical examiners



Why we need medical examiners

The introduction of medical examiners is designed to:

- provide bereaved people with opportunities to ask questions and raise concerns
- enhance safeguards for the public and healthcare providers through improved and consistent scrutiny of all non-coronial deaths
- improve the quality and accuracy of medical certification of cause of death, and ensure referrals to coroners are appropriate
- support local learning and improvement by identifying matters for clinical governance and related processes
- align with existing mortality initiatives

How we are implementing medical examiners

- Medical examiners form part of the DHSC's death certification reforms programme, which will create a statutory requirement for the medical examiner system.
- During 2019/20 NHS acute trusts were asked to set up medical examiner offices on a non-statutory basis.
- The medical examiner will become statutory from April2024
- The next step is to consider with local partners how medical examiner scrutiny can be extended to deaths in non-acute settings. Regional medical examiners will support medical examiner offices and partner organisations.

Coroners

A doctor may report a death to a coroner if the:

- cause of death is unknown
- death was violent or unnatural
- death was sudden and unexplained
- medical certificate is not available
- person not visited by a medical practitioner in final illness
- person not seen by the doctor who signed the medical certificate within 28 days before death or after they died
- death occurred during an operation or before the person came out of anaesthetic
- death may have been caused by an industrial disease or industrial poisoning

Patient Story – Medical Examiner reviewing a faith death

Agenda Number: CoG (07/23) Item: 3.2

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Dr Kate Wood, Chief Medical Officer	
Contact Officer/Author	Mr J G McAdam Lead ME, Carolyn Phillips Lead MEO	
Title of the Report	**Medical Examiners overview and patient story**	
Purpose of the Report and Executive Summary (to include recommendations)	To inform CoG about the Medical Examiner system and provide an example of the work in the form of a patient story.	
Background Information and/or Supporting Document(s) (if applicable)	PowerPoint presentation	
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

Agenda Number: CoG (07/23) Item: 4.1

Name of the Meeting	**Council of Governors**
Date of the Meeting	13 July 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Alison Hurley, Assistant Trust Secretary
Title of the Report	**Council Of Governors & Trust Board Engagement Policy**
Purpose of the Report and Executive Summary (to include recommendations)	The Engagement Policy outlines the mechanisms by which Governors and the Trust Board will interact and communicate with each other. This will support ongoing interaction and engagement, and takes into account the statutory role of Governors and their duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The policy has been reviewed and updated as per the usual cycle Document Control process to reflect: • general updates • the Health and Care Act 2022 • the Addendum (2022) to 'Your statutory duties – a reference guide for NHS foundation trust governors' • the NHS Code of Governance for Provider Trusts 2023 • additional details to add clarity to the various sections as noted. All additions are in blue and deletions are scored out and in red text to illustrate the changes made. CoG members are asked to consider the updates and approve the revised policy.
Background Information and/or Supporting Document(s) (if applicable)	**Council Of Governors Engagement Policy**
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 **To live within our means:** ☐ 3 - 3.1 ☐ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ✓ 5

	☐ 1 - 1.6 **To be a good employer:** ☐ 2	☐ Not applicable
Financial implication(s) (if applicable)	N/a	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/a	
Recommended action(s) required	✓ Approval ☐ Discussion ☐ Assurance	☐ Information ✓ Review ☐ Other: Click here to enter text.

*Board Assurance Framework (BAF) Descriptions:

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

Northern Lincolnshire and Goole NHS Foundation Trust

~~Chief Executive's Office~~ Director of Corporate Governance

COUNCIL OF GOVERNORS & TRUST BOARD ENGAGEMENT POLICY

Reference:	DCP231
Version:	3.0
This version issued:	July 2023
Result of last review:	Minor updates
Date approved by owner (if applicable):	
Date approved:	
Approving body:	Council of Governors / Trust Board
Date for review:	July 2026
Owner:	Helen Harris ~~Wendy Booth~~, ~~Trust Secretary~~ Director of Corporate Governance
Document type:	Policy
Number of pages:	16 (including front sheet)
Author / Contact:	Alison Hurley, Assistant Trust Secretary ~~Membership Manager~~

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

Contents

1.0 PURPOSE

This policy:

- outlines the mechanisms by which Governors and Executive and Non-Executive Directors (the Directors) will interact and communicate with each other to support ongoing interaction and engagement, and takes into account the ~~expanded~~ role of Governors, set out in the:
  - National Health Service (NHS) Act 2006
  - Health & Social Care Act 2012
  - Health and Care Act 2022 (the Act)
  - Addendum (2022) to 'Your statutory duties – a reference guide for NHS foundation trust governors'
  - NHS ~~Foundation Trust~~ Code of Governance for Provider Trusts 2023 (Appendix B, Section 1.2).
- This includes ~~including~~ the ~~new~~ duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors (detailed as the Trust Board);
- describes the methods by which Governors ~~may~~ are able to engage with the Trust Board in order to support each other with ongoing interaction and engagement, ensure compliance with the Regulatory Framework and specifically provide for those circumstances where the Council of Governors has concerns about:
  - the performance of the Trust Board;
  - compliance with the Trust's Provider Licence (as granted by the Act); or
  - other matters related to the overall wellbeing ~~the welfare~~ of the NHS Foundation Trust.
- ~~provides details of the independent panel for supporting Governors of Foundation Trusts in their role and to whom Governors may refer a question as to whether the Trust has failed or is failing to act in accordance with its Constitution.~~

2.0 AREA

2.1 Holding to Account definition

2.1.1 The Health and Social Care Act 2012 specified the duty of the Council of Governors is to hold the Non-Executive Directors individually and collectively to account for the performance of the Trust Board. The definition of this is open to interpretation, but broadly speaking this duty requires Governors to question Non-Executive Directors about how they have set the Trust's proposed strategy and forward plan and measured its performance against them, so that they are satisfied that the Board has acted to take the interests of members and of the public appropriately in to account and ensure that the Trust is not at risk of breaching its Licence. In performing this duty, Governors should keep in mind that the Trust Board manages the Trust and continues to

bear ultimate responsibility for the Trust's strategic planning and performance and must promote the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

2.1.2 The Health and Care Act 2022 additionally requires Governors to also hold Non-Executive Directors, individually and collectively, to account for the Trust's contribution to the delivery of the objectives for the local Integrated Care System (ICS), being Humber and North Yorkshire ICS.

2.1.3 The process of engagement between the Council of Governors and Trust Board is clearly one which is already ongoing and routine, however, this policy, agreed between the Trust Board and the Council of Governors, aims to outline existing and additional mechanisms which have been agreed and which will be used by the Trust to ensure communication between the Council of Governors and the Trust Board and ensure that Governors are able to discharge the above ~~new~~ ~~duty~~ duties effectively, harmoniously and recognising the different and complimentary roles of each body.

2.1.4 In support of the duty to hold to account, the Council of Governors also has the statutory power to require one or more of the Directors to attend a Governors' meeting for the purpose of obtaining information about the Trust's performance of its functions or the Directors' performance of their duties (and for deciding whether to propose a vote on the Trust's or Directors' performance). Whilst it is recognised that this power will rarely be exercised, should this power be invoked, it must be reported in the report and accounts. The aim of this policy is to have agreed levels of engagement which will eliminate or at least minimise the need of Governors to ever invoke this statutory power.

2.2 Raising Concerns/Resolution of Disputes

2.2.1 Where material concerns exist regarding the performance of the Trust Board, compliance with the Trust's Licence or matters relating to the general well-being of the Trust, this policy should be followed. This policy is not to be invoked for minor issues raised by an individual Governor. A concern, in the meaning of this policy, must be directly related to:

- the performance of the Trust Board;
- compliance with the Trust's Licence;
- the welfare of the Foundation Trust.

2.2.2 The procedure for a situation in which the Council of Governors as a whole is in dispute with the Trust Board is covered in section 42.0 ~~43.0~~ of the Trust Constitution. It is noted that the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute. The Chair has the authority to make a decision on behalf of the Trust, which will communicated in writing, to all members of both the Trust Board of Directors and the Council of Governors.

2.2.3 Governors should acknowledge the overall responsibility of the Trust Board for running the Trust and should not try to use the powers of the Council, or the provisions of this policy, to impede the Board in fulfilling its duty.

~~2.2.4 To support Governors in their new expanded role, Monitor has set up a 'Panel for Advising Governors of FTs' who may refer a question as to whether the Trust has failed or is failing to act in accordance with its Constitution. The Council of Governors should only consider referring a question to the panel in exceptional circumstances, where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Chair or another Non-Executive Director. Please also see section 4.1.3 below.~~

3.0 DUTIES IN RELATION TO COMMUNICATION AND ENGAGEMENT

3.1 Throughout this document the Vice Trust Chair will deputise for the Trust Chair if and as required.

3.2 Trust Chair~~man~~/Vice Chair

The Trust Chair~~man~~/Vice Chair:

- acts as the principal link between the Council of Governors and the Trust Board ~~He/she~~ and will therefore, have the main role in dealing with any issues raised by Governors, and will involve the Chief Executive and/or the ~~Director of~~ Chief Finance Officer and other Directors as necessary;
- ensures that the Trust Board and Council of Governors work together effectively and enjoy constructive working relationships (including the resolution of any disagreements);
- ensures good information from and between the Trust Board, Committees, Council of Governors and members and between the Senior Management and Non-Executive Directors, members of the Council of Governors and Senior Management;
- ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties;
- constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate);
- encourages the participation of the Trust Board in the induction, orientation and training of Governors as required.

3.3 Chief Executive

The Trust Chief Executive:

- ensures the provision of information and support to the Trust Board and Council of Governors and ensures that Trust Board's decisions are implemented;

- facilitates and supports effective joint working between the Trust Board and Council of Governors;

- supports the Trust Chair~~man~~ in ~~his/her~~ their task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Board, elected and appointed members of the Council of Governors and between the Trust Board and Council of Governors;

- with the Trust Chair~~man~~, ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties;

- with the Trust Chair~~man~~, constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate);

- supports the Trust Board to request the Trust Chair to seek the views of the Council of Governors on such matters as the Trust Board may from time to time determine.

3.4 **Senior Independent Director**

The Senior Independent Director:

- can act~~s~~ as an alternative source of advice to Governors from the Trust Chair;

- shall be available ~~to members and~~ to Governors if they have concerns which contact through the normal channels of the Trust Chair~~man~~, Chief Executive and ~~Finance Director~~ Chief Finance Officer has failed to resolve any issues which have been raised or for which such contact is inappropriate.

3.5 **Governors**

- Individual Governors have a responsibility to act in accordance with this policy, to raise concerns (as defined in this policy), and to assure themselves that issues have been resolved. In addition, the Council of Governors as a body has a duty to inform NHS England ~~Monitor~~ if the Trust is at risk of breaching the terms of its Licence.

- The Lead Governor shall make themself available to provide informal advice to any Governor who may seek it in advance of a concern being raised with the Director of Corporate Governor or the Trust Chair.

3.6 **Director of Corporate Governance**

As Trust Secretary for the Trust, the Director of Corporate Governance shall:

- be a further point of contact for any Governor or group of Governors who wish to raise a concern covered by this policy, and where possible,

resolve the matter informally and/or advise as to whether it is appropriate to the take the concerns to the Chair; and

- arrange informal meetings between Governors and Directors (including the Trust Chair and the Chief Executive) outside of formal Council of Governor meetings to answer questions and confirm decisions taken by the Trust Board (where appropriate) where requested to do so by the Trust Chair.

4.0 ACTIONS

4.1 Holding to Account

4.1.1 The relationship between the Council of Governors and Trust Board is critical and there are a number of ways an open and constructive relationship can be achieved between the two. ~~Board members~~ Non-Executive Directors and Governors should have the opportunity to meet at regular intervals and Governors should feel comfortable asking questions regarding the management of the Trust. Executive Directors should keep Governors appropriately informed, particularly about key Board decisions and how they affect the Trust and the wider community via their reports to Board committees and the subsequent Committee Highlight Report to the Governor Assurance Group and Trust Board meetings. Governors are also invited to attend Trust Board meetings and have access to the associated documentation.

4.1.2 Governors will hold the Trust Chair and other Non-Executive Directors to account partly through effectively undertaking the specific statutory duties summarised here:

- Governors are responsible for appointing the Chair and other Non-Executive Directors and may also remove them in the event of unsatisfactory performance;
- Governors have the right to receive the annual report and accounts of the Trust, and can use these as the basis for their questioning of Non-Executive Directors;
- Governors have the power to appoint or remove the external auditor;
- Directors must take account of Governors' views when setting the Forward Plan for the Trust, giving Governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in the strategy. ~~Since 1 October 2012,~~ Where Directors put a proposal in the forward plan for an activity outside of the principal purpose of the Trust, the Governors must decide whether carrying on the activity, to any significant extent, interferes with the Trust's principal purpose, and must notify the Directors of its determination. However, Governors should understand there may be valid reasons why member views cannot always be acted upon.

Governors and Non-Executive Directors should have enough time to discuss these matters so Governors can be satisfied with the reasons behind the Board decisions;

- ~~since 1 October 2012,~~ Governors have ~~also had~~ the ~~specific~~ power of approval on any proposal by the Trust Board to increase non-NHS income by 5% a year or more. They therefore need to be satisfied with the reasons behind any such proposals;

- Governors also have the power to approve amendments to the Trust's Constitution, approve 'significant transactions' and approve any mergers, acquisitions, separation or dissolution and will need to be satisfied with the reasons behind any proposals (as per Section 45 of the Trust Constitution).

4.1.3 It is clear that there are already a number of well-defined mechanisms in existence within the Trust for Governors to receive or seek information from and hold the Board and the Directors and Non-Executive Directors to account including:

- receiving the agenda and minutes of Board meetings and requesting any specific papers. Governors are also invited to attend Trust Board meetings and have the opportunity to ask questions as public members on the contents of the Board minutes and decisions at Council of Governor meetings;

- receiving the annual report and accounts and asking questions on their content;

- receiving the annual Quality Account and asking questions its content;

- receiving in-year information updates e.g. finance, performance ,quality and workforce ~~mortality~~ and asking questions on their content;

- receiving performance appraisal information for the Trust Chair and other Non-Executive Directors, via the Appointments & Remuneration Committee, and using this to inform decisions on remuneration for the Trust Chair and the other Non-Executive Directors;

- the attendance of the Chief Executive, other Executive and Non-Executive Directors at Council of Governors meetings and using these opportunities to ask them questions;

- the attendance of the Chief Executive, other executive and Non-Executive Directors at the annual review of performance of the Council of Governors;

- receiving information on internal consultations, developments and media releases;

- ~~briefings from the Chief Executive and Chairman for Governors leading on the Governor/member clinics for their constituencies~~

- receiving information on issues or concerns likely to generate adverse media interest and providing Governors with the opportunity to raise questions or seek information or assurances;

- involvement of Governors in the Trust's strategy and planning process through the holding of an annual planning / briefing session for Governors led by the Chief Finance Officer ~~Director of Finance, Planning & Performance.~~

4.1.4 The following additional measures (some of which are mandatory under the Health & ~~Social~~ Care Act), are intended to support Governors in their ~~extended~~ role and to ensure that Governors are well briefed about the decisions which they may be required to make and the context in which the Trust Board is working. This includes the requirements of relevant external stakeholders including Commissioners, NHS England and the Care Quality Commission, have and are being introduced:

- engagement with Directors to share concerns or raise questions about performance, such as by way of joint meetings between the Council of Governors and Non-Executive Directors (which can be conducted within the Governor Assurance Group) or separately and without the Trust Chair~~man~~ (and in private) if required;

- ~~a briefing from the Trust Chairman and Chief Executive to precede each meeting of the Council of Governors. The briefing will cover the agenda and any matters on the agenda which the Trust Chairman and Chief Executive consider requires special attention. There will be sufficient time for Governors to ask questions on any item on the agenda;~~

- receiving information on proposed significant transactions, mergers, acquisitions, separations or dissolutions and questioning the Directors on these;

- receiving information on documents relating to non-NHS income, in particular any proposals to increase this by 5% a year or more, and questioning the Directors on these;

- the holding of Governor briefing and training opportunities ~~annual development workshops~~ – not least in order to ensure that Governors are equipped with the skills and knowledge they require in order to fulfil their ~~expanded~~ role;

- the attendance of the Chair of the Governor Assurance ~~Steering~~ Group at meetings to set the agenda for the Council of Governors;

- each Council of Governors meeting to ~~be preceded by~~ include a briefing(s) for Governors from the Trust Chair~~man,~~ Chief Executive or appropriate Executive Director or senior officer;

- the submission of a formal bi-monthly briefing from the public Trust Board to Governors on key decisions made following each Board meeting;

- the provision of an annual report to the Governor Assurance ~~Steering~~ Group from each Trust Board ~~sub-~~committee Chair to include the outcome of the annual review of performance and in turn a report from the Governor Assurance ~~Steering~~ Group to the full Council of Governors;

- Governors have ~~already taken the decision to~~ elected a Lead Governor and Deputy Lead Governor. These roles have specific responsibilities in terms of Governor and Board engagement ~~might also be~~ built into the role description for ~~this~~ these positions. ~~There are already~~ Joint meetings regularly take place between the Chair~~man~~, ~~and~~ Lead Governor, Deputy Lead Governor and~~. These are being formalised to include an agenda for and written record of the meeting. The Trust Secretary~~ the Director of Corporate Governance. ~~will attend part of these meetings. Dates and times of~~ Feedback from these meetings is provided ~~will be are published in the Annual Calendar of Events and will be are available to all members of the Council of Governors. The highlights report of the most recent meeting of the Trust Board will be a standing item on the agenda for the meeting. The minutes from these meetings will be submitted~~ to the Governor Assurance ~~Steering~~ Group;

- ~~the direct involvement of individual Governors with the Non-Executive Director appraisal process, possibly through the Lead Governor.~~

- ~~Non-Executive Directors will, in future, chair the plenary sessions at the Annual Review of Performance of the Council of Governors.~~

4.1.5 Additional statutory means available to Governors for holding Non-Executive Directors to account (where serious concerns exist and in extreme circumstances):

- dialogue with ~~Monitor~~ NHS England via the lead Governor. **Note**: "The existence of a lead Governor does not, in itself, prevent any Governor making contact with ~~Monitor~~ NHS England directly if they feel it is necessary" but see also 4.3.3 below.

- ~~putting questions to the new Monitor Governor Panel where the circumstances meet the requirements in the 2012 Act – see section 4.3.3 below.~~

4.2 Raising Concerns

4.2.1 Governors should not raise concerns that are not supported by evidence. That evidence must satisfy the following criteria:

- any written statement must be from an identifiable person or persons who must sign the statement and indicate that they are willing to be interviewed about its contents;

- other documentation must originate from a bona fide organisation and the source must be clearly identifiable.

4.2.2 Newspaper or other media articles will not be accepted as prima facie evidence, but may be accepted as supporting evidence.

4.2.3 Governors (operating as a group or on their own) may raise concerns in the following circumstances:

- the performance of the Trust Board;

- compliance with the Trust's Provider Licence; or

- other matters related to the overall wellbeing of the Trust.

4.2.4 Notwithstanding the central role of the Trust Chair~~man~~ in providing the link between the Council of Governors and the Trust Board, it is highly recommended that any Governor or group of Governors who have concerns covered by this policy should, in the first instance, consult the ~~Trust Secretary~~ Director of Corporate Governance for advice and guidance. They ~~He/she~~ will seek to resolve the matter informally and will certainly be able to advise the Governor/s on the acceptability of the evidence offered and so whether it is appropriate to take their concerns to the Trust Chair~~man~~. The advice of the ~~Trust Secretary~~ Director of Corporate Governance is not, however, binding upon the Governor/s and they retain at all times the right to raise the matter with the Trust Chair~~man~~. For concerns which it would be inappropriate to raise with the Trust Chair~~man~~, for example, regarding his or her own performance, the role of the Trust Chair~~man~~ as described in this section will be undertaken by the Senior Independent Director.

4.2.5 The Trust Chair~~man~~ (or Vice-Chair if the dispute involves the Chair) shall investigate all concerns brought to ~~him/her~~ them by Governors, involving the Chief Executive and/or the ~~Director of~~ Chief Finance Officer ~~& Performance Management~~ at ~~his/her~~ their discretion. The Trust Chair will endeavour to resolve the dispute informally, through discussions within the Council of Governors following investigation which shall include a review of the evidence offered and discussions with Trust officers as appropriate.

4.2.6 As soon as practicable after the conclusion of the investigation the Trust Chair~~man~~ shall meet with the Governor/s to discuss the findings. This meeting has three possible outcomes:

- the Governor/s are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required;

- the Governor/s are satisfied that their concerns have been resolved during the course of the investigation. The Trust Chair~~man~~ shall write a report on

the concerns and the actions taken and present this the Council of Governors;

- the matter is not resolved to the satisfaction of the Governor/s. The Trust Chair~~man~~ shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if two thirds of the Governors present agree, to invoke the escalation process described from section 4.3.1 onwards.

4.3 Escalating Concerns

4.3.1 At this stage of the process the Senior Independent Director takes over the lead role from the Trust Chair~~man~~. Should the Senior Independent Director be unavailable, or be prevented from participating because of a conflict of interest, then the Council of Governors may choose any other Non-Executive Director to fulfil the role.

4.3.2 The first duty of the Senior Independent Director is to establish the facts of the matter. This will be accomplished by reviewing the evidence offered by the petitioner/s, the process of the investigation and any documentation produced and also by meetings/interviews with the Governor/s and any Trust officers involved. In carrying out this process the Senior Independent Director shall seek the agreement of all interested parties and shall have the authority to commission whatever legal or other advice is required.

4.3.3 Once the facts are established to ~~his/her~~ their satisfaction, the Senior Independent Director shall make a decision on the course of action to be followed in the best interests of the Trust and shall describe the reasons for that decision in a written report. The decision of the Senior Independent Director shall be binding upon the Trust. In the first instance, the Senior Independent Director shall present the decision and the report to the Governor/s and to interested parties within the organisation.

4.3.4 The Trust Chair~~man~~ shall then, at the request of the Senior Independent Director, call a closed extra-ordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution. The purpose of this meeting, and the sole item on the agenda, will be for the Senior Independent Director to present his or her report and decision and for the council to give its response. Three outcomes are possible:

- the Council accepts the decision of the Senior Independent Director. In this case no further action is necessary;

- the Council does not accept the decision of the Senior Independent Director but chooses not to escalate the matter further. No further action is prescribed by this policy but the Council of Governors may choose to keep the matter under review at future meetings;

- the Council votes to refer a question for legal review ~~or make a formal notification to the Panel for Advising Governors of FTs~~. The seriousness of the latter cannot be overemphasised. If such a question or any other important issue or uncertainty arises, Governors should always seek to discuss it in the first instance with the Trust Chair or another Non-Executive Director. ~~Monitor~~ NHS England strongly encourages all FTs and Governors to try to resolve questions internally before posing a question for legal review ~~to the Panel~~ only as a last resort. The Council of Governors should only consider referring a question for legal review ~~to the Panel~~ in exceptional circumstances, where there is uncertainty within the Council about whether the Trust may have failed, or is failing, to act in accordance with the Trust's Constitution or with Chapter 5 of the 2006 Act, and this uncertainty cannot be resolved through repeated discussions with the Trust Chair or another Non-Executive Director.

  A Governor may only refer a question for legal review ~~to the Panel~~ if more than half of the members of the Council of Governors voting approve the referral. Individual Governors may not bring a question for legal review ~~to the Panel~~ without the approval of the Council as a whole. ~~The panel will then decide whether to carry out an investigation on a question referred to it. If an investigation is carried out, the panel will publish a report on the conclusion.~~ It is noted that once a legal response is provided, the Trust will not necessarily be required to adhere to the ~~panel's decision~~ legal advice provided.

5.0 MONITORING COMPLIANCE AND EFFECTIVENESS

This policy will be kept under review, compared with the provisions developed by other Foundation Trusts and revised in accordance with emerging best practice and national guidance ~~from Monitor~~.

6.0 ASSOCIATED DOCUMENTS AND REFERENCES

~~6.1 The NHS Foundation Trust Code of Governance, Monitor, 2014~~

6.2 NHS Code of Governance for Provider Trusts 2023

6.3 Trust Constitution

6.4 Monitor Your statutory duties: a reference guide for NHS Foundation Trust Governors, Monitor, 2013

6.5 Addendum to 'Your statutory duties – a reference guide for NHS foundation trust governors' 2022

6.6 National Health Service (NHS) Act 2006

6.7 Health & Social Care Act 2012

6.8 Health and Care Act 2022 (the Act)

7.0 DEFINITIONS

Chair means the Trust Chair of the Trust appointed in accordance with the Constitution.

Chief Executive means the Chief Executive (and Accounting Officer) of the Trust appointed in accordance with the Constitution.

Constitution means the Constitution of the Trust.

Council of Governors means the Council of Governors of the Trust as constituted in accordance with the Constitution .

Director means a person appointed as a Director on the Board of Directors (whether executive or Non-Executive Director) in accordance with the Constitution.

Director of Corporate Governance is the Company/Trust Secretary of the Trust.

Governor means a member of the Council of Governors, being either an elected or an appointed Governor.

Independent Regulator the independent regulator of Foundation Trusts known as is NHS England (NHSE), previously Monitor.

Lead Governor means one Governor appointed by the Council of Governors to communicate directly with Monitor in certain circumstances.

~~**Monitor**~~ **NHS England** is the independent regulator of NHS Foundation Trusts and Trusts (and superceded Monitor)

Petitioner(s) is a Governor or Governors raising concerns under this policy.

Provider Licence means the Trust's provider licence granted by the Independent Regulator under section 87 of the NHS Act 2006.

Senior Independent Director means the Non-Executive Director appointed by the Trust Board to provide an alternative to the Trust Chair~~man~~ as source of advice to Governors.

Trust means the Northern Lincolnshire and Goole NHS Foundation Trust.

Trust Directors means the Board of Directors as constituted in accordance with the Constitution.

8.0 DISSEMINATION

8.1 This policy will be made available to Trust staff as a controlled document ~~in~~ on the ~~Chief Executive's section of the~~ intranet/hub.

8.2 This policy will be distributed ~~in hard copy~~ to all Governors as soon as possible after their election or appointment and whenever it is revised.

9.0 CONSULTATION

9.1 Council of Governors.

9.2 Trust Board.

10.0 EQUALITY ACT (2010)

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

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

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

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

11.0 FREEDOM TO SPEAK UP

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this policy, please speak in the first instance to your line manager. Guidance on raising concerns is also available by referring to the Trust's Freedom to Speak Up Policy and Procedure (DCP126). Staff can raise concerns verbally, by letter, email or by completing an incident form. Staff can also contact the Trust's Freedom to Speak Up Guardian in confidence by email to nlg.tr.ftsuguardian@nhs.net. More details about how to raise concerns with the Trust's Freedom to Speak Up Guardian or with one of the Associate Guardians can be found on the Trust's intranet site.

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

Agenda Number: CoG (07/23) Item: 5.1

Name of the Meeting	**Council of Governors**
Date of the Meeting	13 July 2023
Director Lead	Dr Kate Wood, Chief Medical Officer
Contact Officer/Author	Fiona Moore, Head of Quality Assurance Richard Dickinson, Associate Director of Quality Governance
Title of the Report	**Annual Quality Account 2022/23**
Purpose of the Report and Executive Summary (to include recommendations)	Each year the Trust is required to publish an annual Quality Account by the national deadline of 30th June 2023. The attached paper is the final version of the Quality Account which has been published and is available on the Trust's website in accordance with national guidance. The Quality Account provides an overview of the Trust's performance, particularly the progress made against the Quality Priorities for 2022/23 and sets out future priorities going into 2023/24. As per national guidance no external audit was required for this year's publication. However, the Trust commissioned Audit Yorkshire to undertake an internal audit to gain assurance that the Trust has appropriate and effective controls in place to ensure it produces a robust Quality Account in line with national guidance. The review found that adequate arrangements have been put in place to ensure timely completion of the Quality Account, and that data reported within the Quality Account is accurate, up to date and from a reliable source. No formal recommendations were made. The Trust shared the Quality Account with stakeholders from the ICBs, Healthwatch, local Council Overview and Scrutiny Committees and the Trust Governors. All of whom provided positive responses that are included in the final publication.
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)	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

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2022/2023

Kindness · Courage · Respect

CONTENTS

PART 1: Statement on quality from the Chief Executive of the Northern Lincolnshire and Goole NHS Foundation Trust

After two years dominated by responding to the COVID-19 pandemic directly the 2022/23 financial year was a year of coping with the indirect consequences of it. The most obvious impact of the pandemic has been the increase in the number of patients waiting for operations and procedures across the country. At our Trust we saw an increase although it was proportionately lower than many other areas as we did everything we could during the pandemic to keep our operating theatres running. Given this we were asked to provide support to other local hospitals – in particular Hull and, to a lesser extent, York – and take some patients from their waiting lists. This work amounted to several hundred patients.

Another consequence of the pandemic has been the impact it has taken on our staff. After two of the toughest years the NHS has ever faced our staff started the 2022/23 year tired, stressed and facing a difficult year in terms of both their work and the economic climate they were facing. I must report, as I have in my statements in previous Quality Accounts, our staff responded superbly to all the challenges put in front of them throughout the year. Throughout our hospital, community services, pathology services and support functions our teams went above and beyond, again and again, to do everything they could to care for patients and provide services. As in previous years we continued to experience growing demands – for example from patients attending our Emergency Departments (EDs) and in responding to changing guidance and to discharging patients from our wards. And all this in some working environments which are not always the best to work in and in some services where we are carrying more staff vacancies than we would want. Our staff coped incredibly with all this, and more – I want to thank them publicly through this statement for everything they have done in the past year.

Despite the pressures our staff faced and their own levels of tiredness they still managed to achieve some fantastic results. I should start by noting the Trust's continued and sustained performance in its Summary Hospital-level Mortality Indicator (SHMI). The SHMI reports on mortality at trust level across the NHS in England using a standard and transparent methodology and is one of the best overall indicators for the delivery of safe services in hospitals. It is the ratio between the actual number of patients who die following hospitalisation at the Trust and the number that would be expected to die based on average England figures, given the characteristics of the patients treated. At the time of writing (April 2023) the Trust had a SHMI of 101.35 for the period December 2021 to November 2022. This was in the 'as expected' banding, was a lower score than the previous month (102.79 - 'as expected', November 2021 to October 2022) and the lowest ever SHMI score for the Trust since the figure was first introduced. It is also above the median for all trusts in England, a dramatic improvement on just a few years ago, when the Trust was consistently among the very worst performers in the country. This really is an excellent performance in a key indicator.

Another key indicator of the quality and safety of the services provided by hospitals is the results of a Trust's Care Quality Commission (CQC) inspection. I'm pleased to report the Trust achieved what is necessary to leave the Quality Special Measures it

has been in since 2017 after a CQC inspection in June and July 2022 recognised many improvements in the Trust's hospitals. Published in December 2022, the CQC's report recognises efforts to improve leadership, culture, safety, complaints and to tackle our waiting lists. Inspectors said they saw many good examples of patients receiving compassionate care, with staff ensuring patients' privacy and dignity were maintained and it was evident that staff worked hard to achieve the best possible outcomes for people throughout the services they inspected. The Trust is no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Scunthorpe General Hospital and the Diana Princess of Wales Hospital in Grimsby are both rated 'Requires improvement' and Goole and District Hospital is rated 'Good' overall. The Trust's community services were not inspected on this occasion. The CQC grade our services across our three hospitals in 112 'service domains'; we saw improvements across 35 of these 'service domains' and saw a reduced grading in only two. The CQC inspection covers five areas; Safe, Effective, Caring, Responsive and Well Led. At a Trust level Caring is 'Good' across the board and Safe, Effective, Responsive and Well Led are rated 'Requires Improvement'.

The CQC also releases the results of several patient surveys it undertakes throughout the year and we have seen improvement in those scores too. There was improvement in the feedback regarding our maternity services and I was particularly pleased to see the positive changes in our national inpatient results (which surveys patients who have stayed in hospital for one night or more) after the Trust was showing as an outlier in 2019. We have also seen some huge improvements in where we see and treat patients. We invested more than £35 million in the construction of new Emergency Departments in both Grimsby and Scunthorpe. Not only are these units twice the size of those they replace, helping us to meet the growing demand for our care, but our clinical teams have been involved in the design and build from the very beginning. In doing so, they have ensured that everything from the layout of the building to the location of equipment has been designed around what is best for our patients. Work is now underway on the refurbishment of our former Emergency Departments to convert them into Acute Assessment Units and Same Day Emergency Care provision, with both expected to open later in 2023. We also completed a series of smaller schemes, which are providing significant benefits to our patients. These included at Grimsby: a fully upgraded oxygen supply system, replacing the aging structure we previously had in place with a modern system that allows us to provide a consistent strong level of flow across the site; installing state-of-the-art digital X-ray equipment; creating a new lung function testing area; installing a second CT in our new Emergency Department; the demolition and removal of the temporary building which once housed our Critical Care Unit; and improving the safety of all patients, staff, and visitors to the site by installing a new fire alarm system. At Scunthorpe we have undertaken a full refurbishment of Ward 25, which has been transformed into a light and airy space, purpose built to limit the spread of infection; fully refurbished our fluoroscopy facilities and installed new equipment; installed new Maxillio Facial facilities to boost these services; and replicated the mortuary improvement works being done at Grimsby.

So, an incredible year of change and progress at the Trust. Of course, not everything has gone as we would have wanted. Because of our hospitals being so often full, too often patients waited a long time to be seen and treated in our EDs or to be transferred to a ward, and this meant that, with our EDs full, we didn't always have the space in our

EDs to take patients out of ambulances as quickly as we wanted to help the ambulance crews attend other calls. And, despite some great work which you can read about later in the document, we still have much work to do to improve the experience of patients who are reaching the end of their life. An area where we still, sadly, see ratings of 'Inadequate' from the CQC. Improving our end-of-life provision remains a key priority for the Trust in the coming year, as it has been in previous years.

As it has been in previous years our challenge for 2023/24 remains the same: to make sure our staff are able to offer the best possible patient care, by looking after them (our staff) and supporting them as they recover from such an intense few year, whilst at the same time doing everything we can to maintain our waiting lists and managing the increased demand we are experiencing for urgent care. If anyone can manage to do this, our staff can; they are superb and deserve huge credit. Once again, very many thanks to them all.

I can confirm that the Board of Directors has reviewed the 2022/23 Quality Account and can confirm that to the best of my knowledge, the information contained within this report is an accurate and fair account of our performance.

Signature:

Chief Executive and Accountable Officer: Dr Peter Reading
Date: 14 April 2023

About Northern Lincolnshire and Goole NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust (referred to as 'the Trust' throughout this report) consists of three hospitals and community services in North Lincolnshire and therapy services at all our sites. The Trust provides acute hospital services and community services to a population of more than 450,000 people across North and North East Lincolnshire and East Riding of Yorkshire and has approximately 750 beds across three hospitals. The site locations are:

- Diana, Princess of Wales Hospital in Grimsby (also referred to as DPoW),
- Scunthorpe General Hospital located in Scunthorpe (also referred to as SGH),
- Goole & District Hospital (also referred to as GDH), and
- Community nursing services in North Lincolnshire.

The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to reflect that the Trust did not just operate hospitals in the region. The Trust is now known as **Northern Lincolnshire and Goole NHS Foundation Trust.**

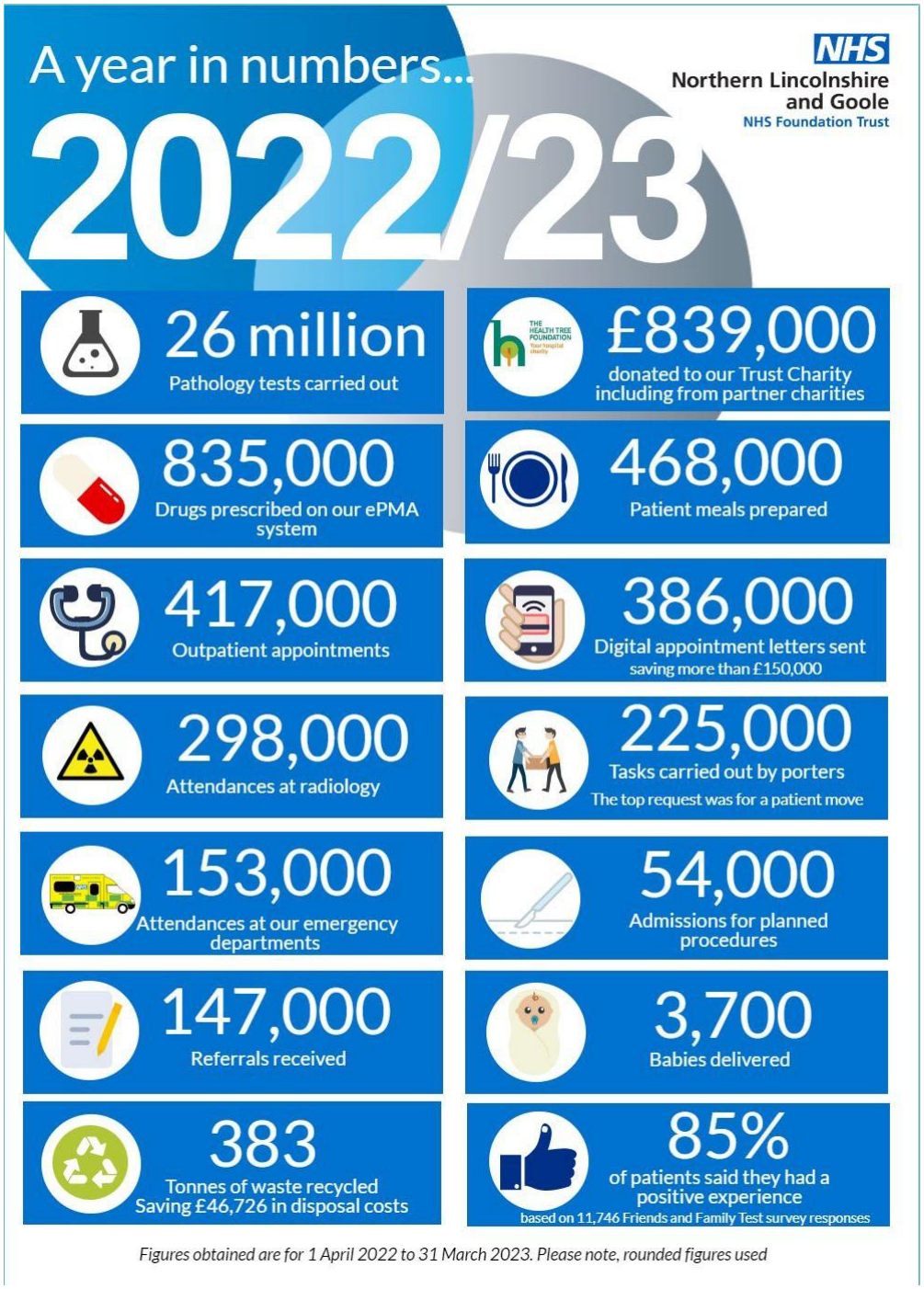


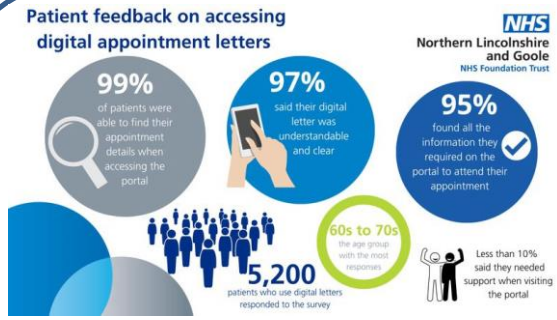
Figure 1: 2022/23 - A year in numbers

Proud Moments of 2022/23

The Trust was proud to be shortlisted as finalists in two categories at the 2022 Health Service Journal (HSJ) Partnership Awards which recognise outstanding contribution to healthcare. Staff have been working hard to get patients who are fit to leave hospital home as soon as possible. The Discharge Improvement Project, which has been a whole system effort across Northern Lincolnshire, has been recognised in the Integrated Care Partnership of the Year category. As a result of our efforts over the last two years the Trust is well under the national average for 'long length of stay' figures which reflect the length of time patients stay in hospital and is one of the best performing trusts in the North. The success of North Lincolnshire's vaccination programme was also recognised in the Covid Vaccination Programme category.

The Trust's latest CQC report showed an improving picture with the Trust no longer rated 'Inadequate' for safety in any of its services and has maintained its 'Requires Improvement' rating. Goole & District Hospital was rated as **Good** overall and the Diagnostic Imaging Core Service was highlighted for 'Outstanding practice'.

The Trust's infection control rates are among the lowest in England.



Our move over to digital appointment letters in Outpatients has been featured in a national digital playbook. The article covers the scope of the project, the functionality and the benefits to patients and staff. It highlights how the Trust have saved £152,000 in the first year, after switching over to digital letters.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase and celebrate QI initiatives from across the trust. It has over 160 QI projects documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Showcase allows staff to share their QI journey with others enabling cross divisional learning whilst inspiring and empowering colleagues to undertake their own QI projects.

Proud Moments of 2022/23

April Schwartz Round

Introduction of Schwartz Rounds offering a safe, reflective space for staff to share stories with colleagues about their work and its impact on them. The Rounds increase feelings of compassion towards patients, improve communication, and create more openness to receiving support.

First internationally educated midwives joined the Trust from their home country of Ghana. They will be supported through the Trust's preceptorship programme.

Development of two new EDs and AAUs. This has been supported by a significant national capital investment of £25m.

A range of improvements to clinical and education environments, mammography room at Grimsby and a maxillofacial room, a HYMS room and a fluoroscopy room at Scunthorpe, supported through charitable funding.

Introduction of Maternity triage telephone service. The service, which is for anyone who has medical concerns in pregnancy from 16 weeks onwards, has taken 3,500 calls since it launched on 31 October 2022. It is receiving great feedback and providing an invaluable service. Phase 3, which will see dedicated triage areas for people to attend at Scunthorpe and Grimsby, is coming soon.

We continue to see areas achieve good and outstanding in the 15 steps Programme. This is a continuous audit cycle that allows us to observe the environments from which we deliver care, review our documentation and through patient and staff feedback, highlight good practice and areas for improvement.

Proud Moments of 2022/23

The End of Life team were shortlisted in the Nursing Times Awards for team of the year.

The team, who work across hospitals in Scunthorpe, Grimsby, and Goole, as well as in the North Lincolnshire community, have been recognised for their commitment to improve End of Life care to our patients.

When a patient is near the end of their life, we support them and their loved ones to make it as comfortable as possible in line with their wishes for how they would like to be cared for.

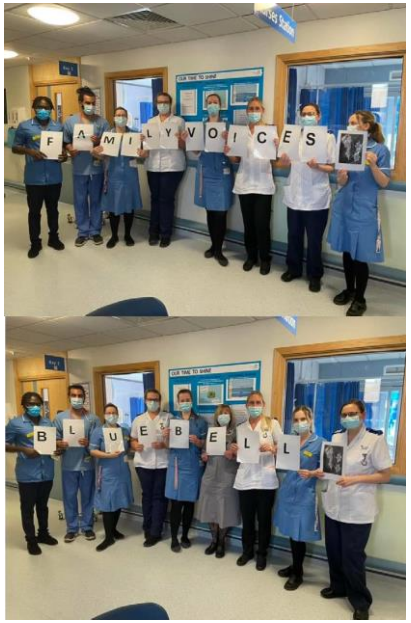
The Bluebell Principles, rolled out across the Trust, focus on better communication with the patients and family, recognising the signs of someone dying and developing individual care plans for each patient to ensure the care we provide is patient-centred, holistic, and consistent.

Sixty-eight End of Life Champions have also been trained to lead on the Bluebell Principles and support colleagues in their areas.

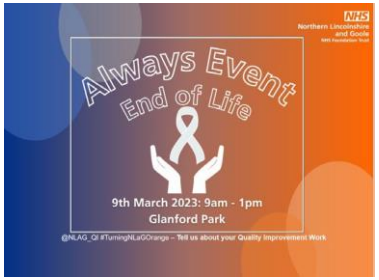
The Bluebell logo has been introduced and will be used in several ways when patients are at the end of their life. A simple Bluebell displayed on the room door of patients who are near the end of their life tells any staff entering the room the person is at the end of their journey with us. Bluebells symbolise humility and kindness, two important qualities to show our patients.

During the pandemic, many of our staff were faced with caring for patients at the end of their lives. Our hope is the Bluebell Principles will support any member of staff privileged enough to care for someone at such an important time of their lives and lead to even better patient care.

The Trust recognises that early recognition of patients at End of Life and support for patients and families goes beyond the End-of-Life team and is everyone's responsibility.



The Trust held an End-of-Life Quality Improvement 'Always' Event in March 2023 which focussed on understanding how we can support recognition and appropriate care planning for people who are approaching End of Life on our wards. Emerging themes and what good looks like will be the focus of our End of Life Quality Priority, Quality Improvement work in 2023/24.



Gareth's Story

Patient stories are recognised as providing valuable awareness and can help inform the Trust about current and ongoing patient experience or patient safety issues, which can generate debate, learning and actions.

Patient stories tend to be both objective and subjective, highlighting what happened and how that made someone feel. Getting the experience of care right is of the upmost importance to the Trust and we want everyone to receive the care and treatment they require, and this means that sometimes we may have to do things a bit differently, to get that same safe care and treatment outcome.

Gareth and his mum wanted to share their positive experience with us, following working with our Learning Disability Nurse Specialist, Emma Watts. Ensuring Gareth received the treatment he needed meant Emma and our staff worked with him, and his mum, over several weeks before his treatment date to ensure his visit went both smoothly and safely.

Gareth sums up his own experience below and details the collaborative approach used in delivering safe, person centred care.

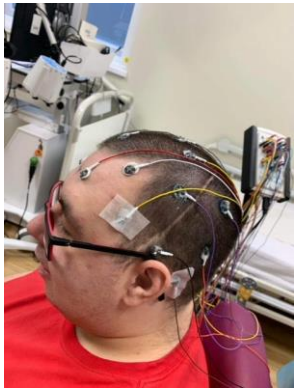
My name is Gareth, I am 28 years old with a learning disability, autism and cerebral palsy. My mum is writing this for me as I don't read or write but can understand what I want and in my own way let her know what I like and what I don't like.

As I have grown older I don't like hospitals, I won't go to appointments or have someone come to my house. But things have changed a little this year and as I had a 'bad toe' that needed surgery, I needed to have it done. With the help and support of Marie my learning disability support worker and Emma the Learning Disability Nurse from hospital as well as the theatre staff and nurses on ward 28 and of course the surgeon the surgery has been completed and all is well.

Marie and Emma worked together with my mum to put together a plan to visit the hospital as a fun trip, have a drink of Dr Pepper and sit in the hospital car park. I did that a few times and I enjoyed the trips out. My mum was included in an MDT on teams with the surgeon and other professionals as my LPA /mum to discuss what was the best plan for me. On the day of the operation I went for my usual trip out to the hospital but this time I had an important job to deliver a letter to Emma inside the hospital, I like helping.

I took the letter with Marie, we all went to sit in the garden where I met some nice nurses who asked me what I liked to eat. "Ham sandwiches and strawberry ice cream" I said. I drank my Dr Pepper but this time it helped me be relaxed and not anxious as I usually was in different places. After a while I went for a ride in a wheelchair to theatre and two nice men helped me on a trolley. I wasn't anxious Marie was there.

I didn't know but my mum was in the car park waiting for me to go to sleep. When I woke up I was on a ward still on the trolley, not a hospital bed as I don't like them. Marie and my mum were there to give me a hug for being so brave. My toe was better. The nurses I had seen in the garden brought ham sandwiches and strawberry ice cream for me. I am so pleased I had my toe made better. Since then I have also been to Grimsby Hospital for an EEG twice.



I can't promise to always go to hospital but they have a plan that's just for me for when I need help to go. My mum isn't as worried now she has support to help me if I am not well. I have even agreed to help Emma with the

garden for learning disabilities and sent ideas for lights and animals to make it nice to visit. I am waiting for Emma to let us know when there is some money to buy the things for the garden.

Thank you for taking the pain away from my bad toe and helping me and my mum to get the help I needed without any extra anxiety and stress.

PART 2: Priorities for improvement, statements of assurance from the Board and reporting against core indicators

2.1 Quality priority planning for 2023/24

Quality priorities for 2023/24 were developed and set in accordance with the Trust's quality strategy and drawing on triangulated information from a wide range of quantitative and qualitative data sources including complaints, incidents, inquests, litigations, Structured Judgment Reviews (SJRs), clinical audit, risk registers, staff, and patient surveys. A long list of potential quality priority topics was developed and formed the basis of a survey monkey that was shared with all staff, the Trust Governors, stakeholders including Healthwatch, the Integrated Care Board (ICB) and local residents and service users through the Trust's communications and social media channels.

Analysis of the survey feedback was then used for wider consultation within the Trust which resulted in a short-list of quality topics. Building on the momentum and success of the Trust's Quality Improvement team the Trust took the opportunity to implement a new bottom up, Multi-Disciplinary Team (MDT) approach to setting the quality priorities and associated Key Performance Indicators (KPIs) by hosting a one day Quality Improvement quality priorities workshop to ensure engagement with the correct people drawing on feedback from all disciplines to identify what the problem is, what the root cause and drivers are, what needs to change, how the Trust will change it and how the Trust will measure success. This approach will improve Trust wide ownership and engagement and will facilitate coproduction to ensure that the quality priorities and KPIs that are set are Specific Measurable Achievable Relevant Timely (SMART) as well as triangulation with the CQC actions. The workshop took place on the 26 January 2023 and was a positive engaging session with 52% of participants rating the session as excellent and 48% rated it as good. Each topic table produced fishbone diagrams, driver diagrams, measurement plans and project charter documents to help develop the quality priorities. These were refined further by the Trust's Quality & Safety Committee and Trust Board.

5 quality priorities for 2023/24, covering the 3 domains of quality – patient safety, clinical effectiveness, and patient experience were selected:

(1) End of Life: To improve personalised palliative and end of life care to ensure patients are supported to have a good death. *(Clinical effectiveness and patient experience).*

(2) Deteriorating Patient: Improved recognition and responding to the deteriorating patient in patients age 16+. *(Clinical effectiveness and patient safety*).

(3) Sepsis: Improved recognition and responding to sepsis in patients. *(Clinical effectiveness and patient safety).*

(4) Medication safety: To improve the safety of prescribing weight dependent medication to adults. *(Clinical effectiveness and patient safety).*

(5) Mental capacity: Increase the compliance and quality of Mental Capacity Act (MCA) assessments and best interest recording. *(Clinical effectiveness and patient experience).*

Recognising that communication is a key element linked to our workstreams, it will be included within the quality priorities as an associated qualitative KPI where appropriate. Communication is known to be a broadly applicable element of many aspects of how care is provided, so focusing on patient communication for critical phases of care, such as End of Life and managing patients' mental capacity to make decisions are areas where undertaking patient and their carers views through surveys to gain insight into their experiences brings value. We also see that elements of communication between staff can contribute to safe and effective care, so the Trust will explore this through the Deteriorating patient workstream as well.

Progress against the 2023/24 quality priorities will be monitored monthly through a defined approach of data analysis and review in the Quality and Safety section of the Integrated Performance Report (IPR), with overall outcome measures included in the Trust Board IPR. Success will be measured through tracking progress and trends against baseline and targets for each of the quality priorities associated KPIs.

Assurance and performance against the Quality Priorities will also be monitored via the Trust Management Board, Quality & Safety Committee, Quality Governance Group and Divisions monthly performance meetings.

2.2 Looking back on our priorities for improvement in 2022/23

As part of the Trust's annual setting of priorities in 2022/23, the Trust had set 6 quality priorities:

(1) Mortality improvement: Focusing on care at the end of life, we will reduce the number who die within 24 hours of admission and reduce emergency admissions for those in the last 3 months of life.

(2) Deteriorating Patient: In line with the CQUIN to improve safety, we will ensure we observe NEWS2, escalate when it is high, and respond with treatment.

(3) Sepsis: Focus on improving sepsis six screening and the response within 1 hour.

(4) Increasing Medication safety: Improve the recording of patient weights, reduce medication omissions, and improve appropriate antibiotic prescribing.

(5) Friends & family Test and PALS: These are key to patient experience so we will aim to respond to 70% of PALS in 5 days by the end of the year and improve response rates in the Friends and Family test so we better understand what our patients want.

(6) Safety of Discharge: Focusing on seamless safety across organisation boundaries, by improving the timeliness of discharge letters and helping ensure hospital beds are for those who need them by improving the speed of discharge once a patient is well.

The Trust has not fully achieved all its priority ambitions however there is evidential progress in several areas with sustained improvements. The tables and narrative below show a summary of achievement against the key measures of success for each of the quality priorities.

Key	
	Target achieved
	Improvement but below target
	No statistically significant change
	Decline, target not achieved

Mortality Improvement - Summary of milestones achieved, challenges and next steps

Mortality Improvement	Target	Outcome
Reduction in the number of patients dying within 24 hours of admission to hospital	Reducing	Target achieved. The number of patients dying within 24 hours of admission to hospital has decreased year on year from 249 in 2020/21, to 201 in 2021/22 and 193 in 2022/23.
Reduction in the number of emergency admissions for people in the last 3 months of life	Reducing	No statistically significant change. Common cause variation with 181 emergency admissions for people in the last 3 months of life in March 2023 compared to 208 in March 2022 and 202 in March 2021.
Reduction in the out of hospital SHMI to 110	Reducing	No statistically significant change. The out of hospital SHMI rolling 12 month position remains high at 140.1 in August 2022 compared to 138 in April 2022, 125 in April 2021 and 143 in April 2020.

The Trust expanded the Medical Examiner Service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths providing oversight and scrutiny of the quality of care for patients who die during admission. Case studies have been presented at the Trust's Mortality Improvement Group to share learning and improve quality of care.
The Trust was a pilot site, providing feedback to NHS England, for the new national mortality reporting system SJR plus and was one of the first Trust's in England to successfully transition to the new system in December 2022. This has provided the Trust with improved oversight of high-level mortality information and learning from structured judgement reviews to identify themes and improve quality of care.

The system wide roll out of Electronic Palliative Care Coordination system EPaCCs as the single shared record for preferred place of care and advanced decisions on escalation has progressed during 2022/23 although there were delays experienced in community nursing. Full access to the shared document will see the joint working of all agencies come together to maintain patients care at home where possible. The Trust has been working to promote access to EPaCCs through communication channels on social media and on the Trust's intranet. Respiratory, frailty and paediatric virtual wards were introduced which enhance community services visibility and accessibility at the front door of both hospitals where patients who present as End of Life can be supported to be cared for in their preferred place.

Case reviews of patients who die within 24 hours of admission or who are admitted to hospital in the last 3 months of life have been undertaken alongside community and primary care partners to discuss the quality of care provided, identify gaps in provision of services or pathways that could have enabled patients to die in their preferred place.

The Trust's percentage of deaths reported in the SHMI with palliative care coding continues to be low in comparison to peers and national average. This is linked to gaps in access to a

Palliative care consultant at Grimsby. Appointment of Palliative Care Nurse to focus on advanced care planning in the community was successful but a gap in consultant recruitment remains. Future rounds of Palliative care consultant recruitment are planned.

Care home staff were provided with equipment to undertake basic observations to better inform GPs of the patient's condition to reduce hospital admission. A pilot project was introduced to implement a NEWS2 type system in care homes to help with monitoring of the deteriorating patient. Early identification of palliative care, frailty index and standard palliative resources were rolled out across North East Lincolnshire care homes, with training to upskill staff on palliative management. A community dashboard is in development by NHSE to understand admission reason by care home to allow comparison with Primary Care Network/GP frailty and End of Life rates. This work will be taken forward in 2023/24.

The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and End of Life and a bespoke training package was developed for ED staff. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

The themes and learning identified from this work will be carried forward and developed further in 2023/24 as part of the Trust's End of Life Quality Priority and on-gong quality improvement projects.

Deteriorating Patient - Summary of milestones achieved, challenges and next steps

Deteriorating Patient	Target	Outcome
Percentage of patient observations recorded on time (Adults)	90%	Target achieved for adult observations recorded on time with mean 90.55% and median 90.69%.
Percentage of patient observations recorded on time (Paediatrics)	90%	No statistically significant change for Paediatric observations recorded on time. The target was met or exceeded for 6 out of 12 months and achieved 100% in August 2022. However, overall, no statistically significant difference as remained below target with 75% recorded in March 2023 and April 2022. The mean value was 84.37% and the median was 86.62% over the 12 month period.
Escalation of NEWS in line with policy	No target	No statistically significant change with 3% in February 2023 compared to 0% in April 2022.
Clinical assessment undertaken within 15 minutes of arrival in ED	90%	Whilst the target was not met there was no statistically significant change with 47.4% recorded in March 2023 compared to 44% recorded in April 2022.

The Trust achieved the financially incentivised CQUIN CCG3 recording, escalation and response to NEWS2 for unplanned critical care admissions achieving over 80% in each quarter against a target range of 20 to 60%. The Trust's Critical Care Outreach team keep a record of all patients they review (times of referral, times of review, any areas of good practice). This data is supporting the Quality Improvement team to identify areas for improvements if patients have had delayed escalation.

Wards identified not achieving current target have been supported with focused support from the Deteriorating Educational lead. A standard of the month was introduced and the Paediatric and Neonatal Patient Safety Lead Nurse provides teaching to students about Paediatric Early Warning Score (PEWS) requirements and reinforcement as part of safety huddles. Stop and Check safety huddles were introduced on wards which highlights any patient at risk of deterioration.

Quality improvement work continues and will be carried forward as part of the Deteriorating Patient Quality Priority in 2023/24.

Sepsis - Summary of milestones achieved, challenges and next steps

Sepsis	Target	Outcome
Rate of patients screened for Sepsis	90%	Whilst the target was not met there was improvement from 40% of adults screened in April 2022 to 57.89% screened in February 2023. Similarly, an improvement in paediatric screening from 25.92% in April 2022 to 40% in March 2023.
Rate of patients who had the Sepsis six completed within 1 hour for patients who have a red flag	90%	0% of adults had documented evidence of the Sepsis six being completed within 1 hour. Paediatric patients improved from 21.42% in April 2022 to 42.1% in March 2023.

The Critical Care Outreach Team monitor all escalations into the team and share any good practice and opportunities for learning. Ward spot checks are carried out on all wards by the Educator and Deteriorating Patient/Sepsis nurse. Follow up discussions with staff to check staffs understanding of sepsis has demonstrated improvements. Stop and Check safety huddles continue to highlight any patients requiring a sepsis screening.

Sepsis tool completion is included on Doctors induction and Clinical Leads are supporting conversations with medical staff to promote completion of the Sepsis tools and dispel 'paper exercise' opinion. A booklet for agency/bank staff has been developed so that they are aware of the escalation process.

Escalation either from the healthcare support workers, who undertake patients' observations, to the registered nurses or onward to the Critical Care Outreach team is not electronically documented and so accountability is lacking resulting in missed opportunities for timely treatment. Sepsis screening is optional to complete on Web V rather than automatic or mandatory. Digital solutions have been explored and will be carried forward for discussions in 2023/24.

Adult and paediatric sepsis screening is not recorded electronically in ED. This has proved challenging as Trust wide data reported for sepsis screening via PowerBi does not include

primary sepsis screening in ED. In the interim until we can provide further assurance through robust reporting mechanisms, we are assured that patients are safe and cared for appropriately through triangulation of other robust data sources such as our incidents, claims, complaints, and mortality data. The Trust is not an outlier for Sepsis shock in the SHMI diagnosis group and identification of Sepsis is not a theme from the Medical Examiner case record reviews or Structured Judgement Reviews. Introducing electronic primary sepsis screening in ED will be the focus of work carried forward as part of the Sepsis 2023/24 Quality Priority.

Medication Safety - Summary of milestones achieved, challenges and next steps

Medication Safety	Target	Outcome
Percentage of patients admitted to IAAU with an actual, estimated or patient reported weight recorded on EPMA of WebV	Increasing	No statistically significant change with common cause variations between 61.62% in April 2022 to 70% in March 2023 and peak of 78.57% in May 2022.
Percentage of patients admitted to IAAU with an ACTUAL weight recorded on EPMA or WebV	Increasing	Target achieved. Significant improvement from 13.13% in April 2022 to 56% in March 2023.
Reduction in medication omissions without a valid reason for ward areas using EPMA	Reduction	Target achieved. Sustained low percentage of omissions over the past 16 months and achieved reduction from 1.9% in April 2022 to 1.4% in March 2023 compared to 13% in August 2021.
Reduction in patients prescribed an antibiotic	Reduction	Increase from 40.7% in March 2022 to 65.6% in February 2023. Although this is comparable to 66.4% in June 2021.
Antibiotic prescriptions have evidence of a review within 72 hours	70%	Decline from 69.1% in March 2022 to 48.7% in February 2023. Although the target was exceeded in June 2022 with 72.5% reviewed within 72 hours.

The two new ED builds completed at DPoW and SGH have the facility to weigh patients in ambulance arrivals area to aid compliance with actual weight being documented. The Trust has taken several other steps to improve medication prescribing safety in relation to recording patient's weight including introducing Paracetamol templates on EPMA. The paracetamol templates in the EPMA system have all been restricted and modified to aid the prescriber. Templates were created with the dose and frequency locked down so that the prescriber could not deviate from the BNF dosing for Paracetamol. Multi-route templates with weight-based calculations for the IV doses were then implemented, resulting in the prescriber having to input the patients' weight before the prescription can be added to the drug chart.

Unfortunately, the weight field in the EPMA system cannot be made mandatory, however the way that the multi-route templates have been set up means that it is easier to input the patient's weight (for the dose to be calculated) than it is to override the warnings. Warning notifications have also been added to the templates.

Role specific help buttons have been added to user logins. These include links to guides on the inputting of weights and numerous other guides, help topics and top tips for using the system.

Changes to the EPMA system were made such that the weight now expires in the system after 30 days. If a prescriber tries to use an expired weight, they are informed to update the weight to a current one, this also happens at each subsequent administration. They can override this and continue to use the old weight however the overriding is recorded in the system. A 30-day expiry ensures that weights from previous episodes/visits are expired and prompts staff to update.

Improved communication of system changes via emails, WhatsApp groups and top tip announcements are included on the Trust's intranet site, the HUB. A Medication Safety Newsletter is produced and distributed monthly highlighting the importance of documenting actual patient weight for prescribing.

A new 'weight' button has been added to EPMA to enable easier access to the weight recording page within the system, with the intention of making weight recording easier by all healthcare staff involved in patient care.

A key challenge is that the Trust's electronic patient record system Web V is not linked to the Trust's electronic prescribing system EPMA which prevents sharing of weight data between the two systems. Reporting functionality in EPMA relating to the weight field has also been limited. The next steps are to improve reporting from the EPMA system to improve oversight to enable improvement support to be targeted. The Trust is exploring the possibility of a BOT to overcome cross system data transfer and will be carried forward as part of the 2023/24 Medication Safety Quality Priority.

The Trust continually assesses suitability of new antimicrobials for inclusion to the Trust formulary and is reviewing the indications on EPMA to ensure they are fit for purpose. The Trust facilitates education and training both practically on the wards and in a classroom setting for pharmacists, junior doctors and nurses. The aim is to reduce unnecessary or inappropriate antimicrobial prescribing through an effective stewardship programme and annual strategy plan. Results of audits are shared with relevant governance committees and clinicians to highlight issues around stewardship and prescribing.

The Pharmacy Technician workforce is currently fully established across both main hospital sites. There is work ongoing to upskill the technician workforce to further support the pharmacist teams at both sites. However, Pharmacist staffing levels continue to be challenging with gaps at the SGH site. The Trust has been exploring all options to improve capacity including a recruitment drive, use of locum agencies, relocations packages offered, Star Chamber and shared working with Hull University Teaching Hospitals NHS Trust is being explored.

Friends and Family Test and PALS - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
PALS concerns are managed within timescale (5 working days)	70%	No statistically significant change. 62.85% of PALS concerns trust wide were closed within timescale in March 2023 compared to 62.5% in April 2022.
To improve the Friends and Family response rates	Inpatient 40%, ECC 20%, OPD 4%, Community 5%, Day case 25%	Although the FFT response rates for the 5 areas has not increased in line with the ambitious target percentages identified, overall, the Trust FFT response rate has increased by 45.17% with 932 FFT reviews in April 2022 and 1352 FFT reviews in March 2023. The response rate increased by 51% between September 2022 and February 2023 with the introduction of the PALS manager.

The Trust set a target of 60% of PALS concerns managed within timescale (5 working days) for Quarter 1/2, aiming for a stretch target of 70% by Quarter 4. The PALS team have taken a proactive approach to managing PALS concerns which has maintained performance over the past year. Steps taken include:

- Weekly reports sent to Divisional Senior Management Team of current PALS position.
- PALS Team proactive in sending out reminders to Divisions on the date the PALS concern is due.
- Improvement in PALS Team engaging with and offering support to Divisional Teams.
- Improved communication between Wards, Matrons & PALS Team when concerns raised regarding an inpatient for earlier resolution.
- Early escalation to senior leaders/managers if concerns are not being addressed in a timely manner.
- PALS Teams more proactive in supporting Divisions in resolving concerns prior to them being sent to Division.
- Dedicated oversight for a six month period, resulting in interventions in long standing concerns and resolution.
- Monthly updates of Divisional changes distributed within the PALS Team.
- Triangulation of data from FFT/PALS/Insights is captured at Round Table and Nursing Metric Meetings.

The 5 working days target is challenging for complex PALS concerns that have multi team involvement, but do not warrant formal complaint investigation. Increased clinic activity and priorities also impacts the timescales of those concerns that involve clinical and nursing teams. Change of handlers or concerns being sent to incorrect handlers can cause unnecessary delays.

The Trust has taken the following steps to improve Friends and Family Test (FFT) response rates:

- Engagement between the Patient Experience Manager & Department/Ward/Area Managers with individual meetings.
- Development of monthly FFT report for Senior Management Teams.

- Development of monthly feedback reports to each Department/Ward/Area Manager.
- Attendance at Governance and Departmental Meetings.
- Review and amendments to A&E survey.
- Weekly meetings with external provider.

Increased clinic activity and staffing levels means FFT collections and discussions have been challenging. There are limited methodologies for data collection in some areas which will be explored in future. Mandatory verification email address requested on external providers collection site has caused a barrier to patient's/families leaving anonymous feedback. This will be resolved in 2023/24. The Trust will continue to review and explore different collection methodologies and engage with staff and external providers in the future.

Safety of Discharge - Summary of milestones achieved, challenges and next steps

Friends & Family Test and PALS	Target	Outcome
Discharge letter completed within 24 hours of discharge.	85%	Target achieved with an annual mean of 89.42%.
Outpatient Clinic Summary to be sent to the patient's General Practitioner within 7 days of the appointment	50%	Target achieved in most recent months with 70% in March 2023 compared to 30.26% in April 2022.
Improve the proportion of patients discharged before 12 noon	30%	No statistically significant change with 16.56% in March 2023 compared to 18.01% in April 2022 and 16.56% in April 2021.
Improving trend showing a reduction in length of hospital stay 21 days	12%	Fluctuating performance but overall below the national average and the Trust is one of the best performing trusts in the region. Lowest value 7.83% achieved in week commencing 20 June 2022.

The trust set a target of 85% of discharge letters to be completed within 24 hours of discharge. Mid-year a stretch target of 90% was set to drive further improvement. The Trust's performance for the percentage of extended stay patients beyond 21 days is under the national average and one of the best performing Trusts in the region. The Trust has introduced consultant ward rounds on weekends, an electronic handover system and created a 7-day escalation process to address any blockages relating to discharge. Work has been undertaken to ensure patients who require support on discharge are supported by the most relevant team in a timely manner, ensuring they have prompt access to the services they require to enable them to leave a hospital bed. The use of voluntary sector organisations has also been increased to support timely discharge.

Other steps taken to improve performance include:

- 7-day Same Day Emergency Care (SDEC) ward set up.
- Virtual wards for respiratory, frailty and paediatrics established.
- Acute Frailty Assessment service and two integrated hospital discharge Hubs have been established for North Lincolnshire and North East Lincolnshire.
- Outpatient Parenteral Antibiotic Therapy (OPAT) and Home first now implemented.

- Work taking place within care homes to support falls, therapy and training provided within Northern Lincolnshire, SAFE service now operating direct referrals from Urgent Care Service (UCS) and Single Point of Access (SPA) to enable anticipatory/proactive management of frailty.
- Acute and Community joint work group established between Medicine and Community & Therapies.
- Community Response Team GP supporting Category 3 & 5 calls.
- Daily 12 Noon meetings chaired by the site senior team within the operation centre 7 days per week, who work with system partners to have a clear action plan for delayed discharge and escalation plan
- Themes are collated during the week from escalations and fed back to a fortnightly discharge improvement meeting which feeds our improvement plan.
- Multiagency discharge events have been held.
- Early identification of complex discharges prior to having no criteria to reside.
- Pilot for complex discharges and multiple admissions discharge expert panel.

The discharge lounge at SGH is no longer able to facilitate patients with stretchers which has caused flow delays due to a move to allow Ward 18 to be used. The DPoW discharge lounge is being used ad-hoc for inpatient beds which has impacted on discharge times. The Trust is exploring upgrading the discharge lounge capacity and opening hours

2.3 Statements of assurance from the Board

2.3a Information on the review of services

During 2022/23 the Northern Lincolnshire and Goole NHS Foundation Trust provided and/or subcontracted 7 relevant health services. The 7 services are taken from the Trust's standard contract with the ICB as the "categories of service which the Provider is commissioned to provide under this contract". These are:

- A&E Services
- Acute Services
- Cancer Services
- Community Services
- Diagnostic, Screening and/or Pathology Services
- End of Life Care Services
- Urgent Treatment Centre Services

The Trust has reviewed all the data available to them on the quality of care in 7 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2022/23 represents 100% of the total income generated from the provision of relevant health and care services for 2022/23.

2.3b Information on participation in clinical audits and national confidential enquires

During 2022/23, 53 national clinical audits and 10 National Confidential Enquiries into Patient Outcomes and Deaths (NCEPODs) were listed in the Quality Accounts for completion. During 2022/23, 51 national clinical audits and 7 NCEPODs covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 50 (98%) of the national clinical audits and 7 (100%) of the NCEPODs. Whilst 2 projects were listed for completion at the beginning of the year, these were delayed by the national audit supplier and will commence in 2023/24. Both audits have been excluded from the Trust's overall participation rate.

Participation did not occur for 1 (2%) national clinical audit; the National Ophthalmology Database Audit as the audit data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.

The tables below list all National Clinical Audits, Clinical Outcome Review Programmes and other national quality improvement programmes which NHS England advise Trusts to Participate in. It also provides a breakdown of those applicable to the Trust and participation details during 2022/23.

Table 1: National Clinical Audits

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
1.	Breast and Cosmetic Implant Registry	✓	✓	20	100%	Report writing/Action planning
2.	Case Mix Programme	✓	✓	1,353	100%	Project still underway
3.	Child Health Clinical Outcome Review Programme	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
4.	Cleft Registry and Audit Network Database	X	X	N/A	N/A	N/A
5.	Elective Surgery: National PROMs Programme	✓	✓	625	90.1%	Awaiting publication of results
6.	**Emergency Medicine QIPs:**					
	a. Pain in children	✓	✓	166	100%	Action Planning
	b. Assessing for cognitive impairment in older people	✓	N/A	N/A	Commences April 2023	Planning underway
	c. Mental health self-harm	✓	✓	40	On-going	Project still underway
7.	Epilepsy 12 - National Clinical Audit of Seizures and Epilepsies for Children and Young People	✓	✓	169	100%	Awaiting Publication of Results
8.	**Falls and Fragility Fracture Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Fracture Liaison Service Database	✓	✓	669	On-going	Project still underway
	b. National Audit of Inpatient Falls	✓	✓	6	On-going	Project still underway
	c. National Hip Fracture Database	✓	✓	483	100%	Report writing/Action planning
9.	**Gastro-intestinal Cancer Audit Programme:**					
	a. National Bowel Cancer Audit	✓	✓	273	100%	Awaiting Publication of Results
	b. National Oesophago-gastric Cancer	✓	✓	104	100%	Awaiting Publication of Results
10.	Inflammatory Bowel Disease Audit	✓	✓	522	100%	Action Planning
11.	LeDeR - learning from lives and deaths of people with a learning disability and autistic people	✓	✓	22	100%	Action Planning
12.	**Maternal and Newborn Infant Clinical Outcome Review Programme:**					
	MBRRACE - UK; Saving Lives, Improving Mother care - Maternal mortality surveillance and confidential enquiries	✓	✓	0	100%	Report writing/Action planning
	MBRRACE - UK Perinatal Mortality Surveillance and Confidential Enquiries	✓	✓	8	100%	Report writing/Action planning
13.	Medical and Surgical Clinical Outcome Review Programme (NCEPOD)	✓	✓	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
14.	Mental Health Clinical Outcome Review Programme	X	X	Please refer to Table 2	Please refer to Table 2	Please refer to Table 2
15.	Muscle Invasive Bladder Cancer Audit	✓	✓	14	100%	Report writing/Action planning
16.	**National Adult Diabetes Audit:**					
	a. National Diabetes Core Audit	✓	✓	1220	100%	Action Planning
	b. National Diabetes Foot Care Audit	✓	✓	157	On-going	Project still underway
	c. National Diabetes Inpatient Safety Audit	✓	✓	9	On-going	Project still underway
	d. National Pregnancy in Diabetes Audit	✓	✓	36	100%	Awaiting Publication of Results
17.	**National Asthma and Chronic Obstructive Pulmonary Disease Audit Programme:**					

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	a. Adult Asthma Secondary Care	✓	✓	180	On-going	Project still underway
	b. Chronic Obstructive Pulmonary Disease Secondary Care	✓	✓	652	On-going	Project still underway
	c. Paediatric Asthma Secondary Care	✓	✓	31	On-going	Project still underway
	d. Pulmonary Rehabilitation Audit (Primary Care)	X	X	N/A	N/A	N/A
18.	**National Audit of Breast Cancer in Older Patients**	✓	✓	239	100%	Awaiting Publication of Results
19.	**National Audit of Cardiac Rehabilitation**	✓	✓	1074	100%	Report writing/Action planning
20.	**National Audit of Cardiovascular Disease Prevention (Primary Care)**	X	X	N/A	N/A	N/A
21.	**National Audit of Care at the End of Life**	✓	✓	89	100%	Awaiting Publication of Results
22.	**National Audit of Dementia**	✓	✓	80	On-going	Report writing/Action planning
23.	**National Audit of Pulmonary Hypertension**	X	X	N/A	N/A	N/A
24.	**National Bariatric Surgery Registry**	X	X	N/A	N/A	N/A
25.	**National Cardiac Arrest Audit**	✓	✓	73	On-going	Project still underway
26.	**National Cardiac Audit Programme:**					
	a. National Congenital Heart Disease Audit	X	X	N/A	N/A	N/A
	b. Myocardial Ischaemia National Audit Project (MINAP)	✓	✓	267	On-going	Project still underway
	c. National Adult Cardiac Surgery Audit	X	X	N/A	N/A	N/A
	d. National Audit of Cardiac Rhythm Management	✓	✓	273	On-going	Project still underway
	e. National Audit of Percutaneous Coronary Interventions	✓	✓	411	On-going	Project still underway
	f. National Heart Failure Audit	✓	✓	287	On-going	Project still underway
27.	National Child Mortality Database	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
28.	National Clinical Audit of Psychosis	X	X	N/A	N/A	N/A
29.	National Early Inflammatory Arthritis Audit	✓	✓	28	On-going	Project still underway
30.	National Emergency Laparotomy Audit	✓	✓	200	On-going	Project still underway
31.	National Joint Registry	✓	✓	740	96%	Report writing/Action planning
32.	National Lung Cancer Audit	✓	✓	346	100%	Action Planning
33.	National Maternity and Perinatal Audit	✓	✓	3445	100%	Report writing/Action planning
34.	National Neonatal Audit Programme	✓	✓	657	100%	Awaiting Publication of Results
35.	National Obesity Audit	X	X	N/A	N/A	N/A
36.	National Ophthalmology Database Audit	✓	X*	N/A	N/A	N/A
37.	National Paediatric Diabetes Audit	✓	✓	284	On-going	Project still underway
38.	National Perinatal Mortality Review Tool	✓	✓	8	100%	Action Planning
39.	National Prostate Cancer Audit	✓	✓	294	100%	Awaiting Publication of Results
40.	National Vascular Registry	X	X	N/A	N/A	N/A
41.	Neurosurgical National Audit Programme	X	X	N/A	N/A	N/A
42.	Out-of-Hospital Cardiac Arrest Outcomes	X	X	N/A	N/A	N/A
43.	Paediatric Intensive Care Audit	X	X	N/A	N/A	N/A
44.	Perioperative Quality Improvement Programme	✓	✓	11	55%	Project still underway
45.	**Prescribing Observatory for Mental Health:**					
	a. Improving the quality of valproate prescribing in mental health services	X	X	N/A	N/A	N/A
	b. The use of melatonin	X	X	N/A	N/A	N/A
46.	**Renal Audits:**					
	a. National Acute Kidney Injury Audit	X	X	N/A	N/A	N/A

Count	Programme / Workstream	Eligible for NLAG	NLAG Participated	No. of Cases Submitted	Rate of Participation	Outcome
	b. UK Renal Registry Chronic Kidney Disease Audit	X	X	N/A	N/A	N/A
47.	**Respiratory Audits:**					
	a. Adult Respiratory Support Audit	✓	✓	N/A	Commenced March 2023	Project still underway
	b. Smoking Cessation Audit- Maternity and Mental Health Services	✓	N/A	Commences April 2023	Planning underway	N/A
48.	Sentinel Stroke National Audit Programme	✓	✓	242	100%	Report writing/Action planning
49.	Serious Hazards of Transfusion UK National Haemovigilance Scheme	✓	✓	17	100%	Awaiting Publication of Results
50.	Society for Acute Medicine Benchmarking Audit	✓	✓	107	100%	Action Planning
51.	Trauma Audit and Research Network	✓	✓	494	Ongoing	Project still underway
52.	UK Cystic Fibrosis Registry	X	X	N/A	N/A	N/A
53.	UK Parkinson's Audit	✓	✓	60	100%	Awaiting Publication of Results

**Note: The Trust did not participate in the National Ophthalmology Database Audit as this is not a mandated audit and data collection is expected to be via an automated Electronic Patient Record System such as Medisoft that the Trust does not have. Therefore, it was agreed through the Trust's Quality Governance Group not to participate in the audit as diverting clinical resources to collect the vast amount of data required manually would be an adverse risk to the quality of the service. Instead, it was agreed that a local audit project of cataract surgery covering the key standards would be undertaken in its place to allow some level of benchmarking in comparison to the published national audit data.*

Table 2: National Confidential Enquires

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
3.	**Testicular torsion**	✓	✓	7	100%	Awaiting National Report
	Transition from child to adult health services	✓	✓	3	75%	Awaiting National Report
	Juvenile Idiopathic Arthritis	✓	✓	Ongoing		
13.	**Community Acquired Pneumonia**	✓	✓	4	57%	Project still underway
	Chron's Disease	✓	✓	6	75%	Project still underway

Count	Programme / Workstream	Eligible for NLAG	NLAG participated	No. of cases submitted	Participation Rate	Outcome
	End of Life Care	✓	N/A	Commences Spring/Summer 2023	N/A	N/A
	Endometriosis	✓	✓	Ongoing		
	Epilepsy: Hospital Attendance	✓	✓	7	100%	Ongoing
	Physical Health in Mental Health Hospitals	X	X	N/A	N/A	N/A
14.	**Real-time surveillance of patient suicide**	X	X	N/A	N/A	N/A
	Suicide (and homicide) by people under mental health care	X	X	N/A	N/A	N/A

The reports of 30 National clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

National Audit Programme	Summary of some actions taken
National Neonatal Audit Programme (NNAP)	- Doctors to visit the mother on Maternity Wards where appropriate and within 24 hours of admission to the neonatal unit. - Where parents are unable to be present at ward rounds, ensure contact is made alternatively to provide an update. - Posters to be displayed on nursery doors to ensure parents are aware that they are to be involved and updated in the care of their baby. - PeriPrem passports implemented to ensure standards are being met. - Ensure staff are aware of the importance to utilise the Jitsi Meet App and alternative communication methods to involve parents and update them on their baby within 24 hours of admission. - Safety Huddles (where medical staff are present) to include standards summary of NNAP standards for awareness purposes. - BadgerNet is to be included within the doctor induction training day to raise awareness of the NNAP measures. - The Quarterly dashboards (published by NNAP) are to be presented at the Trust wide Children's service clinical audit meeting to ensure staff are aware of the NNAP standards and any shortfalls in compliance are identified.
National Pregnancy in Diabetes Audit	- Young patients are made aware of the importance of the issues relating to unplanned pregnancy during their appointment in the young adult diabetes clinic. - Patients are offered DESMOND structured education in relation to weight management and diabetes prevention. - Reinforce the benefits of pregnancy preparation by way of a diabetes interface forum with primary care.

National Audit Programme	Summary of some actions taken
	- Local practice nurses to be made aware of the preconception clinic.
Sentinel Stroke National Audit programme (SSNAP)	- Stroke awareness marketing campaign launched to raise awareness of stroke signs and symptoms to aid early recognition/intervention. - Liaise with relevant teams to ensure patient goals are clear.
IBD Registry	- Updated consent process implemented so patients now get up to date information from the registry regarding latest developments in treatment/management of IBD.
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal morbidity confidential enquiry – Saving Lives Improving Mothers Care.	- Diagnosis and Treatment of Cancer whilst Pregnant Guidance to be reviewed. A new guideline is being written to ensure women are aware of risks and choices available to them.
National Oesophageal Cancer Audit (NOGCA 2020)	- Contact to be made with Primary Care to raise the consistently above average rate of patients diagnosed with OG Cancer following emergency admission.
National Emergency Laparotomy Audit (NELA) 2021	- Audit Department to pass a list to the Surgery Business Manager of any cases that are in the NELA sample but show as incomplete on NELA webtool. This is to then be raised with the surgeons at the weekly Quality Meeting.
COPD Audit	- Review of COPD cases undertaken identifying an issue with an algorithm which will boost case ascertainment for future publications.
NACAP Children's & Young People Asthma audit	- Discharge Bundle to be raised with all nursing staff and encouraged to compete on WebV. - - Clinical Nurse Specialists are included within the Junior Doctors Induction, to highlight the KPIs. - Review the prescribing of steroids with the Paediatric Emergency Nursing Team to ascertain if this can be included within their roles.
Fracture Liaison Service Database	- Annual review through radiology reports to boost identification of Vertebral Fractures to ensure submission rates are in line with best practice
Elective Surgery: National PROMS Programme	- Deep dive of data carried out to establish if there are any issues that have contributed to the deterioration of patient reported outcomes.
Early Inflammatory Arthritis	- Specific Early Inflammatory Arthritis Clinics to be introduced to provide more clinic time to assess progress and outcomes with regards to Disease Modifying Drugs
Royal College of Emergency Medicine: Pain in Children	- Introduction of mandated field for Pain Scoring on arrival into the ED/ECC electronic systems.
National Audit of Dementia	- Pilot document introduced to aid the completion of Delirium Screening in patients over 65.
National Audit of Breast Cancer in Older People	- To introduce the Fitness assessment form for older patients and ensure this is uploaded to the Somerset system.

The reports of 31 local clinical audits were reviewed by the provider in 2022/23 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Local Audit Topic	Summary of some actions taken
Audit of GI Beed	- Implementation of Glasgow/Blatchford score as a mandated electronic field into ED/ECC Symphony System.
Emergency Department Documentation	- Adoption of stamps by ED/ECC Nursing Staff to improve documentation.
Audit of Weighing Prescribing	- Introduction of Weight Bridges in the ED/ECC to improve the weighing of patients and ensure accuracy of weight dependent drug doses
Cirrhosis Fibrosis CQUIN Audits	- Introduction of new Alcohol Care Team as well as Web V screening and referral tools to ensure best practice pathways are met for this subset of patients to assess kidney health early in the pathway
Local Version of National Ophthalmology Database Audit (NOD)	- Medical Secretaries to highlight any patient who has gone more than 6 months from their pre-operative assessment when they attend for their cataract operation that they need the Visual Acuity check performing prior to the operation.
Paediatric SEPSIS Audit	- The Monthly Dashboard is used to monitor the use of the SEPSIS pathway in children who are admitted, and the results are presented at the Clinical Audit Meeting to raise the importance of adhering to policy.
Paediatric Early Warning Scoring	- The Monthly Dashboard is used to monitor the use of the PEWS Tool and presented at the Clinical Audit Meeting. - Areas of low compliance are displayed as standard of the month in the wards.
Facing the Future Audits	- Paediatric collaborative document (electronic and paper version) to be reviewed to ascertain if additional fields for capturing information can be added.
Audit of Paediatric Documentation Audit:	- The monthly rapid cycle documentation audit is discussed at the Clinical Audit meeting to highlight the standards which consistently have low compliance and to raise the importance of documenting patient height, weight, head circumference and centiles.
Pain Assessment Audit	- Processes surrounding pain scoring within the Trust are to be reviewed as part of a Quality Improvement Project.
Audit of Electronic Discharge Summaries (Surgery)	- Surgery Doctors Induction to include a summary of the standards required when completing Discharge Summary Letters to ensure staff are aware. - Electronic Prescribing system (EPMA) to be linked to Web-V system to pre-populate medication information on the discharge summaries.
ReSPECT Audit	- Development of a continuing 'Lead Educator' post to raise awareness and deliver education regarding the importance of ReSPECT. - Education plan produced and shared at the End-of-Life Operational Group.
Gynaecology Electronic Discharge Summary Audit	- Presenting complaint, to be added as a compulsory field relating to surgical cases. - Consultant job plans to be reviewed to ensure patients have a clinical assessment within 14 hours of admission.
Paediatric Documentation	- Implementation of electronic documentation at DPOW, awaiting role out at SGH.

Local Audit Topic	Summary of some actions taken
Hernia Day Case Rate Audit:	- The General Surgery Business Support Manager has discussed with the relevant administration Teams the importance of categorising Hernia procedures correctly on the booking system, reinforcing that unless stated otherwise by the surgeon or pre-assessment staff then hernia procedures should be day cases. - The General Surgery Management Team to provide data to the clinicians about any Day Case hernia procedure that results in an admission so this can be reviewed for learning points. - Urology clinicians to provide guidance on how best to send patients home with a catheter and place this information in posters on relevant wards. - An audit of the completion of booking forms inputted on to the booking system will be undertaken, to assess whether Day Case/Inpatient bookings matched the resultant procedure.

The Trust takes part in the annual benchmarking audit that measures performance against the learning disability improvement standards. The improvement standards were launched in 2018 by NHS Improvement to ensure the provision of high quality, personalised and safe care from the NHS for adults and children with learning disabilities and/or autism across England. The NHS Long Term Plan (2019) further pledged that over the next five years, the improvement standards would be implemented by all services funded by the NHS. The improvement standards against which trust performance is measured are respecting and protecting rights, inclusion and engagement, workforce and specialist learning disability services, the first three are universal standards that apply to all NHS trusts, and the fourth is a specialist standard that applies specifically to trusts that provide services commissioned exclusively for people with a learning disability or autism In addition to the data collection by the Vulnerabilities team, 50 staff and 100 patient surveys were sent out that were directly returned to NHSBN. Compliance with these standards demonstrates that a trust has the right pathways and resources in place to deliver high quality patient outcomes that people with a learning disability or autism, their families and carers deserve and expect. The results of the survey were published in November 2022 and the Trust compares favourably to other trusts that took part, for those areas where there is an identified gap the Trust is developing an improvement plan to address these issues.

2.3c Information on participation in clinical research

Clinical research is an essential part of maintaining a culture of continuous improvement. In 2022/2023 there was a reduced focus on COVID-19 public health trials and the Research Team were able to re-commence studies that had been put on hold during the pandemic. The team also commenced a broad range of new clinical research studies, for example, studies relating to, cardiology, urology, dermatology amongst other specialities. The Trust has received several congratulations of achievement from studies relating to how the Trust has conducted the research and the recruitment it has achieved. Whilst undertaking these studies the team are due to, or will achieve close to, the recruitment figure set by the Clinical Research Network.

The number of patients receiving NHS services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2022/23 that were recruited during that period (01 April 2022 to 31 March 2023) to participate in research approved by a research ethics committee or Health Research Authority was 1100.

The Trust has 23 studies recruited. 2023/24 will see the team continuing their reduced focus on providing research post COVID public health trials and continue to increase recruitment via a mixture of non COVID commercial/portfolio studies. The recruitment will include focussing on collaborative working with other organisations, to take research out to previously underserved communities in line with the Trust's high level objectives agreed with the Clinical Research Network.

Clinical research has allowed the world's population to gain knowledge and develop treatments and the Trust continue to support this by providing clinical research for our local communities.

2.3 d Information on the Trust's use of the CQUIN framework

The Commissioning for Quality and Innovation (CQUIN) framework is about improving the quality of healthcare. Commissioners reward excellence by linking a proportion of income to the achievement of locally set and agreed improvement goals. These goals are embedded into contracts and are essential for the implementation of National Institute for Health and Care Excellence (NICE) Quality Standards, resulting in improved patient care, experience, and improvements against outcomes.

Use of the CQUIN payment framework

A proportion of the Trust's income in 2022/23 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement, or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

For 2022/23 the requirement for national ICB CQUINs was to report on all applicable CQUINs but also choose 5 schemes, for each contract, that would have a financial value attached.

The breakdown of the National CQUIN indicators is based on 1.25% of contract value. Funding was given to the Trust based on the assumption that the Provider would achieve full compliance with the applicable CQUIN Indicators and would therefore earn the full 1.25% value. Due to the contractual arrangements in 2022/23 there was no financial risk to the Trust for non-achievement of the CQUIN.

National CQUIN schemes 2022/23 for ICBs include:

- Staff Flu Vaccinations (Non-financial)
- Appropriate antibiotic prescribing for UTI in adults aged 16+ (Non-financial)
- Recording of NEWS2 score, escalation time and response time for unplanned critical care services (Financial)
- Compliance with timed diagnostic pathways for cancer services (Non-financial)
- Anaemia screening and treatment of all patients undergoing major elective surgery (Financial)
- Timely communications of changed to medicines to community pharmacists via the Discharge Medicines Service (Financial)
- Supporting patients to drink, eat and mobilise after surgery (Financial)

- Cirrhosis and Fibrosis test for alcohol dependent patients (Financial)
- Treatment of community acquired pneumonia in line with BTS care bundle (Non-financial)
- Assessment, diagnosis, and treatment of lower leg wounds (Non-financial)

NHS England Specialised Services (NHSE):
The Trust receives a CQUIN value of 1.25%. The CQUIN payment was based on the block contract value: however, CQUIN is not payable on high-cost drugs, devices, listed procedures identified in the National Payment System and all other expenditure contracted on "pass through" basis.

The NHSE specialised schemes of 2022/23 include:

- Shared Decision Making (SDM) conversations (Financial)

NHSE took a light touch approach to the reporting of CQUINs and agreed that where a provider has engaged and fully participated with the CQUIN schemes but has failed to achieve the requirements fully, due to issues outside of their control (including any future Covid surges) the commissioner would reinvest the CQUIN scheme monies it has recovered with the provider but may identify areas of quality and innovation for the provider to focus the investment on.

The Trust has achieved the highest performance to date with achievement against all the financial incentivised CQUIN, exceeding the maximum targets. For the non-financial CQUIN, the Trust achieved the target for 1 and showed improvement over each quarter for a further 2 CQUINs. The most improvement was seen in the financial incentivised CQUIN **CCG9** Cirrhosis and fibrosis tests for alcohol dependent patients where the Trust achieved 68% in Quarter 4 compared to 11.4% in Quarter 1.

Key	
	Target achieved or exceeded
	Target not achieved but Improvement over full year
	Target not achieved

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG1 Flu vaccinations for frontline healthcare workers	Non-financial	**70%**	**90%**	**N/A**	**N/A**	**31%**	**31%**	
CCG2 Appropriate antibiotic prescribing for UTI in adults aged 16+	Non-financial	**40%**	**60%**	**42%**	**43%**	**37%**	**42%**	
CCG3 Recording, escalation and response to NEWS2 for unplanned critical care admissions	Financial	**20%**	**60%**	**85%**	**84%**	**80%**	**96%**	

Indicator	Financial / Non-financial	Min	Max	Q1	Q2	Q3	Q4	Full year performance
CCG4 Compliance with timed diagnostic pathways for cancer services	Non-financial	**55%**	**65%**	**18.35%**	**22.3%**	**18.1%**	**30%**	
CCG5 Achieving 70% of patients with confirmed community acquired pneumonia to be managed in concordance with relevant steps of BTS CAP Care Bundle.	Non-financial	**45%**	**70%**	**16%**	**17%**	**27%**	**17%**	
CCG6 Anaemia screening for those undergoing major elective surgery	Financial	**45%**	**60%**	**86%**	**85%**	**76%**	**92%**	
CCG7 Timely communication of medication changes via discharge medicines IT software	Financial	**0.5%**	**1.5%**	**N/A**	**N.A**	**1.53%**	**1.495%**	
CCG8 Supporting patients to eat drink and mobilise post-surgery	Financial	**60%**	**70%**	**72%**	**78%**	**77%**	**73%**	
CCG9 Cirrhosis and fibrosis tests for alcohol dependent patients	Financial	**20%**	**35%**	**11.4%**	**18.7%**	**67%**	**68%**	
CCG14 Assessment, diagnosis and treatment of lower leg wounds	Non-financial	**25%**	**50%**	**1.63%**	**0**	**10%**	**23%**	
PSS2 Achieving high quality shared decision-making conversations in specific specialised service (Cardiology)	Financial	**Min 65%**	**Max 75%**	**88%**	**92%**	**NA**	**87%**	

2.3e Information relating to the Trust's registration with the Care Quality Commission

Northern Lincolnshire and Goole NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is unconditional.

The Care Quality Commission has not taken enforcement action against the Trust during 2022/23.

The Trust has not participated in special reviews or investigations by the Care Quality Commission during the reported period.

Care Quality Commission (CQC) ratings grid for the Trust:

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

From their last inspection of the Trust in June and July 2022 (of which the report was published on the 2nd December 2022) the outcome was as follows:

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Diana Princess of Wales Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Goole & District Hospital	Good ↑↑ Nov 2022	Good →← Nov 2022	Good →← Nov 2022	Good ↑↑ Nov 2022	Requires Improvement →← Nov 2022	Good ↑ Nov 2022
Scunthorpe General Hospital	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022
Overall trust	Requires Improvement ↑ Nov 2022	Requires Improvement →← Nov 2022	Good →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022	Requires Improvement →← Nov 2022

Several significant improvements were published in the report, including:

- The improvement of Goole District Hospital rating to ‘Good’ overall
- The Trust safety rating improved to ‘Requires improvement’ from ‘Inadequate’.
- Maternity and Surgery Core Surgery ratings increased to ‘Good’ for responsive
- Rating increase to ‘Good’ from ‘Inadequate’ for Outpatients Core Service
- The Diagnostic Imaging Core Service was highlighted for ‘outstanding practice’ and a ratings increase from ‘Inadequate’ to ‘Good’ overall for Goole District Hospital and Scunthorpe General Hospital

The Trust celebrated several positive findings within the report, including no significant concerns around fundamentals of care and no requirement notices were issued. Inspectors also said they saw good examples of patients receiving compassionate care, with staff ensuring patients privacy and dignity were maintained and it was evident staff worked hard to achieve the best possible outcomes for people throughout the services they inspected. The report recognised improvements in leadership, culture, safety, complaints, and the elective backlog along with a commitment to learning and quality improvement highlighted. The report identified improvements to data management as was strengthening of operational financial management and governance arrangements.

The 2022 report had 93 ‘Must do’ and 59 ‘should do’ actions across all three sites, these have been reviewed and incorporated into a robust action plan which the Trust has already made progress with. Initial actions and feedback to the CQC was completed in December 2022 following publication of the report.

During the last year and whilst waiting for the new report, the Trust progressed completion of several actions that were identified as part of the 2019 actions. At the time of publication of the 2022 report, 85% of 2019 actions were rated green or blue meaning they were on target or complete.

Following the latest report, the Trust amended the assurance ratings from blue/green/amber/red to language in line with Recovery Support Programme:

Full assurance	Evidence of embedded and sustained improvement
Significant assurance	Evidence of improvement and the improvements becoming embedded, but yet to be sustained
Moderate assurance	Some evidence of improvement but this has yet to be embedded and sustained
Limited assurance	Limited evidence of improvement and limited evidence of the improvements being embedded or sustained
No assurance	No evidence of improvement

A monthly report provides detail and assurance on progress and is presented at the Trust Management Board and various sub-committees. At the time of writing in March 2023, the Trust had 123 open CQC actions, of those, two were rated full assurance, 23 were rated significant assurance, 52 moderate assurance and 39 rated limited assurance. There are no actions with no assurance and seven to be rated. At the time of publication (June 2023), further progress has been made and the Trust currently has eight rated full assurance, 27 rated significant assurance, 48 rated moderate assurance and 42 rated limited assurance with no actions with no assurance and none awaiting a rating. The Trust continues to have regular engagement meetings with the CQC and provides them with regular updates on progress with the plan along with supporting evidence.

2.3 f Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2022/23 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data (as of April 2023):

- Which included the patient's valid NHS Number was:
  - 99.98 % for admitted patient care
  - 99.97 % for outpatient care
  - 99.57 % for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:
  - 100 % for admitted patient care

- 100 % for outpatient care
- 100 % for accident and emergency care.

2.3 g Information governance assessment report

The Information Governance Data Security and Protection Toolkit (DSPT) is part of the Department of Health's commitment to ensuring the highest standards of information governance. It allows organisations to measure their compliance against legislation and central guidance and helps identify any areas of partial or non-compliance.

It remains Department of Health and Social Care policy that all organisations that process NHS patient information provides assurance via the IG Toolkit and is fundamental to the secure usage, sharing, transfer, storage, and destruction of data both within the organisation and between external organisations. The submission deadline for the 2022/2023 DSPT Assessment is 30th June 2023.

The 2021/22 Version of the DSPT was released on the 20 July 2021, with an initial baseline assessment date of the 28 February 2022 followed by the final submission of the 30 June 2022. The current status for Northern Lincolnshire and Goole Hospitals NHS Foundation Trust following submission of the 21/22 DSPT is Approaching Standards.

As of March 2023, there were two actions remaining on the improvement plan. Responses to these actions will be captured in the 23/24 return. The remaining actions are as follows:

20/21 DSP ref	2020/21 DSPT Evidence Item Text
3.2.1	Have at least 95% of all staff, completed their annual Data Security Awareness Training?
10.1.1	The organisation has a list of its suppliers that handle personal information, the products and services they deliver, their contact details and the contract duration.

2.3 h Information on payment by results clinical coding audit

Northern Lincolnshire & Goole NHS Foundation Trust was not subject to the payment by results clinical coding audit during the reporting period by the Audit Commission as these no longer take place.

To provide coding quality assurance Northern Lincolnshire & Goole NHS Foundation Trust completed a Trust-wide random sample audit of 200 Finished Consultant Episodes (FCEs - the time a patient spends under the continuous care of one care professional) for the period November 2021 – March 2022 and, in addition, re-commenced regular staff audits in April 2022. These audits were performed by NHS Digital approved auditors based at Hull University Teaching Hospitals as part of the Clinical Coding shared service.

The Trust-wide audit attained the level of standards met, and 77% of staff audits achieved either standards met or standards exceeded, using the Data Security and Protection Toolkit Attainment Levels for Clinical Coding in an Acute Trust to determine the standard achieved (table below). Any below the target of standards met are given additional training and are re-audited within 3 months. The Trust will continue a rolling programme of yearly audits for all Clinical Coding staff throughout 23/24

	Level of Attainment	
	Standards Met	Standards Exceeded
Primary Diagnosis	>=90%	>=95%
Secondary Diagnosis	>=80%	>=90%
Primary Procedures	>=90%	>=95%
Secondary Procedures	>=80%	>=90%

2.3i Learning from Deaths

During 2022/23, 1,648 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died in hospital as an inpatient. In addition to this, 243 deaths occurred in ED or were dead on arrival and there were 6 still births. The inpatient deaths comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 388 in the first quarter
- 341 in the second quarter
- 441 in the third quarter
- 478 in the fourth quarter

As at the 31st March 2023, 1546 have been reviewed by the Medical Examiners, 216 have had a Structured Judgement Review (SJR) and 1 has been subject to a serious incident investigation. In 1 case, a death was subjected to both a SJR and a serious incident investigation. The number of deaths in each quarter for which an SJR or a serious incident investigation was carried out (as of 29 May 2023) was:

- 87 in the first quarter
- 84 in the second quarter
- 44 in the third quarter
- 14 in the fourth quarter

(Note the number of cases in quarter three and four will be less at the time of publication due to a time lag incurred through coding validation and the SJR review process).

3 representing 0.18% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. [Definition: using Royal College of Physicians (RCP) question: "Avoidability of Death Judgement Score" for patients with a score of 3 or less – see narrative below for more information].

In relation to each quarter, this consisted of:

- 1 representing 0.06% for the first quarter
- 2 representing 0.18% for the second quarter
- 0 representing 0% for the third quarter
- 0 representing 0% for the fourth quarter.

These numbers have been estimated using the SJR which includes a 6 factor Likert scale ranging from Score 6: "Definitely Not Avoidable" to Score 1: "Definitely Avoidable". The above number of cases includes all those deaths that were classified as scoring less than or equal to 3 on this 6 factor scale. This assessment is the initial reviewer's evaluation from the retrospective analysis of the medical record.

Any SJR completed that identifies that further understanding is needed is subject to a second independent review. This process links into the Trust's Serious Incident process. This data is not a measure of deaths that were avoidable, but as an indicator to support local review and learning processes with the aim of helping to improve the standard of patient safety and quality of care.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2022/23

And,

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2022/23

And,

An assessment of the impact of the actions taken by the Trust during 2022/23:

Following on from the success of the introduction of the Medical Examiner Service at the Diana Princess of Wales Hospital site in April 2021 the Trust expanded the service in July 2022 to include Scunthorpe General Hospital and all Emergency Department non-coronal deaths. The service now has full establishment with 1.1 whole time equivalent Medical Examiners comprising of 9 Medical Examiners and 4 full time equivalent Medical Examiner Officers. This is an invaluable service that oversees and scrutinises the quality of care for patients who die during admission. The benefits of the service for the families or carers are likely to be the most impactful as the service provides clarity, dissipates doubts, and helps to alleviate negative thoughts and experiences the families or carers may be experiencing. Providing a voice to the bereaved at this most difficult of times is critically important and rewarding. It allows them to make significant improvements in what happens after death, including identifying areas for improvement as well as highlighting good practice. The service ensures a correct and accurate cause of death is registered and appropriate deaths are referred to the coroner. Representatives from the Medical Examiners attend the Trust's Mortality Improvement Group and share a case review for learning bi-monthly. The Trust has invested in a bespoke module for SystmOne to allow primary care to refer deaths to the Medical Examiner Service for review. This will facilitate more robust scrutiny of community deaths.

In 2021/22 the Trust worked collaboratively with NHS England's Better Tomorrow: Learning from Deaths, Learning for Lives team to pilot the national Mortality Reporting Dashboard and transitioned from paper SJRs to NHS England's electronic SJR system, ORIS. This collaborative working has continued and strengthened in 2022/23 with the Trust invited, by NHS England, to deliver a presentation to Blackpool Teaching Hospitals NHS Foundation Trust as well as presenting at national webinars to share the Trust's experiences of transitioning to the new electronic system. The Trust was also a pilot site, providing feedback to NHS England, for the new national SJR plus system that was developed by NHS England to replace ORIS. The Trust was one of the first in England to successfully transition from ORIS to the new SJR Plus system in December 2022.

The Trust is committed to continuously learning from deaths to improve the quality of care provided to patients, their families, and carers. The following learning themes have been identified in 2022/23:

- Incomplete or poor quality documentation in Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) and Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) documents.
- Missed opportunities to discuss DNACPR and ReSPECT documents.
- Missed opportunity for recognition of End of Life (EOL) pathway at earlier stage.
- Lack of anticipatory care planning.

- Mental capacity assessments not completed/poor documentation.

Actions implemented to address areas for improvement include:

- The Divisional Doctors Induction has been updated to include an early introduction to ReSPECT and EOL.
- ReSPECT forms require counter signature by a Consultant.
- A revised last days of Life Document has been produced and has been piloted, with plans to roll out to all wards. It is hoped that the revised version will promote better utilisation. The document review identified a gap in spiritual support to EOL patients and their loved ones. This has led to the development of a small working party and a draft leaflet regarding spirituality is currently in progress.
- Bespoke EOL training package developed for all ED staff.
- EOL Champions in place within ward areas.
- Medical Defence Union representatives have attended Quality and Safety/Audit Meetings to raise awareness of the risks of poor quality documentation.
- The Mental Capacity Act/Deprivation of Liberty Safeguards team have been providing additional training and support to staff to improve compliance and quality of mental capacity assessments and best interest forms. This work will be continued into 2023/24 as part of the Trust's Mental Capacity Quality Priority.
- A Trust wide quality improvement project is underway aiming to deliver a single pain assessment tool which will be used for all patients, including those who are at the end of their life. This is on track to deliver by the end of March 2023.

Building on the success of the Bluebell model introduced on several acute ward areas in 2021/22, the model has been rolled out to all ward areas in 2022/23. The model encourages the discussions and earlier identification of EOL and provides staff with the skills and confidence to identify and discuss patients EOL care needs. The positive impact of implementing this model is demonstrated in staff feedback as well as feedback from families using the Family Voices Diary. The Bluebell project has been instrumental in demonstrating good care as reported in the Trust's CQC report.

Compliance with syringe driver training has significantly improved due to targeted training via in reach onto ward areas where operational pressures inhibit staff from being released to attend classroom or virtual sessions. ReSPECT awareness compliance has also improved however authorship training remains low and will be an area for further improvement work in 2023/24.

A Trustwide Quality Improvement 'Always' Event was held in March 2023 which engaged frontline clinicians in articulating change ideas focussed around:

- The quality of ReSPECT documents which support appropriate ceilings of escalation and preferred place of care.
- Appropriate use of the Last Days of life pathway which underpins evidence-based care.
- Timely recognition of EOL.

This work will be developed further in 2023/24 as part of the Trust's EOL Quality Priority and on-gong quality improvement projects.

2.3j Details of ways in which staff can speak up

Annual Update on Speaking Up:

All NHS staff should be able to speak up regarding any concerns they may have in full confidence of not suffering any form of detriment as a result. The Trust is committed to ensuring that employees working for the Trust are not only encouraged to do this but are actively supported and guided as to how they can do this, should they feel the need to, whether they are concerned about quality of care, patient safety or bullying and harassment within their workplace.

The Trust has encouraged and supported staff to speak up by instituting several mechanisms for staff to raise concerns, these include:

- Raise concerns with their line manager. If this is not possible for any number of reasons, staff have further established routes in place and available to them to speak up, including:
    - Through the Trust's nominated Freedom to Speak Up Guardian
    - Via the Human Resources Department, a part of the Trust's People Directorate
    - Using 'Shout Out Wednesday' in Family Services to raise any concerns.
    - Logging an incident on the Trust's incident reporting tool hosted on Ulysses
    - Contacting 'Ask Peter' which provides an anonymous channel to communicate concerns directly to the Chief Executive.

Freedom to Speak Up Guardian

The Trust's Freedom to Speak Up Guardian, their role, contact details and the principles of Freedom to Speak Up process is communicated to all new starters within the Trust as part of the corporate induction programme. The Trust's appointment of a substantive guardian in 2020 has led to a significant increase in the number of concerns raised and the role of the Guardian is widely publicised to all. Feedback shows staff would feel safe to speak up again.

The Guardian role and the Speaking Up process is further promoted through printed and digital materials in the Trust and in the past 12 months there have been several promotional events (including a highly publicised campaign for the NGO Speak Up month in October), and additional magazine features. The Guardian is active on social media and regularly uses it as a way of communicating to staff. The Freedom to Speak Up Guardian is accessed via a generic email

address and a dedicated mobile telephone number. Staff can also raise concerns using the Staff App, which gives another portal to access Guardian support.

In February 2023, the Trust formally adopted the Freedom to Speak Up Policy and Process for the NHS, which was developed by the NGO and NHSE with a recommendation that all Trusts adopt it. The Policy has been amended to include relevant Trust contacts. The Freedom to Speak Up Guardian responds to all concerns raised under this process and follows through each case according to the individual requirements providing regular communications and feedback until the case is concluded. Evaluation feedback from staff raising concerns has shown confidence in the Guardian and the overall process.

The Trust's Freedom to Speak Up Guardian meets monthly with the Chief Executive and the Director of People (who is the Executive Sponsor) and bi-monthly with the Trust Chair and Non-Executive Director with specific responsibility for Freedom to Speak Up who provides support to this function. The Freedom to Speak Up Guardian also meets monthly with the Trust Patient Safety Specialist to discuss any concerns raised in relation to Patient Safety. A quarterly Freedom to Speak Up Guardian report is reviewed by the Trust Management Board and the Workforce Sub-committee prior to being presented to the Trust Board by the Freedom to Speak Up Guardian. This ensures the Trust, and its board are kept up to date on concerns including sufficient details as per the National Guardian's recommendations. An overview of the report is shared with all staff by quarterly infographics. The Guardian is also sharing information to all Divisions about the number and nature of the concerns raised via the HR business partners. This information now forms part of the Divisions performance review meetings and information and can be used in conjunction with other HR intelligence data to highlight potential areas for further analysis.

During 2021/22 there was a significant increase in concerns raised with 157 cases brought to the Guardian, and in 2022/23, 220 concerns were brought to the Guardian. The latest staff survey indicates increased confidence in staff being able to raise concerns about anything and an increase that the organisation will address concerns, however there is a decline in staff feeling safe to raise concerns about unsafe clinical practice and that the organisation will address them. Although disappointing, the figure is still in line with national average figures for a Community & Acute Trust and reflects a national trend.

The Freedom To Speak Up Guardian has produced an annual progress report against the Trust's Freedom To Speak Up Strategy 2020-2024 which looked at the objectives set out in the strategy, progress made against them, and if additional actions are required to fulfil them. It is hoped that the majority of objectives set out in the strategy will be met by 2024 and no additional actions were identified at this stage.

2.3 k Information about the Guardian of Safe Working Hours

The 2016 national contract for junior doctors encouraged stronger safeguards to prevent doctors from working excessive hours. With this came the introduction of a 'Guardian of Safe Working Hours' in organisations that employ, or host, NHS doctors and dentists in training to oversee the process of ensuring they do not work excessive hours with inadequate breaks. The contract has stipulations on the length and frequency of shifts as well as rest breaks. Exception reporting is a valuable instrument that provides up to date information regarding pressure points in the system. It ensures safe working hours and improves the morale of doctors in training, the quality of medical training and patient safety. It is also the agreed contractual mechanism for ensuring that trainees are paid for all work done.

The Guardian of Safe Working will support safe care for patients through protection and prevention measures to stop doctors working excessive hours. The Guardian of Safe Working oversees the exception reporting process and has the power to levy financial penalties where safe working hours are breached. The role sits independently from the management structure, and the Guardian is responsible for protecting the safeguards outlined in the 2016 Terms and Conditions of Service (TCS) for doctors and dentists in training. The Guardian will ensure that issues of compliance with safe working hours are addressed, as they arise, with the doctor and / or employer, as appropriate; and will provide assurance to the Trust Board or equivalent body that doctors' working hours are safe.

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

There are no trainees within the Dentistry service at the Trust and so the Annual Report applies only to doctors in training. Fill rates for doctors in training at the Trust continue to be high, over 80%, which has helped with rotas, working hours, and ensuring access to educational opportunities.

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

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

Targeted support is provided to support specialties in reducing exception reporting and provide a good learning environment for the doctors in training. The Trust was granted £60,000 of national funding in 2021 to improve facilities for doctors in training and working in partnership with the doctors this has now been used to upgrade the doctors rest facilities and enhance the doctor's mess. This work has now been completed and upgraded rest areas are available on both sites.

Current numbers of Doctors in training within the trust is as follows (as of 1 January 2023):

Number of Training Posts (WTE)	302.74
Number of Doctors/Dentists in Training (WTE)	262.32
Number of Less than full time (LTFT) Trainees (Headcount)	20
Number of Training post vacancies (WTE)	40.42
Total number of trainees: SGH	155.74
Total number of trainees: DPOW	147
Total number of trainees: GDH	0

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

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

The Guardian of Safe Working attends meetings between the Trust and Health Education England to monitor the learning environment. During the past year these meetings have concentrated on Medicine and Gastroenterology, following concerns raised in the GMC annual trainee survey.

The Guardian of Safe Working holds Junior Doctor Forums (JDF) every month. Issues addressed over the past year have included:

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

There is now a defined slot at the JDF to discuss quality improvement and there is a dedicated point of contact within the quality improvement office to support the Junior doctors. The Trust continues to see an improvement in engagement with our doctors in training. We will continue to build on this during 2023/24.

Since returning rota coordination management to the divisions in May 2022 there has been an impression of them being more directly responsive to the divisions. Recruitment and training are ongoing in Medicine for Rota Coordinators. Medicine is now engaged in getting all additional hours onto e-Rostering and to getting job plans onto e-Rostering for senior clinicians. This is work in progress that will be completed in 2023/24. This will allow a greater level of visibility across the division of activities undertaken by all clinicians.

2.4 Reporting against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital. However, due to the impact of COVID-19 some national data collection was paused leading to delays in publication. Consequently, to retain consistency and to comply with the national guidance the tables within the report have been populated with the latest published data that is available from NHS Digital. Where appropriate the narrative provides a local update.

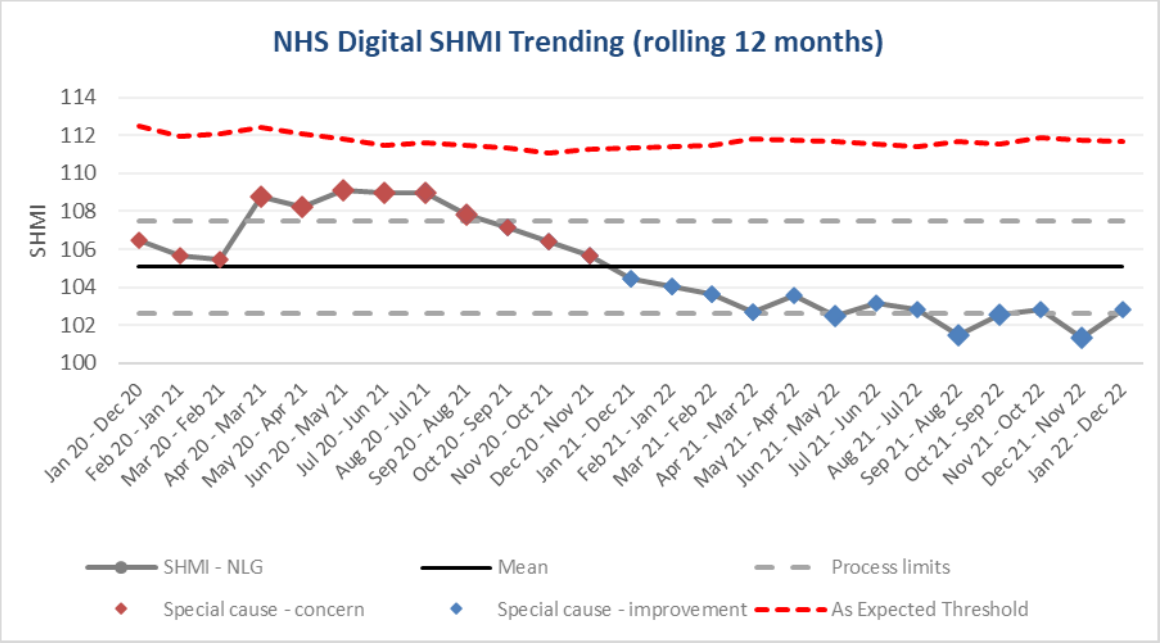
For each indicator, the number, percentage value, score, or rate (as applicable) for the last two reporting periods as well as the lowest and highest values and national average for each indicator for the latest reporting period will be represented in table format below. Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore, the following indicators reported on are only those relevant to the Trust.

2.4a Domain 1 – Preventing people from dying prematurely

Indicator	Trust value Jan 2021 – Dec 2021	Trust value Jan 2022 – Dec 2022	NHS (England) Jan 2022 – Dec 2022	National highest Jan 2022 – Dec 2022	National lowest Jan 2022 – Dec 2022
The value of the SHMI for the Trust for the reporting period*	1.04	1.03	1	1.22	0.71
The banding of the SHMI for the Trust for the reporting period*	2 (as expected)	2 (as expected)	2 (as expected)	1 (higher than expected)	3 (lower than expected)
The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period*	23%	23%	40%	65%	12%

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). *Reporting period January 2021 to December 2022

It should be noted that from May 2019 the SHMI was released on a monthly basis by NHS Digital, an increase in frequency from the previous quarterly releases. All values rounded to 2 decimal places.



- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths out-of-hospital (within 30 days of hospital discharge). The SHMI is a measure of observed deaths compared with 'expected deaths', derived statistically from the recording and coding of patient risk factors.

- NHS Digital guidance on SHMI interpretation states that the difference between the number of observed deaths and the number of expected deaths cannot be interpreted as 'avoidable deaths'. The 'expected' number of deaths is not an actual count but is a statistical construct which estimates the number of deaths that may be expected based on the average England figures and the risk characteristics of the Trust's patients. The SHMI is therefore not a direct measure of quality of care.

- The Trust, as demonstrated in the chart above, has demonstrated statistically significant improvement in the SHMI resulting in the Trust being categorised as having mortality that is 'as expected' and has maintained this position over the past two years. The rolling 12 month SHMI value for the Trust for the period December 2021 – November 2022 was 101.35 which is the lowest on record for the Trust.

- Palliative care coding is a group of codes used by hospital coding teams to reflect palliative care treatment of a patient during their hospital stay. There are strict rules that govern the use of such codes to only those patients seen and managed by a specialist palliative care team.

- The SHMI does not exclude or make any adjustments for palliative care. Other Standardised Mortality Ratios (SMRs) like the Hospital Standardised Mortality Ratio (HSMR) adjust for palliative care.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust continue with the processes to improve the quality and accuracy of the data that underpins statistical mortality calculations like the SHMI and improving the consistency of the learning from deaths programme of work.

- Data continues to highlight a difference between hospital sites with SGH having higher levels of palliative care coding than DPoW. This reflects the disparity of consultant-led Palliative care provision between both hospitals. This forms part of the End of Life improvement plan and is being addressed collaboratively between primary and secondary care. Funding has been secured and recruitment of a Palliative Care Consultant at Grimsby will be pursued in 2023/24.

The Trust has taken the following actions to improve the indicator and percentage in indicators a and b, and so the quality of its services by:

- Clinician led coding validation sessions and mortality screening reviews have continued throughout 2022/23. Key learning points around linking acute conditions to underlying problems have also been identified as follows:
  - Clinicians specifying electrolyte disorders or disturbances with the specific disorder, as each have a specific code. If the conditions are not specified only one code will be assigned, for the unspecified issue. If all conditions are specified, e.g. hypokalaemia, hypercalcaemia and hypernatraemia, all can be recorded which will improve the depth of coding and provides greater specificity around the conditions treated.
  - Multi-organ failure is also a 'catch-all' term used by clinicians to describe a patient's deterioration. When the individual organs that are failing are not specified only one ICD-10 code for unspecified multi-organ failure can be assigned. If each organ that has failed, each can be recorded individually (e.g. heart, respiratory, renal, liver). This accurately specifies the conditions that the patient is being treated for and improves depth of coding (Charlson comorbidities) and HRG assignment.
  - Heart failure diagnosed on diagnostic imaging e.g. chest x-ray requires diagnostic confirmation in the body of the medical record. Coders cannot code suggested diagnoses made on radiology reports and require confirmation for the condition to be coded.
- Teaching sessions and case study presentations have been shared at Divisions Quality & Safety meetings to share learning and reduce coding errors.

- The Trust is taking a pro-active approach to monitoring outcome risk of death for each SHMI diagnosis group and undertakes deep dive work with case reviews to learn from any early warning indicators to prevent future outlier alerts.

- The Community and Therapies Division works in partnership with the Northern Lincolnshire EoL Steering group to implement the Sub System EoL Improvement plan which focuses on delivering the National Ambitions for Palliative & End of Life care.

- The Trust is working in collaboration with Lindsey Lodge Hospice in Northern Lincolnshire to embed a single point of access 9am-5pm (7 days a week) where clinicians in the hospital and community can be directed to appropriate specialist palliative care team/professional for Face to face or virtual support. Outside of these hours on call specialist nurses and consultants can be contacted via Northern Lincolnshire Sigle Point of Access for phone or virtual support. This is underpinned by 7 days a week admission to the hospice and 7 day a week access to face to face specialist care nurses and consultants in Northern Lincolnshire. The Northern Lincolnshire Steering group continues to focus on the development of a consistent offer across Northern Lincolnshire, working with CPG and St Andrews Hospice to provide parity.

- The Clinical Coding team receive monthly palliative care contacts extract from North Lincolnshire Community and Therapy Services and North East Lincolnshire Care Plus Group. This is cross referenced against the patient coded data and any omissions are added for data quality purposes.

2.4b Domain 3 – Helping people to recover from episodes of ill health or following injury

Patient Reported Outcome Measures (PROMS)

The data detailed in the table below was made available to the Trust by NHS Digital with regard to the Trust's patient reported outcome measures scores for:

a) Hip replacement surgery
b) Knee replacement surgery
c) Varicose vein surgery *(Not applicable as no longer performed by the Trust)*

The PROMs is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The table shows the adjusted health gain reported by the patient reported using the EQ-5D index, following their surgery. EQ-5D index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value. The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health). As participation is voluntary, patients can choose not to participate in PROMs.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average	National highest	National lowest
Hip replacement (Primary)	April 2019 – March 2020	0.447	0.459	0.539	0.352
	April 2020 – March 2021	0.410	0.472	0.574	0.393
Knee replacement (Primary)	April 2019 – March 2020	0.335	0.335	0.419	0.215
	April 2020 – March 2021	0.334	0.315	0.399	0.181

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

Patient-reported outcomes following primary hip replacement surgery (published in February 2022) showed a statistical difference to England rates where the Trust had fallen slightly outside the 95% control limit. The Trust scored 0.410, to be within the 95% control limit the Trust would have required a minimum of 0.421. The Trust remains within the 99.8% control limit of 0.392. This alert acts as a 'smoke alarm' and prompts the Trust to investigate processes surrounding primary hip replacement surgery.

The data period of April 2020 – March 2021 was during the peak of the COVID-19 pandemic and this resulted in some activity being cancelled altogether and limited restoration for the remainder of the period, the number of modelled records more than halved from the previous

year. Also, some lower risk patients were transferred to the independent sector which would likely influence the Trust's average patient reported outcomes scores.

Patient-reported outcomes following primary knee replacement surgery remain within the statistically calculated confidence intervals for EQ-5D measures, demonstrating no significantly different performance compared to the UK.

This release of data shows a potential impact from the Covid-19 pandemic which will have impacted upon planned surgery provision.

The Trust has taken the following actions to improve these outcome scores, and so the quality of its services by:

- Data made available from the PROMs dataset is presented within the division of surgery to support reflective practice and agreement of actions required for improvement. A summary report is presented at the Quality Governance Group and also the Quality and Safety Committee.

- Some lower risk patients were transferred to the independent sector to help reduce waiting lists.

- A deep dive investigation was carried out by the Quality and Audit Department and was presented at the Quality and Safety Committee in October 2022. Findings highlighted that although the Trust has fallen outside the 95% control limits for total hip replacements, the data for individual consultants does not highlight any issues that would need further investigation. The health records review further highlighted that over half of the patients for which a worsening in health was recorded had an American Society of Anaesthesiologists (ASA) grade of 3, which is defined as a patient with severe systemic disease. 62% of these patients were clinically classed as obese. This demonstrates that the 21 patients whose health scores deteriorated were high risk patients and may explain why the Trust's overall figures were below the England Average as the Trust does not impose exclusion criteria relating to high BMI and ASA grades.

Patients readmitted to a hospital within 30 days of being discharged

The data made available to the Trust by NHS Digital with regard to the percentage of patients aged:

a) 0 to 15; and
b) 16 or over,

readmitted to a hospital which forms part of the Trust within 30 days of being discharged from a hospital during the reporting period.

Indicator	Trust value April 2020 – March 2021	Trust value April 2021 – March 2022	National average	National highest	National lowest
Percentage of patients aged between 0 to 15 readmitted to a hospital within 30 days of being discharged.	9.3	12.4	12.5	3.3	46.9
Percentage of patients aged 16 or over readmitted to a hospital within 30 days of being discharged.	12.7	12.1	14.7	2.1	142

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts)

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The Trust is below the England average for readmissions in both age groups. This is borne out by local performance reporting against peer benchmarked data.

The Trust intends to take the following actions to improve these percentages, and so the quality of its services by:

The Trust continues to monitor its readmission rates on a monthly basis (from locally available data) and compares these to the national rates in order to benchmark our performance.

2.4c Domain 4 – Ensuring people have a positive experience of care

Responsiveness to the Personal needs of patients

The Trust reviews its responsiveness to the needs of patients through monitoring responses to five specific questions:

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?
4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

There has been no new data made available to the Trust by NHS Digital about the Trust's responsiveness to the personal needs of its patients since 2020. Therefore, the table below shows the data up to the most recent entry covering hospital stays between 01 July 2019 to 31 July 2019 (data collected between 01 August 2019 to 31 January 2020). Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Indicator	Trust value 2019 - 2020	National average	National lowest	National highest
Responsiveness to inpatients personal needs	62.5	67.1	59.5	84.2

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts).

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The data is provided by the national survey contractor.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

Working to ensure that patients can lead decisions in their care management. This is particularly evident in the outpatient transformation work that is ongoing within the Trust. Use of Patient Initiated Follow Up (PIFU) and Patient Knows Best (PKB) are two examples of how patients are encouraged to direct how they are managed according to their health needs.

The Trust continues to gather patient feedback about patient involvement in care and decisions through its monthly INSIGHT survey programme, which supports the national inpatient survey questions, and the 15 Step assurance programme. This feedback provides opportunity for divisions to work closely with areas where feedback indicates further improvement is required. A quality improvement collaborative is in progress focussing on discharge and ensuring patients are involved from the outset and are clear on ongoing care and treatment plans at discharge, including where to seek additional support after leaving hospital. This improvement piece of work also looked at medication at discharge, particularly in the discharge lounge and increased pharmacy support within this.

The most recent national inpatient and maternity surveys both highlighted that patients felt supported by staff, with reference to mental health in pregnancy. This improvement reflects the implementation of the mental health midwifery service. The Trust receives large amounts of positive feedback which references the impact good communication has on patients. Through cultural work, leadership development and training, such as national recognised Sage and Thyme communication workshop, the Trust continues to ensure effective and compassionate communication is a priority.

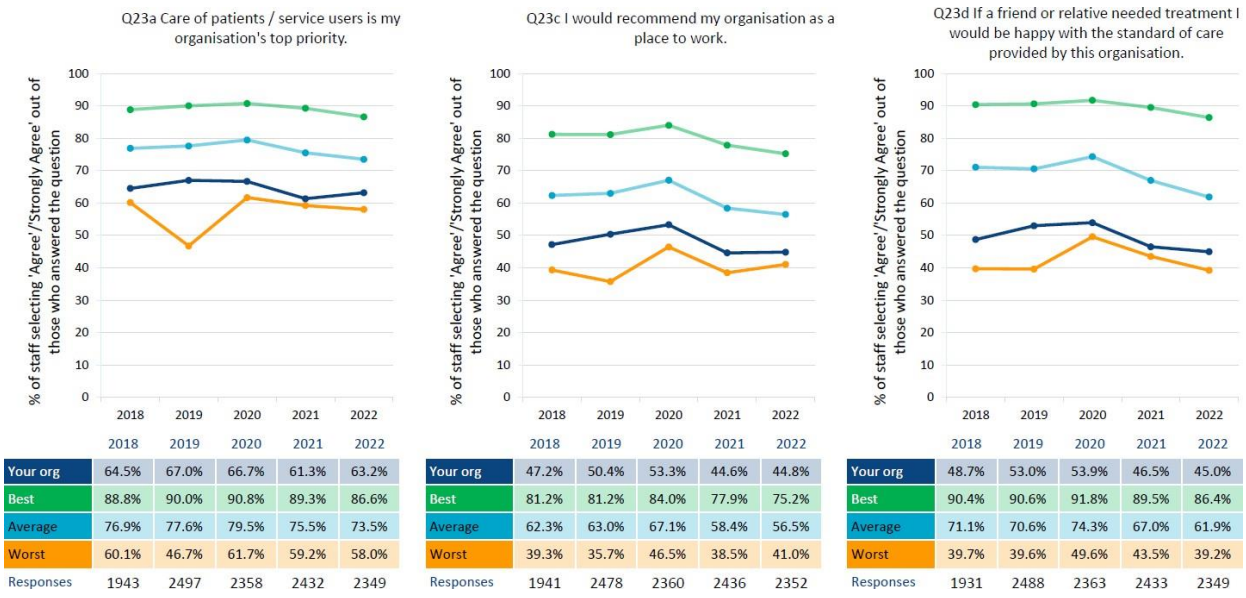
Whilst at times, the patient bedside is the only place to have a clinical conversation, due to the patient's clinical needs, there is further work required to revisit the use of our private spaces. Our charity partner, the Health Tree Foundation, supported a refurbishment programme of quiet rooms across the Trust and a review of this during 2023-24 will help identify the next steps.

The Trust recognises the worry that can arise around care and treatment following discharge. Patient Information leaflets are used within the Trust to provide valuable contact information and signposting. Use of social media platforms and helplines has been successful in our midwifery services, and this should be used to guide other areas wishing to develop this area further. The Trust Patient Advice and Liaison Service (PALS) team always provide a supportive signposting service for patients and families.

Staff recommending Trust as a provider to friends and family

The data made available by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends is taken from the Trust's NHS Staff Survey Benchmark report 2022 published on 09 March 2023.

Indicator	Trust value 2021	Trust value 2022	National average	National lowest	National highest
The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	46.5%	45%	61.9%	39.2%	86.4%



	2018	2019	2020	2021	2022
Your org	64.5%	67.0%	66.7%	61.3%	63.2%
Best	88.8%	90.0%	90.8%	89.3%	86.6%
Average	76.9%	77.6%	79.5%	75.5%	73.5%
Worst	60.1%	46.7%	61.7%	59.2%	58.0%
Responses	1943	2497	2358	2432	2349

	2018	2019	2020	2021	2022
Your org	47.2%	50.4%	53.3%	44.6%	44.8%
Best	81.2%	81.2%	84.0%	77.9%	75.2%
Average	62.3%	63.0%	67.1%	58.4%	56.5%
Worst	39.3%	35.7%	46.5%	38.5%	41.0%
Responses	1941	2478	2360	2436	2352

	2018	2019	2020	2021	2022
Your org	48.7%	53.0%	53.9%	46.5%	45.0%
Best	90.4%	90.6%	91.8%	89.5%	86.4%
Average	71.1%	70.6%	74.3%	67.0%	61.9%
Worst	39.7%	39.6%	49.6%	43.5%	39.2%
Responses	1931	2488	2363	2433	2349

Source: Northern Lincolnshire and Goole NHS Foundation Trust Staff Survey Benchmark Report 2022

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The above table illustrates the percentage of staff answering that they “Agreed” or “strongly agreed” with the question: “If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust” as published on the Staff Survey Coordination Centre website.

45% of staff surveyed would recommend the Trust (-1.6% since 2021); the reduction in the Trust’s score is not as big a decline compared with other organisations as this trend is system wide across the whole NHS and is likely as a response to the pressures and demands on public health presented post pandemic. It should be noted that the England average reduced from 67% to 61.9% in 2022 (-5.1% since 2001).

The unprecedented pressures and backlog of responses to health concerns and treatment the COVID-19 pandemic created continues to impact on overall staff wellbeing and levels of engagement, resulting in a reduction in most scores in 2022 compared to 2021. The Trust notes that there is much work to do across all staff survey themes. It should be noted that despite these pressures the Trust’s score in relation to “Care of patients/service users is my organisations top priority” improved in 2022 compared to the national trend which saw a decline.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

For the last three years significant work has gone into transforming the culture and supporting staff on front line services of the Trust. The Trust is taking the following strategic direction to improve our overall scores:

- The implementation of a Leadership Development Strategy focused on increasing line manager core skills, developing a values based leadership programme centred on improving leadership influence on culture and implementation of structured career pathways and education opportunities for clinical and non-clinical staff. As a result of

investment in leadership development the Trust has now piloted the first cohort with community and therapy and looks to run 6 more in 2023 to priority areas and management groups.

- The launch of a cultural transformation programme developed with our staff through the Big conversation of August 2022 to improve employee experience this resulted in high levels of staff engagement and voice: the Trust has since implemented a culture transformation working group and Board. 2023 will see the development of a culture change academy aimed at individuals, teams, leaders and a network of culture change ambassadors.

- Proactive career planning within nursing, including expanding the apprenticeship framework to enrich nursing career opportunities and retain good staff.

- Improved recruitment strategy and actions to become an Employer of Choice.

- implementation of an Equality, Diversity, and Inclusion action plan to strengthen our inclusion, diversity and equity. The Trust has launched 3 staff networks BME, Disability, LGBTQ+ in 2022 and is looking to launch the Women's network in 2023. A provision of educational programmes from 2023 onwards, ran with and through the staff networks, will support a more inclusive and equitable workforce and workplace.

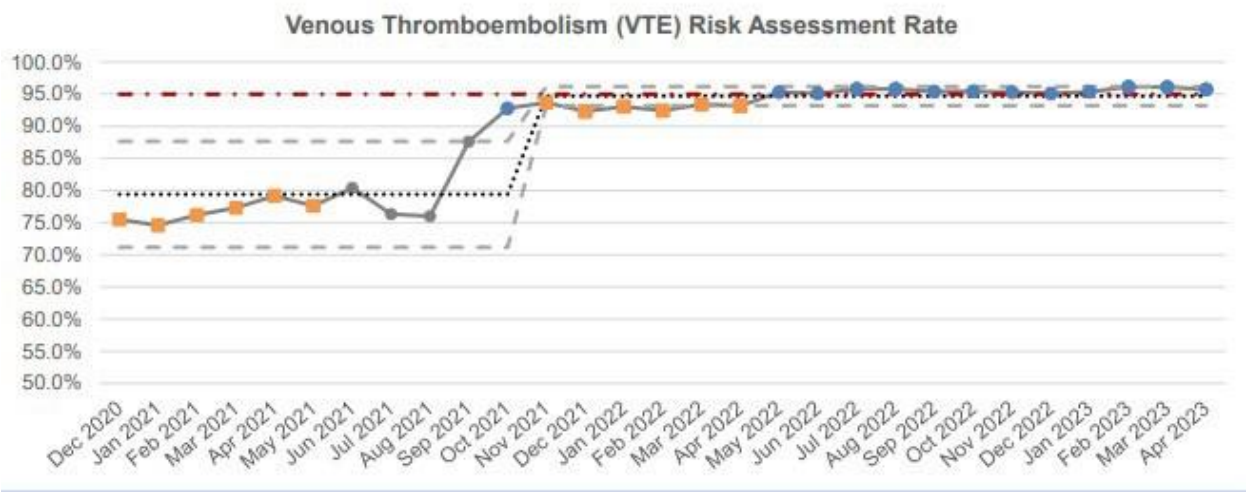
- The Trust has signed up to a two year health and wellbeing plan designed to build on progress made to date and embed effective leadership of our staff's health and wellbeing, introducing Schwartz rounds, growing a network of wellbeing champions and offering training in the field of Mental Health First Aid.

- The Trust aims to further develop this work in 2023 through leadership programme, culture programmes, coaching, mentoring and the development of a culture change academy aimed at individuals, teams, leaders, and a network of culture change transformation.

2.4 d Domain 5 – Treating and caring for people in a safe environment and protecting them from avoidable harm

Risk assessed for Venous Thromboembolism (VTE)

The national VTE data collection and publication was paused to release NHS capacity to support the response to the Covid-19 pandemic. National data collection remains paused, so the below data only reflects local Trust performance data.



Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- The Trust reports on and oversees local VTE risk assessment compliance through the Trust's Performance Review meetings and in the Executive Governance reporting mechanisms. Compliance figures are also available at specialty level, allowing targeted support if indicated.

The Trust has taken the following actions to improve this percentage, and so the quality of its services by:

- The Trust completed the implementation of an Electronic Prescribing and Medicines Administration (EPMA) system in November 2021. The system is having the desired effect in improving patient safety as built-in controls prompt doctors to undertake full VTE risk assessments in a timely manner, prior to prescribing or administering medications. Since the introduction of the EPMA system VTE risk assessment rate has significantly improved and remained above the Trust's 90% target since May 2022 with a 2023/23 year average of 95.3%.

- The Trust's Quality Governance Group receives a highlight report in relation to VTE screening performance.

Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital regarding the rate per 100,000 bed days of cases of Clostridium difficile infection reported within the Trust (hospital onset) amongst patients aged 2 or over is shown in the table below. *(Most recent data published by NHS digital on 29 September 2022).*

Indicator	Trust value 2019/20	Trust value 2020/21	Trust value 2021/22	National average 2021/22	National lowest 2021/22	National highest 2021/22
The rate per 100,000 bed days of cases of C. difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	9.3	7.9	5.1	16.5	0	53.6

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

The data shows that the Trust is beneath the UK average and one of the best performing acute hospitals in the UK which is a major achievement. This level of performance has been maintained in 2022/23.

The definitions for reporting Clostridium difficile cases changed in April 2019 meaning cases detected after 2 days would be attributed as Hospital Onset Healthcare Associated (HOHA) as opposed to the previous guidance, which specified 3 days previously. Cases would also be classed as Community Onset Healthcare Associated (COHA) if the patient was an in-patient within the previous 4 weeks.

Due to success of considerable reduction of cases in previous years, the trajectory for the year 2022 - 2023 of 21 cases was extremely challenging. The Trust had a Clostridium difficile infection objective of no more than 21 cases and ended the year on 24 reported cases combining Hospital-onset healthcare associated and Community-onset healthcare associated cases. There were no significant lapses in practice/care detected from the post infection reviews undertaken. Despite exceeding the threshold, The Trust performed exceptionally well for Clostridium difficile rates for all England acute trusts based on 100,000 bed days and the best performing trust in the region and in the lowest quartile nationally.

The Trust has continued to take the following actions to improve the quality of its services, represented by this data, by:

- Capital and planning teams factored the need to increase isolation capacity in building schemes e.g. Emergency Care Centres and Ward 25.
- The Trust has an evidence-based Clostridium difficile policy and patient treatment care pathway.
- Multi-disciplinary team meetings are held for inpatient cases where required to identify any lessons to be learnt and post-infection review is conducted for hospital onset cases.
- For each case admitted to hospital, practice is audited by the infection prevention and control team based on the Department of Health Saving Lives' audit tools.
- Themes learnt from the Post-Infection Review (PIR) process will be monitored by the Infection Prevention & Control Committee and shared with relevant bodies.
- The development of a bespoke IPC alert that will inform the IPC team to previous cases of Clostridium difficile.
- GPs are sent an email to inform them of a patient's Clostridium difficile status again to help reduce the amount of antimicrobial use and prevent future Clostridium difficile cases; This is now incorporated into the patient discharge letter.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the Infection Prevention & Control group.
- PathLinks antimicrobial formulary reviewed with latest national standards.

- Updated antimicrobial Trust intranet site, the HUB, to make access to content easier for prescribers.

Patient safety incidents

The data made available to the Trust by NHS Digital represents acute (non specialist) trusts only, which is the Peer Group the Trust is benchmarked against for this indicator. Patient safety incident data is now published annually.

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Percentage of safety incidents that resulted in severe harm or death	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 100,00 population	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
October 2019 – March 2020	8,105	65.5	20	0.2	0.25%	0.3	1.95	0.00
April 2020 – September 2020	7,570	79.9	49	0.51	0.65%	Data not available	Data not available	Data not available
October 2020 – March 2021	7,547	69.7	94	0.86	1.25%	Data not available	Data not available	Data not available
April 2021 – March 2022	15,533	72.6	25	0.11	0.16	Data not available	Data not available	Data not available

Source: NHS Digital Quality Account Indicators Portal (https://digital.nhs.uk/data-and-information/areas-of-interest/hospital-care/quality-accounts). There have been no new publications of data by NHS digital since February 2021 which covered the reporting period Oct 2019 – March 2020.

Northern Lincolnshire and Goole NHS Foundation Trust considers that the outcome scores are as described for the following reasons:

- Due to Covid-19 and the lack of available data, the national indicators were not updated with new data periods. Therefore, the table has been populated with local data updates from April 2020 onwards from the National Reporting and Learning System.

- The lack of national data prevents the Trust being able to compare rates of patient safety incidents with other non-specialist NHS organisations. However, the Trust monitors and reports on numbers internally.

- The Trust continues to monitor incident rates locally and continues to actively promote and encourage staff to report all incidents as part of an open and transparent culture designed to support learning and improvement, recognising that high levels of reporting indicate a high level of safety awareness.

- The increase in numbers during April 2021 – March 2022 was due to incidents added retrospectively as severe harm/death for each patient who may have acquired COVID in hospital and then required treatment in ITU or who subsequently died with Covid-19. Letters of apology were sent to each patient's family.

The Trust has taken the following actions to improve this number and/or rate, and so the quality of its services by:

- The Trust continues to promote high levels of incident reporting, viewing this as a learning opportunity promoting a positive patient safety culture.
- The Trust continues to monitor the data for understanding of key themes and sharing for learning lessons opportunities.
- The Trust oversees Serious Incidents (SI) weekly at the SI panel ensuring that appropriate investigation is undertaken in line with agreed timescales.
- The Trust continually works towards improving learning in the organisation and has a learning strategy in place.
- The Trust have a SI Review Group to look back at older cases to determine if there is anything further that can be done to increase safety.

Part 3: Review of Quality Performance

3.1 Performance against relevant indicators and performance thresholds

Performance against indicators that form the Oversight Framework (not already reported on within this document) are shown as follows for 2022/23.

Indicator	Quarter 1 22/23 (Percentage)			Quarter 2 22/23 (Percentage)			Quarter 3 22/23 (Percentage)			Quarter 4 22/23 (Percentage)			Target	Full year average
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar		
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway	71.07	71.79	69.49	67.01	66.98	65.97	66.62	65.98	64.46	65.96	66.56	65.55	92%	67.29%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge	58.90	65.50	63.30	62.10	59.10	62.20	61.20	62.30	53.10	57.60	55.80	56.50	95%	59.8%
All cancers: 62-day wait for first treatment from referral/screening	61.30	53.00	52.20	51.10	42.40	49.80	44.70	54.60	62.40	48.90	58.10	47.50	85%	52.17
Maximum 6-week wait for diagnostic procedures	23.80	20.00	24.40	29.80	32.50	31.40	28.40	29.80	38.60	39.20	33.30	34.40	1%	30.47%

3.2 Information on staff survey report

Summary of performance – NHS staff survey

Each year the Trust encourages staff to take part in the national staff survey. The survey results give each health Trust a picture of how its staff think it's performing as an employer and as an organisation.

Timeline

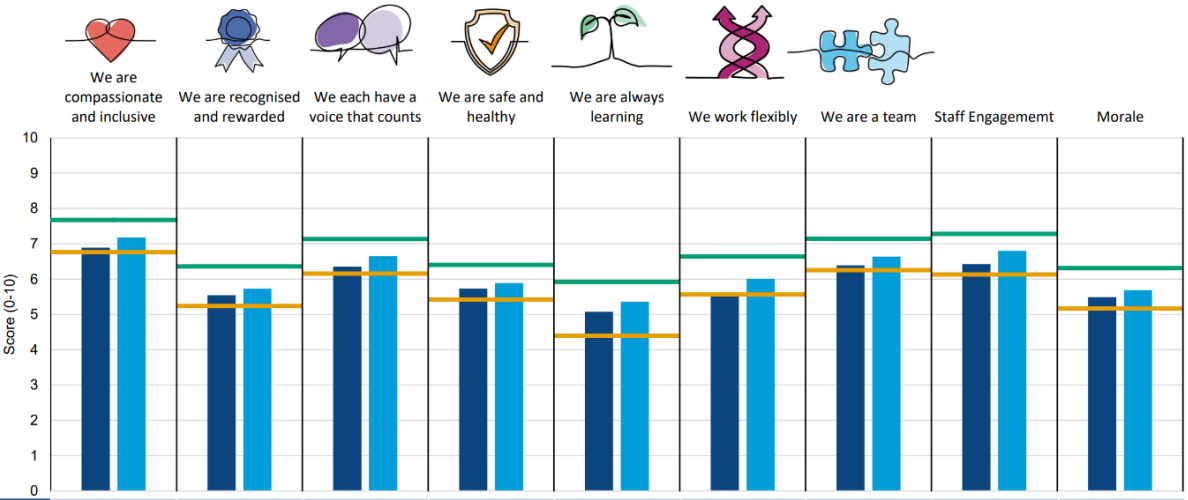
Survey Window: 4th October to 26th November 2022
Embargoed Findings: Received – 24th February 2023
NHSEI Publication: 30th March 2023

Key Facts

Benchmark Comparators: 126 Acute & Acute Community Trusts
Benchmark Response Rate: 46% (+0 % on 2021 survey)
NLaG Response Rate: 36% (-3% on 2021 survey)
NLaG Survey Mode: Online (2,415 completed / -138 on 2021)

Staff Survey 2022 findings

The 2022 survey questions are aligned to the seven themes of the People Promise. Staff Engagement and Morale remain included as in previous years.
The chart below demonstrates Trust results in comparison to peer organisations.



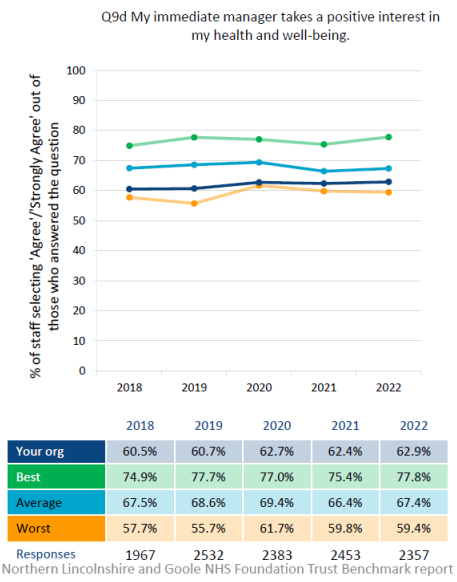
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagememt	Morale
Your org	6.9	5.5	6.4	5.7	5.1	5.6	6.4	6.4	5.5
Best	7.7	6.4	7.1	6.4	5.9	6.6	7.1	7.3	6.3
Average	7.2	5.7	6.6	5.9	5.4	6.0	6.6	6.8	5.7
Worst	6.8	5.2	6.2	5.4	4.4	5.6	6.3	6.1	5.2
Responses	2359	2359	2345	2355	2283	2352	2357	2359	2358

Health and Well-Being

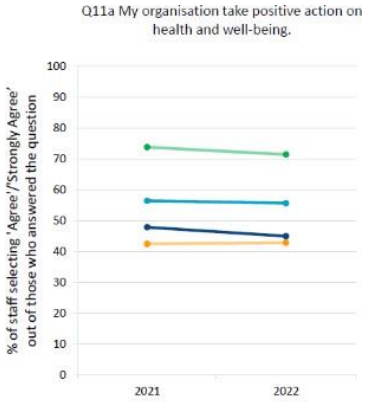
Since last year the Trust can evidence:

- Increased positive action being taken regarding health and wellbeing support
- The uptake of staff working agilely can be evidenced.

Note: Q11a with Trust taking positive action towards Health and Wellbeing is not felt by the respondents yet Q9d respondents felt immediate managers take an interest in health and wellbeing.



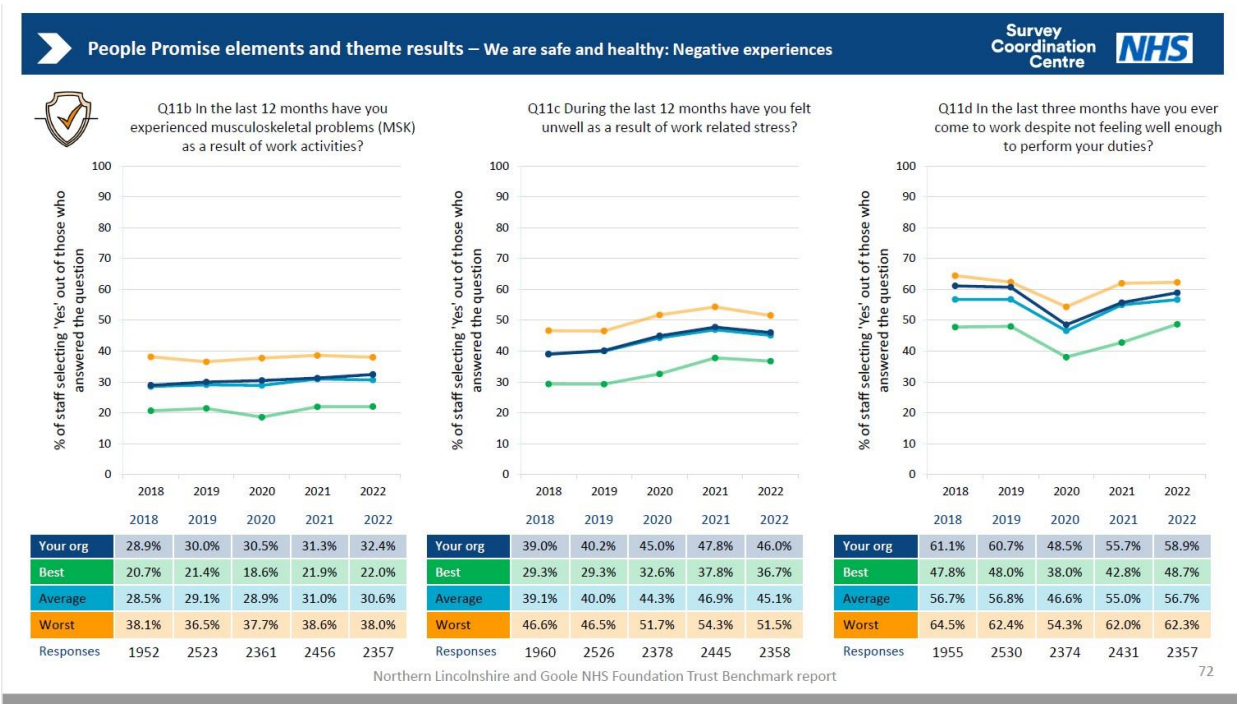
	2018	2019	2020	2021	2022
Your org	60.5%	60.7%	62.7%	62.4%	62.9%
Best	74.9%	77.7%	77.0%	75.4%	77.8%
Average	67.5%	68.6%	69.4%	66.4%	67.4%
Worst	57.7%	55.7%	61.7%	59.8%	59.4%
Responses	1967	2532	2383	2453	2357



	2021	2022
Your org	47.8%	44.9%
Best	73.8%	71.4%
Average	56.4%	55.6%
Worst	42.4%	42.8%
Responses	2426	2306

Northern Lincolnshire and Goole NHS Foundation Trust Benchmark report

The Trust has retained a fairly consistent score on the value managers placed on staff health and wellbeing. This is largely due to a comprehensive and proactive pandemic response action plan implemented in 2020 and retained and enhanced in 2021/2 to support managers and staff through the challenges of the pandemic.



	2018	2019	2020	2021	2022
Your org	28.9%	30.0%	30.5%	31.3%	32.4%
Best	20.7%	21.4%	18.6%	21.9%	22.0%
Average	28.5%	29.1%	28.9%	31.0%	30.6%
Worst	38.1%	36.5%	37.7%	38.6%	38.0%
Responses	1952	2523	2361	2456	2357

	2018	2019	2020	2021	2022
Your org	39.0%	40.2%	45.0%	47.8%	46.0%
Best	29.3%	29.3%	32.6%	37.8%	36.7%
Average	39.1%	40.0%	44.3%	46.9%	45.1%
Worst	46.6%	46.5%	51.7%	54.3%	51.5%
Responses	1960	2526	2378	2445	2358

	2018	2019	2020	2021	2022
Your org	61.1%	60.7%	48.5%	55.7%	58.9%
Best	47.8%	48.0%	38.0%	42.8%	48.7%
Average	56.7%	56.8%	46.6%	55.0%	56.7%
Worst	64.5%	62.4%	54.3%	62.0%	62.3%
Responses	1955	2530	2374	2431	2357

Northern Lincolnshire and Goole NHS Foundation Trust Benchmark report 72

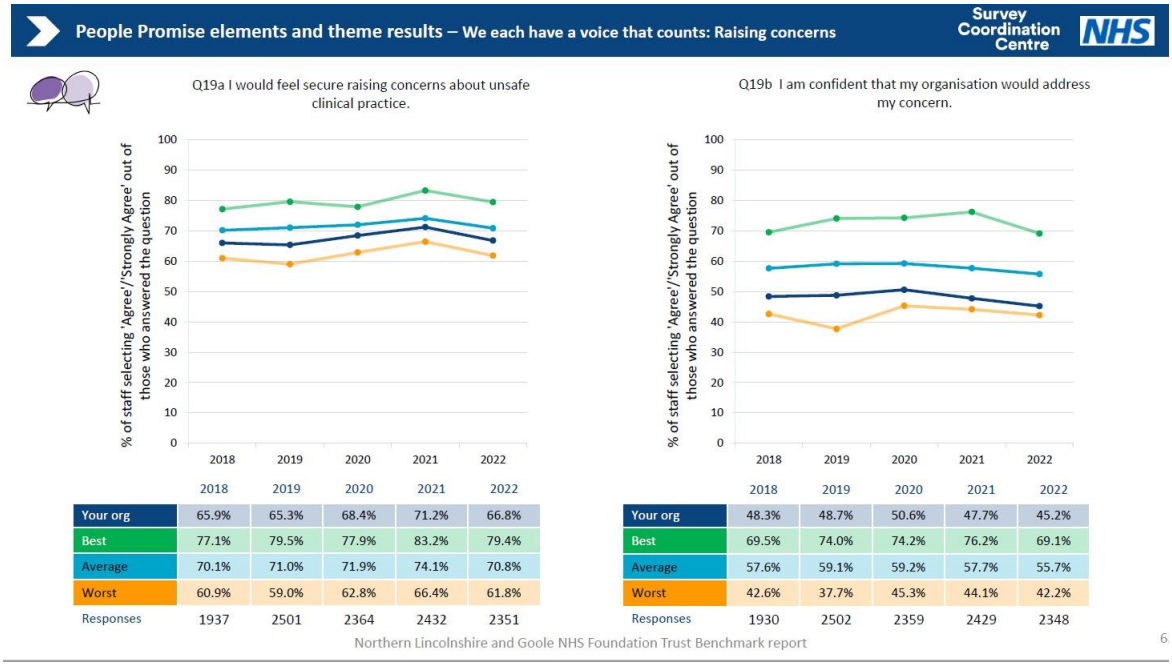
The Trust are committed to further work on health and wellbeing, as set out in our forthcoming two year health and wellbeing plan, and our Trust's recent participation in the NHSE Health and Wellbeing Trailblazer Pilot. The Trust was noted for its strategic perspective in the pilot, focusing on long term improvement of staff wellbeing and line manager capability to proactively support their staff. Further work is mapped to strengthen this including:

- The support of staff psychological wellbeing with skills training and sessions in CISM training, further funding of clinical psychologists, the introduction of Schwartz Rounds

and a series of pop up wellbeing Hubs planned for 2022/23 to continue well into 2023/24.

- Consideration given to supporting staff burnout is required given Q11d and staff continuing to work when unwell is increasing.

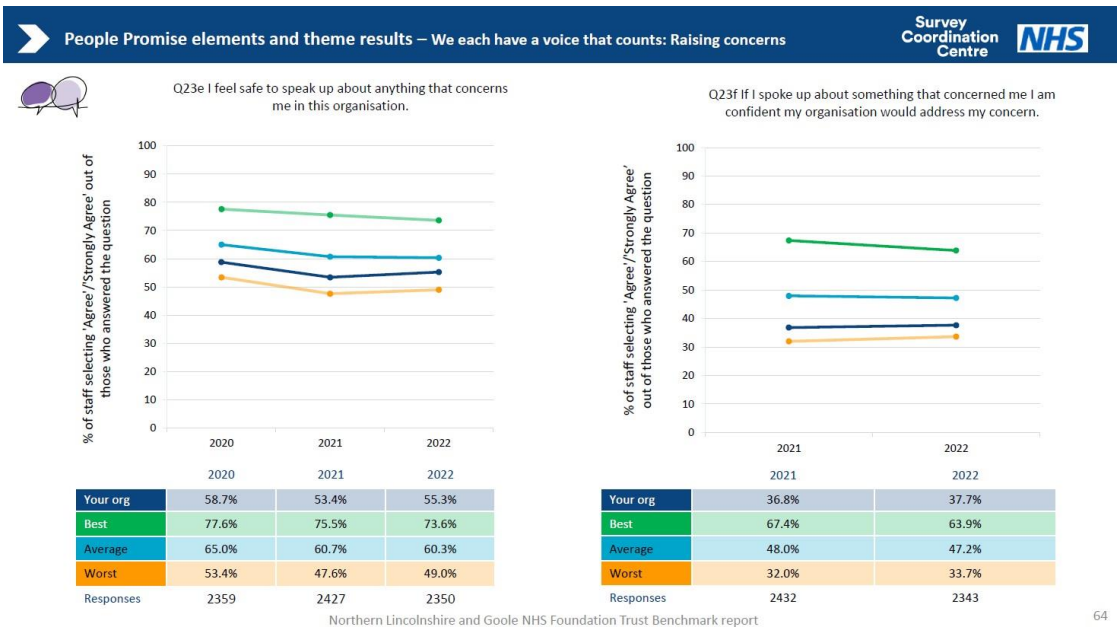
Safety Culture



	2018	2019	2020	2021	2022
Your org	65.9%	65.3%	68.4%	71.2%	66.8%
Best	77.1%	79.5%	77.9%	83.2%	79.4%
Average	70.1%	71.0%	71.9%	74.1%	70.8%
Worst	60.9%	59.0%	62.8%	66.4%	61.8%
Responses	1937	2501	2364	2432	2351

	2018	2019	2020	2021	2022
Your org	48.3%	48.7%	50.6%	47.7%	45.2%
Best	69.5%	74.0%	74.2%	76.2%	69.1%
Average	57.6%	59.1%	59.2%	57.7%	55.7%
Worst	42.6%	37.7%	45.3%	44.1%	42.2%
Responses	1930	2502	2359	2429	2348

Since 2018 significant progress has been made relating to staff feeling secure raising concerns about unsafe clinical practice (+8.9% since 2017 in 2021). However, we see an increase in loss of confidence in raising concerns and addressing these since last year (-4.4% for Q19a and -2.5% for Q19b)

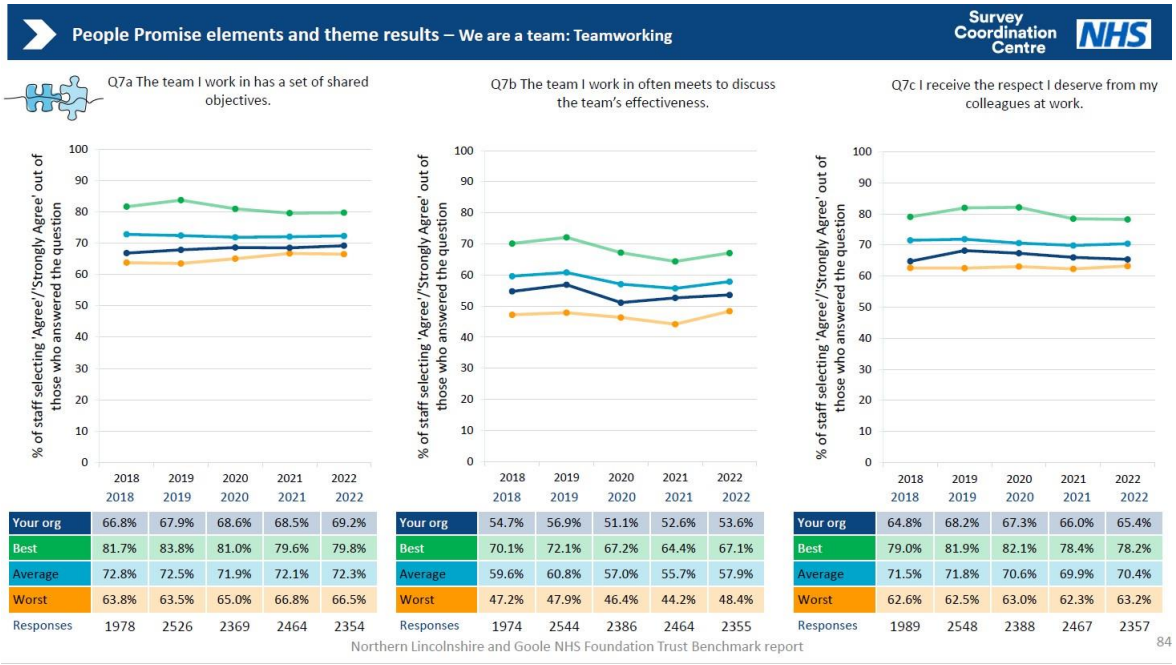


	2020	2021	2022
Your org	58.7%	53.4%	55.3%
Best	77.6%	75.5%	73.6%
Average	65.0%	60.7%	60.3%
Worst	53.4%	47.6%	49.0%
Responses	2359	2427	2350

	2021	2022
Your org	36.8%	37.7%
Best	67.4%	63.9%
Average	48.0%	47.2%
Worst	32.0%	33.7%
Responses	2432	2343

Whereas 2021/22 saw a decrease in staff feeling they are able to speak up about anything that concerns them in the organisation there has been a marked improvement with the introduction of our Freedom To Speak Up Guardian and the Trust taking a proactive approach to improve on this as part of the Culture Transformation programme and Just and Learning Culture.

Team Working



We see a small uplift in scores since last year as an indication that some small improvements have been made and felt by our staff. In addition to the Trusts approving the Leadership Development Strategy last year more Teamworking and Line management skills are required to achieve high levels of staff engagement. Our forthcoming core leadership skills programme of work will support improvement in this theme.

Next Steps:

Begin delivery on revised cultural and leadership objectives aligned to Trust priorities and the Leadership Development Strategy. These are overseen by the Culture Transformation Board and the Workforce Committee.

3.3 Information on patient survey report

The national survey programme provides a year-on-year review of person-centred validated questions and responses. This data allows the Trust to monitor internal progress and benchmarking. During 2022/23 the Trust implemented a comprehensive action plan based on the 2021 national inpatient survey (2022 survey results are still being collated nationally), of which the headlines are detailed below.

The 2021 National Adult Inpatient Survey shows a significant internal improvement for Northern Lincolnshire and Goole NHS Foundation Trust, compared to the 2020 survey results from its survey provider, Picker.

All trusts then have their dated weighted and represented by the CQC. The demographical data indicates most people surveyed were over 66 years of age and had a long-term condition.

On release of the CQC data the Trust is rated in the same mid-range as the other 134 acute trusts surveyed for 46 of the questions asked. It also highlighted significant internal improvement in 5 questions, as shown below:

Q39. Before you left hospital, were you given any information about what you should or should not do after leaving hospital?
Q10. If you brought medication with you to hospital, were you able to take it when you needed to?
Q49. During your hospital stay, were you ever asked to give your views on the quality of your care?
Q42. Before you left hospital, did you know what would happen next with your care?
Q29. Do you think the hospital staff did everything they could to help control your pain?

There has been an organisational quality improvement pain collaborative which has clearly impacted on the patient experience, reflected in the question responses, which provides added assurance to existing monitoring.

The celebration of improvements is shared across the Trust and the whole survey has been reviewed and discussed to determine the proposed improvement actions.

The areas for improvement from the CQC survey, as shown below, have

Where patient experience is best

- ✓ Quality of food: patients describing the hospital food as good
- ✓ Waiting to be admitted: patients feeling that they waited the right amount of time on the waiting list before being admitted to hospital
- ✓ Taking medication: patients being able to take medication they brought to hospital when needed
- ✓ Help with eating: patients being given enough help from staff to eat meals, if needed
- ✓ Dietary needs or requirements: patients being offered food that met any dietary needs or requirements they had

Where patient experience could improve

- ○ Waiting to get to a bed: patients feeling that they waited the right amount of time to get to a bed on a ward after they arrived at the hospital
- ○ Equipment and adaptations in the home: hospital staff discussing if any equipment or home adaptations were needed when leaving hospital
- ○ Changing wards during the night: staff explaining the reason for patients needing to change wards during the night
- ○ Information about medicines to take at home: patients being given information about medicines they were to take at home
- ○ After the operation or procedure: patients being given an explanation from staff of how their operation or procedure went

The survey is shared divisionally, and any actions are designed collaboratively, following discussions around existing quality improvement pathways. This method avoids unnecessary duplication of actions, the overarching action is owned divisionally and monitored every quarter through the Trust's Patient Experience Group. Actions fall under the 4 main headings:

- Person centred care
- Information
- Environment and Facilities
- Discharge

This year's priorities are based on survey results, exiting quality improvement work streams and triangulation of other patient experience data. An example of this is, whilst medications at discharge featured on the CQC report as below the expected range, internally there has been no significant decline in scores and discharge is already a quality improvement priority.

Priorities are also based on which questions mattered most to patients, using the Picker Institutes research-based analysis during review.

Therefore, survey actions are now in place and being monitored around key areas:

- Did not have to wait long time to get to bed on ward
- Not prevented from sleeping
- Explained well how procedure had gone
- Family or home situation considered at discharge

Due to the time span of national surveys, they are, in effect, always year behind by the time results are analysed and shared, the Trust conducts its own ongoing inpatient survey programme. The INSIGHTS local survey programme surveys 10 patients on each adult inpatient ward monthly and monitors this feedback. It remains the Trust's commitment to listen and act on patient feedback and prioritise actions that matter to patients most.

3.4 Quality Improvement Journey

The Quality Improvement (QI) program for the trust has continued to develop in year with 656 staff trained in QI methodologies by the QI Academy during 22/23, including 327 Foundation Level Doctors from across the Integrated Care System at Applying QI level, where they are able to apply their QI skills by delivering a Quality Improvement Project (QIP). 23 Trust staff (and 1 Integrated Care Board staff member) have been trained in Leading & Coaching QI, enabling staff to not only enact their QI skills but lead larger programmes of change. A further 50 Trust staff undertook Applying QI level training with 37 either completing a QIP or in the process of doing so.

In addition, the Trust has run several trust wide QI collaborative events with measurable outcomes involving 38 wards from across the trust. These include the Safe and Secure medications QI collaborative which focused on increasing the compliance of the Safe and Secure Medications audit from a baseline 71.30% compliance to achieving the target of 85% compliance across all inpatient wards at the Trust. An ongoing QI Collaborative commissioned in year focused on the improvement of Pain Assessment and Reassessment, with the 5 pilot wards Increasing the number of electronic pain assessments completed from 497 in March 2022 to 3584 in March 2023. An 'Always' Event was also held during March 2023 to engage clinical colleagues, patients, and families to start a QI programme focusing on the trust End of Life pathways. This work will continue throughout 2023.

The Quality Improvement Showcase launched in Nov 2022 to capture, showcase, and celebrate QI initiatives from across the trust has over 160 QI project documented with over 40% showing a measurable improvement with the remainder at various stages of testing and measuring data.

The Trust will continue to build on its strong QI foundations to deliver outstanding quality of care to our patients in 2023/24.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
Humber and North Yorkshire Integrated Care Board (ICB)
Lincolnshire ICB

This statement has been produced by Humber and North Yorkshire Integrated Care Board (ICB) and includes the reflections of Lincolnshire Integrated Care Board.

The 2022/2023 financial year has been particularly challenging for our health and care system. The Trust has accomplished significant advancements and sustained improvements within the year whilst also being open to opportunities to support the wider healthcare system. The ICB is delighted that the hard work and efforts of the Trust have been formally recognised in their latest CQC inspection and NLaG has moved out of the Recovery Support Programme formally known as Special Measures. The Humber and North Yorkshire Integrated Care Board would like to thank the Trust and all Staff working within the organisation for their significant contribution to supporting the health and care of our population.

The ICB would particularly like to recognise the sustained improvement of the Summary Hospital-level Mortality Indicator (SHMI). An indicator which demonstrates the efforts of the Trust within the organisation and that of the collaboration with health and care partners outside of the Trust to drive system improvement in this area. Additionally, other achievements of the Trust throughout 2022/2023 are highly commended, specifically the vast number of quality improvement initiatives undertaken throughout the year, the establishment of the Maternity Triage Telephone system, the excellent work around the personalisation agenda which is reflected in Gareth's story and the exceptional achievement of the Trust with regards to having some of the lowest Infection Control rates in the country.

The ICB are supportive of the Trust's Quality Priorities for 2023/24, recognising the need to continue to embed the excellent work commenced during 2022/2023 for some areas and the additionality of new quality priorities including End of Life and Mental Capacity which are fundamental to ensuring high quality care for all. With the development of more complex patient pathways, effective communication is key across health and care partners to ensure patient safety and the ICB is reassured that there will also be a specific focus on communication.

We will continue to support the Trust on its improvement journey and will be actively contributing to this by facilitating system health and care innovations within the local health and care system which will impact the quality of our health and care pathways. The two places in Northern Lincolnshire have prioritised Quality Improvement activity to support development in system flow and the quality of care in hospital avoidance and supported discharge. Support into and around care homes is the focus of North and North East Lincolnshire Health and Care Partnerships.

Once again we would like to commend all staff and the Trust on their hard work, resilience and achievements this financial year.

Annex 1.2: Statement from Healthwatch organisations

Feedback from:
Healthwatch North East Lincolnshire
Healthwatch North Lincolnshire
Healthwatch East Riding of Yorkshire

Healthwatch North East Lincolnshire
Suite 4 Alexandra Business Centre
Fisherman's Wharf
Grimsby
DN31 1UL

18.5.23

Dr Peter Reading
Chief Executive
Northern Lincolnshire & Goole NHS Foundation Trust

Dear Dr Peter Reading

Healthwatch response to the Annual Quality Accounts 2022/23

Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire welcome the opportunity to make a statement on the Quality Account for Northern Lincolnshire and Goole NHS Foundation Trust and have agreed to provide a joint statement.

The three local Healthwatch organisations recognise that the Quality Account report is a useful tool in ensuring that NHS healthcare providers are accountable to patients and the public about the quality of service they provide. The following is the joint response from Healthwatch North East Lincolnshire, Healthwatch North Lincolnshire and Healthwatch East Riding of Yorkshire.

The summary clearly sets out what you have achieved during 2022/23 against your 6 priority areas and what still needs working on and where progress has been made. The Trust has also clearly indicated what the priorities will be for 2023/24 and how you hope to achieve them.

Here at Healthwatch we are pleased to hear that the Northern Lincolnshire & Goole NHS Foundation Trust achieved the targets that were necessary to leave the Quality Special Measures after your CQC inspections, these inspections have also shown that through the hard work you and your staff have put in during 2022/23 that your overall CQC rating has gone from 'Inadequate' to 'Requires Improvement'.

The highlight for patients across Northern Lincolnshire has been the opening of the 2 new Emergency Departments, with further developments consisting of Acute Assessment Units and Same Day Emergency Care Provision.

We at Healthwatch are pleased to see the personal account and the impact you have made to an individual with support from staff the young man received the treatment he needed in a caring and compassionate way and the difference this had made to him and his family.

In 2021/22 you reported that you intended to improve the figure for patients being discharged before 12pm. 2022/23 there has still been no statistical change to your position, we at Healthwatch would hope that during 2023/24, with new initiatives being in place that these figures improve. We are aware that you are often reliant on outside agencies to support you and to work collaboratively for the patient and that sometimes things are outside of your control, however improvement in this area is paramount for the wellbeing of patients.

Healthwatch is also pleased to see that the Friends and Family Test has resumed after being paused due to the Covid-19 pandemic, the Trust had set targets to increase the response rates, these may not have been achieved but plans are in place to continue with this action. Healthwatch offers support in this area, if you require it.

The Trusts work and future planning with regards End of Life is welcomed. During 2022/23 we are aware that you have started to roll out the Electronic Palliative care Coordination System (EPaCCs) and this should enable patient's wishes and feelings to written in one place, this will improve their journey and the care they receive. There is still progress to be made in the area of End of Life but the Trust has a clear plan in place to achieve the goals set out.

We would like to thank all of your staff for the hard work they have put in during 2022/23 to achieve a better CQC rating and for the developments that are happening within the Trust. We have still been in Covid-19 recovery, however you have continued to make improvements and to recognise were you still need to make progress.

Yours sincerely,

Tracy Slattery	Jennifer Allen	Cheryl Howley
Delivery Manager	Delivery Manager	Delivery Manager
Healthwatch North East Lincolnshire	Healthwatch North Lincolnshire	Healthwatch East Riding of Yorkshire

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
Lincolnshire – Health Scrutiny Committee for Lincolnshire

Introduction

The Health Scrutiny Committee for Lincolnshire is grateful to representatives from the Trust for presenting its draft quality account and enabling the representatives from the Committee to receive answers to their questions on its content.

Presentation and Clarity of the Quality Account

The Committee believes that the quality account is clearly presented, for example, progress on each of the metrics for the previous year's quality priorities is clearly indicated by colour-coding. The Committee notes that the glossary of terms was included in the draft quality account, and this would be expanded in the final version to cover the acronyms throughout the quality account.

Priorities for Improvement

Progress in 2022/2023

The Committee notes that improvements were made across the metrics for the six priorities for improvement, except antibiotic prescribing, where it was explained to representatives of the Committee that setting targets for reducing antibiotic prescribing may not always be appropriate. The following specific comments are recorded on three of the priorities:

- Priority 1 *(Mortality Improvement)* – Improvements in the Summary Hospital-level Mortality Indicator [SHMI] are particularly welcomed, as are the year on year reductions in the number of patients dying within 24 hours of admission.

- Priority 3 (*Sepsis*) – Although the targets were not met, the Committee accepts that there have been improvements in the percentage of patients screened for sepsis. The Committee looks forward to further improvements as this priority has been carried forward into 2023/24.

- Priority 6 (*Safety of Discharge*) - The Committee supports the contribution of weekend consultant ward rounds to enable the timely discharge of patients, thereby avoiding discharge peaks on Monday mornings.

Priorities for 2023/2024

The Committee supports the five quality priorities selected for 2023/2024, three of which are continuations of actions taken during 2022/23. The Committee looks forward to progress across all five priorities, including the two new priorities (*Improving End of Life and Palliative Care*; and *Increasing the Quality of Mental Capacity Act Compliance*). It was confirmed to the representatives of the Committee that all five priorities were selected with the involvement of patients and staff.

Achievements During 2022/23

The Committee welcomes the following achievements during 2022-23:

- external recognition of the Trust's end of life team and the training of 68 bluebell end of life champions;
- external recognition of the discharge improvement project;
- the development of two new emergency departments and adult assessment units in Grimsby and Scunthorpe; and
- the introduction of the maternity triage system.

Support for Patients with Mental Health Needs

The Committee is grateful for the representatives of the Trust who presented the quality account for outlining the Trust's support for patients needing mental health support, which include some 'in-reach' services provided by the two local mental health providers, as well as access to support from these providers outside the hospital setting. The Committee stresses the importance of mental health support, particularly in emergency departments, as these are places where patients go, when mental health crisis services are not available.

Staff Wellbeing

The number of staff recommending the Trust as a provider to their friends and family had fallen in 2022, and notes that this is likely as a result of staff fatigue and demands on them following the pandemic. Representatives of the Committee were reassured that staff wellbeing was important: the "Ask Peter" initiative, and the *Freedom to Speak Up Guardian* were key elements in valuing staff involvement and supporting their welfare. The Committee was pleased that a higher percentage of exit interviews were being conducted, so that the Trust could learn from staff leaving the service.

Engagement with the Committee

As the Trust engages regularly with three other health overview and scrutiny committees representing the local authority areas where its main sites are located, engagement with the Health Scrutiny Committee for Lincolnshire has previously been limited. The Committee is mindful that the Humber Acute Services Review, with its possible changes to the acute hospitals in Grimsby and Scunthorpe, will affect Lincolnshire patients, and as a result the Committee believes that its engagement with either the Trust or its commissioners is likely to increase.

Conclusion

The Committee is grateful for the opportunity of making a statement on the Trust's quality account for 2022/2023 and looks forward to the Trust continuing with its progress on its standards of care and continuing to provide the acute hospitals of choice for a significant number of patients in the administrative county of Lincolnshire.

Feedback from:
East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee

Northern Lincolnshire and Goole NHS Foundation Trust has engaged with the Council's Health, Care and Wellbeing Overview and Scrutiny Sub-Committee throughout its work programme 2022/23.

The Sub-Committee welcomes the quality priorities set for 2022/23 and feel these have been carefully considered and hopes the Trust can meet these priorities in forthcoming year and that these will help to improve the overall performance of the Trust.
Comments:

- Elective Waiting – In February 2023, the Sub-Committee were presented with a breakdown of NLaG's elective waiting backlog and note that the CQC identified an improvement. A continued commitment to reducing the backlog would be greatly supported by the Sub-Committee.

- Workforce – An approach to address staffing challenges is vital to future proof service delivery. Following on from its consideration of the health care workforce in November 2022, and the continued references throughout the year, the Sub-Committee are pleased to see that activity has been identified for upskilling pharmacists. Opportunities to improve the career prospects of staff, including career planning within nursing, is a positive step towards recruiting and retaining staff.

- Co-production - In preparation for quality priority planning for 2023/24, the Sub-Committee appreciate the engagement with service users as a means to co-produce areas of improvement.

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel

North Lincolnshire Council's Health, Integration and Performance Scrutiny Panel note and welcome the Trust's Quality Account document, including the priorities for the forthcoming year. The Scrutiny Panel intends to work closely with the Trust throughout 2023/24 to discuss services for local patients and residents, to robustly scrutinise forthcoming proposals around acute care, and to hold local decision makers to account.

Feedback from:
North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

No feedback was received for inclusion in the Trust's quality account.

Annex 1.4: Statement from the Trust governors'

The Council of Governors is pleased to have been given the opportunity to comment on the Trust's Quality Account for 2022/23. Despite the Covid pandemic aftermath, this demonstrates a continuation in the significant quality improvements that have been achieved over recent years through the herculean efforts of NLaG staff at all levels of the organisation. It was particularly gratifying that these measurable improvements were reflected in the Care Quality Commission's latest inspection report and the subsequent removal of the Trust from Quality Special Measures or the Recovery Support Programme as it is now known.

Throughout the year governors have continued to prioritise seeking robust assurance regarding the quality and safety of all hospital and community services provided by the Trust in the context of our duty to hold Non-Executive Directors (NEDs) to account for the performance of the Trust Board. We receive regular reports at Council of Governors meetings on progress in implementing the Trust's quality priorities. We are represented at meetings of the Quality & Safety Committee in an observer capacity and the NED chair makes herself available to brief bi-monthly Governor Assurance Group meetings on committee highlights and to answer our searching questions.

Governors are pleased to see the progress that has been made against many of the Trust's 2022/23 quality priorities. Maintenance of a consistent downward in-hospital mortality trajectory has been particularly impressive although more work is required with integrated care system place partners to drive improvements to out of hospital mortality rates. It is also pleasing to see the improvements that have been achieved in the discharge process through much more timely despatch of discharge letters and outpatient clinic summaries to GPs.

The Council of Governors supports the five quality priorities identified for 2023/24. We were pleased that feedback was sought from Trust members and service users in identifying quality improvement areas. It is clearly right that priority is being given to improving palliative and end of life care. This is the one area of NLaG service provision still rated 'inadequate' by the Care Quality Commission, although bringing about the necessary improvements will require concerted action by all system partners. Governors were initially disappointed that communication improvement was not identified as a standalone quality priority as poor communication is too often at the heart of quality lapses. We have since been reassured that communication key performance indicators will be developed for each of the agreed quality priority areas.

Annex 1.5: Response from the Trust to stakeholder comments

The Trust are grateful to stakeholders for their views and comments on the Quality Account for the period 2022/23.

Annex 2: Statement of directors' responsibilities in respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

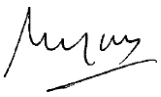
NHS England has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

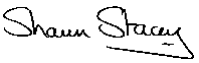
- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2022/23 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
    - Board minutes and papers for the period April 2022 to March 2023
    - Papers relating to quality reported to the board over the period April 2022 to March 2023
    - Feedback from commissioners
    - Feedback from governors
    - Feedback from Local Healthwatch organisations
    - Feedback from Overview and Scrutiny Committees
    - Latest national inpatient survey 2021
    - Latest national staff survey 2023
    - CQC inspection report published 2 December 2022
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the quality report is routinely quality checked to ensure it is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the quality report is routinely quality checked to ensure it is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review
- The Quality Report has been prepared in accordance with NHS England's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board



22 June 2023
…… Date.....Chair



22 June 2023
…… Date.....Interim Chief Executive

Annex 3: Glossary

Ceiling of Care: The course of treatment considered to be the predetermined highest level of intervention deemed appropriate by a medical team, aligning with patient and family wishes, values and beliefs. These crucial early decisions aim to improve the quality of care for patients in whom they are deemed appropriate.

Clostridium Difficile (C. Difficile): A species of bacteria of the genus Clostridium that causes severe diarrhoea and other intestinal disease when competing bacteria in the gut flora are wiped out by antibiotics.

CQUIN or Commissioning for Quality & Innovation Framework: The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Deteriorating Patient: Sometimes, the health of a patient in hospital may get worse suddenly. There are certain times when this is more likely, for example following an emergency admission to hospital, after surgery and after leaving critical care. However, it can happen at any stage of an illness. It increases the patient's risk of needing to stay longer in hospital, not recovering fully or dying. Monitoring patients regularly while they are in hospital and taking action if they show signs of becoming worse can help avoid serious problems.

Electronic Palliative Care Coordination system EPaCCs: Single shared record for preferred place of care and advanced decisions.

EPMA stands for Electronic Prescribing and Medicines Administration and is the digital prescribing system used by Medics and Pharmacists at the Trust.

Family and Friends Test (FFT): From April 2013, all patients will be asked a simple question to identify if they would recommend a particular A&E department or ward to their friends and family. The results of this friends and family test will be used to improve the experience of patients by providing timely feedback alongside other sources of patient feedback.

Harm:

- **Catastrophic harm:** Any patient safety incident that directly resulted in the death of one or more persons receiving NHS funded care.
- **Severe harm:** Any patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
- **Moderate harm:** Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Locally defined as extending stay or care requirements by more than 15 days; Short-term harm requiring further treatment or procedure extending stay or care requirements by 8 - 15 days
- **Low harm:** Any patient safety incident that required extra observation or minor treatment and caused minimal harm, to one or more persons receiving NHS-funded care. Locally defined as requiring observation or minor treatment, with an extended stay or care requirement ranging from 1 – 7 days
- **None/ 'Near Miss' (Harm):** No obvious harm/injury, Minimal impact/no service disruption.

Mortality Data: - How is it measured?

There are two primary ways to measure mortality, both of which are used by the Trust:

1. Crude mortality – expressed as a percentage, calculated by dividing the number of deaths within the organisation by the number of patients treated,
2. Standardised mortality ratios (SMR). These are statistically calculated mortality ratios that are heavily dependent on the quality of recording and coding data. These are calculated by dividing the number of deaths within the Trust by the expected number of deaths. This expected level of mortality is based on the documentation and coding of individual, patient specific risk factors (i.e. their diagnosis or reason for admission, their age, existing comorbidities, medical conditions and illnesses) and combined with general details relating to their hospital admission (i.e. the type of admission, elective for a planned procedure or an unplanned emergency admission), all of which inform the statistical models calculation of what constitutes expected mortality.

As standardised mortality ratios (SMRs) are statistical calculations, they are expressed in a specific format. The absolute average mortality for the UK is expressed as a level of 100.

Whilst '100' is the key numerical value, because of the complex nature of the statistics involved, confidence intervals play a role, meaning that these numerical values are grouped into three categories: "Higher than expected", "within expected range" and "lower than expected". The statistically calculated confidence intervals for this information results in SMRs of both above 100 and below 100 being classified as "within expected range".

Summary Hospital-level Mortality Indicator (SHMI): The SHMI is a measure of deaths following hospital treatment based on all conditions, which occur in or out of hospital within 30 days following discharge from a hospital admission. It is reported at Trust level across the NHS in England using standard methodology.

National Confidential Enquiry into Patient Outcome and Death (NCEPOD): NCEPOD promote improvements in healthcare and support hospitals and doctors to ensure that the highest possible quality of safe patient care is delivered. NCEPOD use critical senior and appropriately chosen specialists to critically examine what has actually happened to the patients.

National Early Warning Score (NEWS2): Nationally defined way of monitoring patients' observations to determine if there are signs of deterioration over time. Sometimes referred to as Early Warning Scores each Trust will have an agreed policy to act on NEWS scores escalating care were appropriate. In some cases, NEWS escalation will not occur, for example when a patient is receiving end of life care, such decisions will be agreed with patients and their families.

Patient Advice & Liaison Service (PALS): The PALS service offers confidential advice, support and information on health-related **matters. They provide a point of contact for patients, their families and their carers.**

Patient Reported Outcome Measures (PROMS): Patient Reported Outcome Measures are questionnaires that ask patients about their health before and after an operation. This helps to measure the results or outcome of the operation from the patient's point of view. This outcome is known as the 'health gain'. All NHS patients undergoing planned hip replacement, knee replacement, varicose vein or groin hernia surgery procedures are invited to fill in PROMs questionnaires.

A Recommended Summary Plan for Emergency Care and Treatment (ReSPECT): Provides a summary for a person's clinical care and treatment in a future emergency in which they do not have capacity to make or express choices.

Same Day Emergency Care (SDEC): Same Day Emergency Care is one of the many ways the Trust is working to provide the right care, in the right place, at the right time for patients. It aims to benefit both patients and the healthcare system by reducing waiting times and unnecessary hospital admissions.

Sepsis: A medical condition that is characterised by a whole body inflammatory state and the presence of a known infection.

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 4: Mandatory Performance Indicator Definitions

No external audit of indicators included in the report has been required as part of the 2022/23 Quality Account reporting process, this follows national guidance received to all NHS Trusts.

This page has been left intentionally blank

Northern Lincolnshire and Goole NHS Foundation Trust

Agenda Number: CoG (07/23) Item: 8.1

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
Director Lead	Lee Bond, Chief Financial Officer	
Contact Officer/Author	Brian Shipley, Operational Director of Finance	
Title of the Report	**Finance Report - M02**	
Purpose of the Report and Executive Summary (to include recommendations)	The report highlights the reported financial position for Month 2of the 2023/24 reporting period.	
Background Information and/or Supporting Document(s) (if applicable)	-	
Prior Approval Process	☐ TMB ☐ PRIMs	☐ Divisional SMT ✓ Other: F&P Committee
Which Trust Priority does this link to	☐ Our People ☐ Quality and Safety ☐ Restoring Services ☐ Reducing Health Inequalities ☐ Collaborative and System Working	☐ Strategic Service Development and Improvement ✓ Finance ☐ Capital Investment ☐ Digital ☐ The NHS Green Agenda ☐ Not applicable
Which Trust Strategic Risk(s)* in the Board Assurance Framework (BAF) does this link to (*see descriptions on page 2)	**To give great care:** ☐ 1 - 1.1 ☐ 1 - 1.2 ☐ 1 - 1.3 ☐ 1 - 1.4 ☐ 1 - 1.5 ☐ 1 - 1.6 **To be a good employer:** ☐ 2	**To live within our means:** ✓ 3 - 3.1 ✓ 3 - 3.2 **To work more collaboratively:** ☐ 4 **To provide good leadership:** ☐ 5 ☐ Not applicable
Financial implication(s) (if applicable)	Contained within the report.	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	-	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other: Click here to enter text.

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

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

Northern Lincolnshire and Goole NHS Foundation Trust

Finance Report Month 2

May – 2023/24

Finance Overview

In month I&E Performance – pages 4 to 6

£0.8m The Trust reported an in-month deficit for month 2 of £2.1m, £0.8m favourable against plan.

YTD I&E Performance – pages 4 to 6

£1.4m The Trust reported a year-to-date deficit for month 2 of £4.3m, £1.4m favourable versus plan.

I&E Forecast Outturn – page 7

(£10.4m) A straight-line projection at month 2 would result in a deficit of £23.8m, £10.4m adrift of plan. This includes the planned release of Technical reserves of £8.5m.

YTD CIP Delivery – page 8

(£0.3m) The Trust delivered £2.3m in CIP against a target of £2.6m.

Underlying I&E – page 9

(£41.5m) The Trust underlying position included in its plan submission is estimated at circa £41.5m.

System Performance – page 11

N/A The ICB System Financial performance is not yet available.

Capital Expenditure – page 13

(£1.9m) Capital spend is £1.9m below plan.

Balance Sheet & Cash – page 14 to 15

£32.2m The Trust cash balance at 31st May 2023 was £32.2m.

Elective Recovery Performance – page 18

TBC The Trust is ahead of its plan in May. However, ERF baselines and profile are still to be agreed. No penalties have been assumed YTD.

Temporary Staffing – page 19

(£0.28m) The Trust has spent £9.9m on agency and bank pay. This is £0.28m more than the same period in 2022/23.

Key Risks

- ❑ Unidentified CIP Stretch Target £10.0m
- ❑ Recruitment & Retention slippage and the continued reliance of Agency
- ❑ Non Delivery of Elective Recovery Target
- ❑ Activity related pressures on Clinical Supplies and Drugs
- ❑ Continued reliance on unfunded Escalation Beds
- ❑ Further Strike Action

Key Actions

[Key actions to achieve financial plan/targets in 2023/24:]

- ❑ Reducing cost pressures - reliance on premium agency, minimising escalation beds and greater control of non-pay consumables.
- ❑ Maximising planned care activity, reducing reliance on IS and WLI premium costs.
- ❑ Delivering a challenging stretch CIP programme - conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Income and Expenditure Performance

Financial Performance Summary

The Trust ended May with a year-to-date deficit of £4.3m, £1.4m better than plan.

- The Trust reported a £2.1m deficit in May 2023, £0.8m ahead of plan. **However, the position is supported by non-recurrent benefits including slippage on independent sector expenditure, reserves and on depreciation and interest received due to capital plan delays. The CIP plan is also much more challenging in the second half of the financial year.**
- Income was £0.50m below plan year-to-date. Clinical Income was £0.60m below plan due to tranche 2 of virtual ward funding and depreciation support both awaiting confirmation. It also included reduced Lung Health Check activity, which was £0.28m below plan, only partly offset by £0.10m expenditure underspends.
- Clinical Pay was £0.2m underspent year-to-date. £0.80m Medical Staff overspends included £0.32m strike costs, temporary staffing premiums covering vacancies, sickness, on-call cover, additional RAT shifts, premium waiting list capacity and weekend ITU cover. These were partly offset by £0.70m nursing and £0.27m AHP underspends due to vacancies across several areas including Maternity, NICU, Pharmacy and Community. Overall escalation bed costs amounted to £0.49m year-to-date for circa 43 beds, partly offset by acute bed capacity funding of £0.29m.
- The above pressures were offset by slippage on investment and elective recovery reserves.
- Non-pay was £0.7m underspent year-to-date due to underspends on Independent Sector, community wheelchairs and estates maintenance, which offset an overspend of £0.21m on energy costs.
- Depreciation and Non-operating Items were £0.6m underspent due to AAU, ED, theatres and IM&T scheme delays, and due to interest received from cash balances.

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical Income	40.4	40.1	(0.3)	79.7	79.1	(0.6)
Other Income	3.6	3.6	0.0	7.1	7.3	0.1
Total Operating Income	**44.0**	**43.7**	**(0.3)**	**86.8**	**86.4**	**(0.5)**
Pay Costs						
Clinical Pay	(25.0)	(24.7)	0.3	(49.3)	(49.2)	0.2
Other Pay	(6.8)	(6.6)	0.1	(13.2)	(12.9)	0.3
Total Pay Costs	**(31.8)**	**(31.3)**	**0.4**	**(62.6)**	**(62.1)**	**0.5**
Clinical Non Pay	(6.8)	(6.4)	0.4	(13.3)	(12.8)	0.4
Other Non Pay	(6.2)	(6.3)	(0.1)	(12.5)	(12.2)	0.2
Total Non Pay Costs	**(13.0)**	**(12.7)**	**0.4**	**(25.7)**	**(25.1)**	**0.7**
Total Operating Expenditure	**(44.8)**	**(44.0)**	**0.8**	**(88.3)**	**(87.1)**	**1.2**
EBITDA	**(0.8)**	**(0.3)**	**0.5**	**(1.5)**	**(0.8)**	**0.7**
Depreciation	(1.6)	(1.5)	0.1	(3.2)	(3.0)	0.2
Non Operating Items	(0.5)	(0.3)	0.2	(1.0)	(0.6)	0.4
Surplus/(Deficit)	**(2.9)**	**(2.1)**	**0.8**	**(5.7)**	**(4.3)**	**1.4**

Financial Performance – Divisions

See Appendix A on page 17 for a summary of the in month and YTD positions for all Divisions and Corporate Directorates.

Divisions	YTD Performance	Key Actions
Operations Directorate **£0.0m** In-month Variance **£(0.0m)** YTD Variance **£0.3m** YTD CIP Variance	• £(0.3)m Pathology overspends due to activity over-performance netted off by £0.1m additional income (note circa 50% CCG activity on block) . • £0.1m pay underspend due to vacancies in Pathology and Pharmacy.	• Conclude Site Management restructure. • Monitor costs of Path Links Over-performance on activity on block.
Family Services **(£0.09m)** In-month Variance **(£0.32m)** YTD Variance **(£0.05m)** YTD CIP Variance	• Medical staff (£0.16m deficit): Improved high locum costs and reduced additional sessions. Failure against CIP target for agency but delivery from M3 onwards. • Nursing (£0.03m Surplus): Significant vacancies in paediatrics and midwifery, which have overachieved against the non recurrent CIP targets set against these. • CIP £0.14m adverse variance in month against unmet CIP target.	• Manage down rota cover costs, reduce sickness and special leave, implement cross site working, address exempt from on call where possible. Reduce F/UP Op activity. • Continue to recruit to substantive posts in order to reduce reliance on bank and agency. • Continue working to replace non recurrent benefits with sustainable recurrent CIP plans.
Surgery & Critical Care **(£0.5m)** In-month Variance **(£1.2m)** YTD Variance **(£0.2m)** YTD CIP Variance	• £1.0m overspent on Medical Staff mainly due to pay premiums covering vacancies alongside restricted duties and on-call cover. Includes £0.1m due to covering Junior Dr's strike. • £0.1m overspent on non pay. £63K HCD adverse variance due to limited delivery of CIP on biosimilars • £106K nursing overspend due to escalation bed cover of £125K unfunded in April & May.	• 13 medical staff on restricted duties . Meetings with individuals to agree ending of restrictions • Recruitment of medical staff to vacancies 35 wte a key priority alongside staff retention • Alternative CIP plans being developed to mitigate for limited delivery of biosimilar savings • Focus on theatre productivity in line with GIRFT targets

Financial Performance – Divisions continued

Divisions	YTD Performance	Key Actions
Medicine **(£0.59m)** In-month Variance **(£1.05m)** YTD Variance **£0.03m** YTD CIP Variance	• Medical Staff (£0.68m deficit) ; 53wte vacancy premium ; (£0.14m) unfunded strike cover costs ; (£0.28m) additional ED / UCS shifts , (£0.25m) Acute vacancies & oncall gaps; LT Sickness cover & GI bleed oncall gaps • Nursing Staff (£0.46m deficit of which £0.29m is ED); vacancy premium 133wte RN & 70wte HCA ; escalation beds part funded (£0.07m) pressure; additional allocation on arrival shifts • Drugs overspent £0.07m ; UCS GP £0.10m underspend off-setting medical staff ED spend	• Medical Staff : Review ED rotas & additional shifts (paper to Exec Team); continue recruitment & retention & mitigate gaps with floater posts ; review of oncall & GI bleed rota gaps • Nursing : Regular ED monitoring; reduce agency spend ; to confirm bed plan to enable reduction of agency usage covering escalation beds, continuation of recruitment & retention; review OOH agency authorisation
Therapy & Community Services **£0.07m** In-month Variance **£0.09m** YTD Variance **£0.05m** YTD CIP Variance	• Community Equipment Services (£0.03m deficit): Team struggling to cope with demand. Use of bank to cover vacancies and create additional capacity. Equipment spend funded to outturn but overspending. • GDH Medical Staffing (£0.06m deficit): Almost entirely vacant posts – covered by locums with high premium cost. • CIP: heavy reliance on non recurrent plans – targets against AHP & nursing vacancies, but currently over-delivering.	• Work to streamline processes and maximise collections and refurbishments to reduce pressure on equipment spend and optimise staff time to meet increased pressure • Recruitment efforts suggest vacancies could be addressed by the autumn. • There are sustainable recurrent opportunities to replace non recurrent plans. These need to be worked up and progressed.
Corporate Directorates & Central Reserves **£1.9m** In-month Variance **£3.9m** YTD Variance **(£0.35m)** YTD CIP Variance	• Estates & Facilities was (£0.24m) overspent due to increased energy costs and unidentified CIP. Chief Nurse was (£0.01m) overspent due to R&D and unidentified CIP. All other Corporate Directorates were break-even or in surplus mainly due to non-recurrent CIP over-delivery. • Central Income was (£0.6m) under plan due to lung health check activity and awaiting formal agreement on tranche 2 virtual wards and depreciation. • The position is supported through slippage on Investment & ERF reserves and centrally held agency premium reserves plus positive variances on interest and depreciation due to capital plan delays and high cash balances.	• Deep dive into non-pay – postage and text reminder cost drivers and overspending areas including electricity, water, sewerage and provisions. • Review of recurrent CIP gaps by individual Corporate Directorates, working up plans to close the gaps. • Review Investment and ERF reserves and expenditure plans.

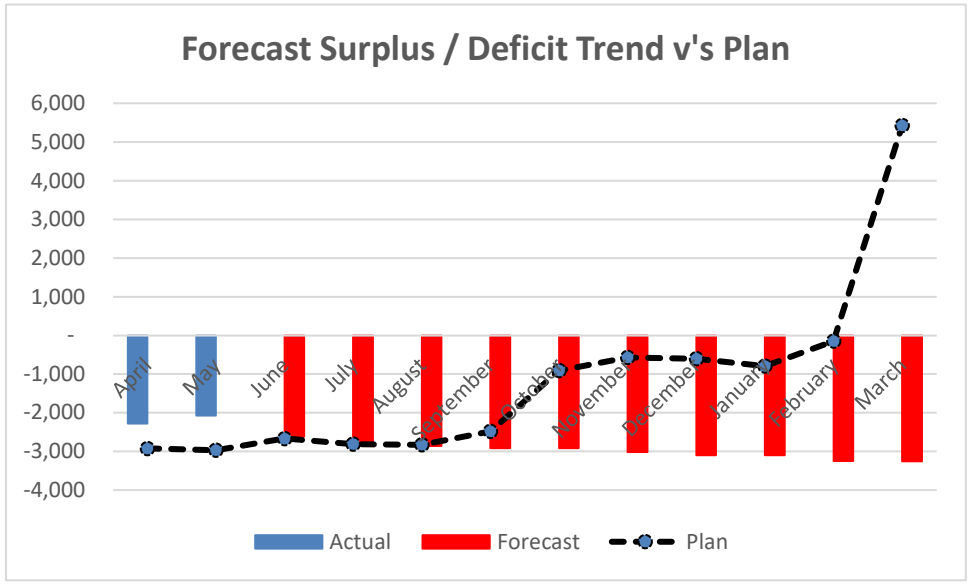
Financial Performance – Forecast Outturn

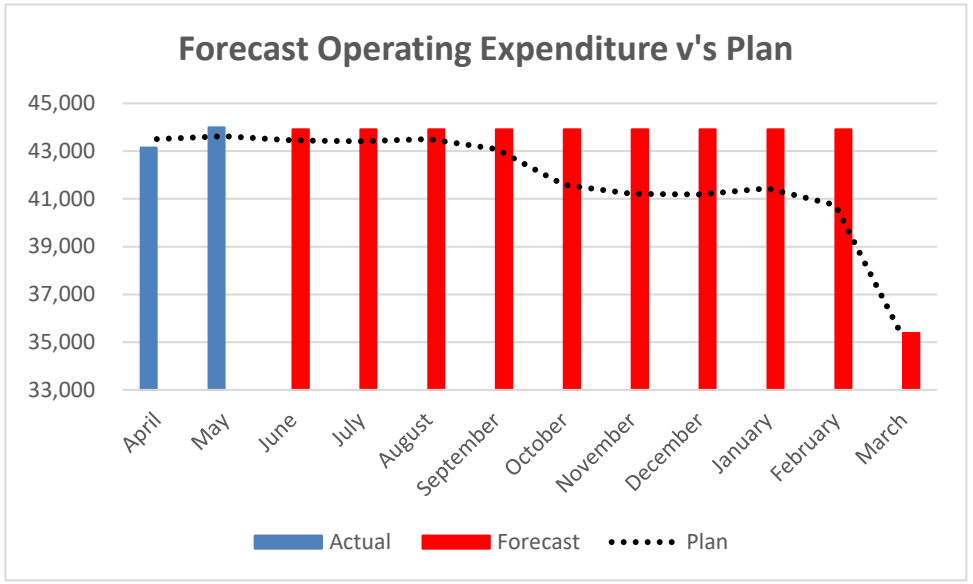
The Trust is forecasting an unmitigated deficit of £23.8m, £10.4m adverse to plan based on a straight-line projection of its current run rate.

The Trust is currently £1.4m ahead of plan at the end of month 2 with a year to date deficit of £4.3m.

However, the financial plan requires a significant reduction in its expenditure run rate in the second half of the year and is also reliant on release of Technical savings support of £8.5m.

If no mitigating actions are taken, a straight-line forecast projects a potential £34.1m end of year deficit risk, £20.8m adverse to plan. The Trust has technical support included within its plan of £8.5m, and expects £1.8m of additional funding for Depreciation support and Tranche 2 capacity (agreed in the plan but not yet transacted), reducing the deficit to £23.8m, £10.4m adverse to plan.

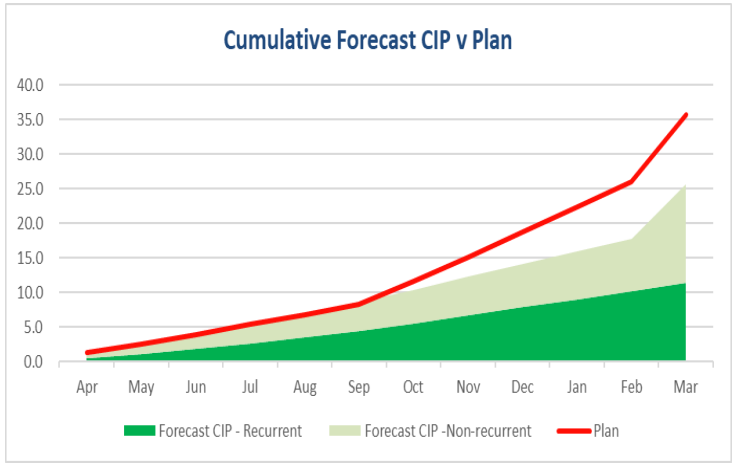




Financial Performance – CIP delivery

The Trust has delivered £2.3m CIP year to date against a target of £2.6m. This has been driven by unidentified plans within the core programme as well as a £0.4m under-delivery on non-recurrent technical reserves.

£million	Current Month			Year to Date			Forecast Year-end		
	Plan	Actual	Var.	Plan	Actual	Var.	Plan	Actual	Var.
CLINICAL WORKFORCE									
Medical Staff	0.1	0.1	(0.0)	0.3	0.2	(0.0)	2.7	2.3	(0.4)
Nursing and Midwifery	0.2	0.3	0.1	0.4	0.6	0.2	4.9	4.8	(0.1)
AHP Staff	0.0	0.3	0.2	0.1	0.4	0.3	0.6	1.2	0.6
TOTAL CLINICAL WORKFORCE	**0.4**	**0.7**	**0.3**	**0.8**	**1.2**	**0.4**	**8.2**	**8.3**	**0.1**
Corporate and Non-Clinical	0.1	0.2	0.1	0.1	0.3	0.2	0.8	1.4	0.7
Non-Pay and Procurement	0.1	0.1	0.0	0.2	0.2	0.0	1.3	1.6	0.3
COVID Expenditure Reduction	0.0	0.0	0.0	0.1	0.1	0.0	0.3	0.3	0.0
Other CIP	0.5	0.3	(0.3)	1.1	0.5	(0.6)	6.7	4.3	(2.4)
TOTAL CORE PROGRAMME	**1.1**	**1.3**	**0.2**	**2.2**	**2.3**	**0.1**	**17.3**	**16.0**	**(1.3)**
Non-recurrent Technical Efficiency	0.2	0.0	(0.2)	0.4	0.0	(0.4)	8.4	8.4	0.0
ICS Stretch	0.0	0.0	0.0	0.0	0.0	0.0	10.1	0.0	(10.1)
TRUST TOTAL EFFICIENCY PLAN	**1.3**	**1.3**	**(0.0)**	**2.6**	**2.3**	**(0.3)**	**35.7**	**24.3**	**(11.4)**



- The Trust is £0.1m ahead of its YTD £2.2m Core CIP plan at the end of May 2023. This is despite unidentified year to date plans of £100k in Surgery, £127k in Family and £37k in Estates & Facilities.
- Additional pressures on the Clinical Productivity and Medical Staff Rota Efficiency schemes have been mitigated by over deliveries on most other workstreams but in particular Corporate and AHP vacancies, Nursing Recruitment and Agency usage and Pathology Income schemes.
- There wasn't a requirement for any non-recurrent technical reserves in-month this is reflected in the CIP delivery with the total Trust efficiency position remaining £0.3m short of the £2.6m plan for the period.
- The Core Programme is forecasting a year-end shortfall of £1.3m due largely to a continuation of the pressure areas identified to date and reduced mitigation provided by other schemes. No progress has been made on the ICS stretch target of £10.1m and as a consequence only £24.3m of savings are forecast against the annual £35.7m plan leaving a forecast deficit of £11.4m

Underlying Position

After adjustments for non-recurrent income and costs in 2022/23, the Trust underlying deficit is £41.5m.

£million	
2023/24 - Surplus/(Deficit) Plan	**(13.4)**
Non-recurrent Adjustments	
Non Recurrent Technical Savings Delivery	(8.5)
Non Recurrent Core Savings Delivery	(5.6)
Unidentified ICB Stretch Target	(10.1)
FYE Investment Programme	(4.0)
Underlying Deficit	**(41.5)**

- The Trust's underlying position reported within its 2023/24 plan submission is an estimated deficit of £41.5m.
- The Trust 2023/24 plan included £24.1m of non recurrent CIP delivery assumptions. This includes the unidentified stretch target of £10.0m, It is currently assumed this will be delivered non-recurrently whilst recurrent mitigation schemes are developed.
- Full year effects on 2023/24 investment are £4.0m

Northern Lincolnshire and Goole NHS Foundation Trust

System Financial Performance

System Financial Performance – April 2023

Information currently not available for Month 1

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Capital and Balance Sheet

Capital Expenditure

Year-to-date capital expenditure is £1.1m against a £3.0m YTD plan, including IFRS16 and donated spend.

£million	Year to Date		
	Plan	Actual	Var.
Estates Major Schemes			
Emergency Department/AAU	2.0	0.4	(1.6)
DPOW & SGH Theatres TIF	0.2	0.0	(0.2)
SGH Fire Alarm	0.4	0.4	(0.0)
Discharge Lounge	0.0	0.0	0.0
N Lincs CDC	0.1	0.1	0.0
Unallocated	0.0	0.0	0.0
Total Estates Major Schemes	**2.6**	**0.9**	**(1.7)**
Other Estates Schemes	0.0	0.0	0.0
IM&T Programme	0.3	0.1	(0.2)
Pathology LIMS	0.0	0.0	0.0
Equipment Renewal	0.1	0.0	(0.1)
Facilities Maintenance	0.0	0.0	0.0
Other Capital Expenditure	0.0	0.0	0.0
Total Capital Programme	**3.0**	**1.1**	**(1.9)**
Funded By:			
Internally Generated	3.0	1.1	(1.9)
PDC Funded	0.0	0.0	(0.0)
Donated	0.0	0.0	0.0
IFRS16	0.0	0.0	0.0
Total Funding	**3.0**	**1.1**	**(1.9)**

The Trust capital funding for 2023/24 is £47.8m. Including donated £0.1m and IFRS16 leases £1.2m. £1.46m of the funding this financial year relates to ICS slippage from York which will have to be repaid in 24/25.

The actual spend to 31st May was £1.1m, all of which related to Trust funded schemes. Key variances are detailed below:

- The AAU schemes are progressing, further delays have been reported with both schemes now forecasting to be completed during November 2023 for DPOW and February 2024 for SGH. The ED/AAU schemes in total are currently forecasting additional costs and risks of **£4.09m,** of this only £3.06m has been included in this years capital plan. Additional costs have been identified at SGH relating to the screed flooring. The forecast deficit is currently under review.
- DPOW and SGH theatre schemes are progressing, the schemes are currently on plan to be operational by the end of quarter 1.
- Facilities maintenance – the water improvements are on plan to be completed in July. SGH Fire alarms is progressing as planned.
- IM&T implementation of PAS is continuing. The Business case for EPR is also progressing.
- The Equipment group has identified priorities to be funded, a number of orders have already been placed. Divisions are working with procurement to agree specifications and obtain quotes.

Balance Sheet

£ million	Actual 31-Mar-23	Actual 30-Apr-23	Actual 31-May-23	In month movement
Fixed Assets	278.9	277.6	277.0	(0.6)
Current Assets				
Inventories	4.0	4.2	4.3	0.0
Trade and Other Debtors	25.4	26.5	30.6	4.1
Cash	41.5	37.9	32.2	(5.7)
Total Current Assets	**70.8**	**68.6**	**67.0**	**(1.6)**
Current Liabilities				
Trade and Other Creditors	64.8	57.3	55.3	(2.0)
Accruals	16.0	19.5	22.4	2.9
Other Current Liabilities	5.3	8.1	7.2	(0.9)
Total Current Liabilities	**86.1**	**85.0**	**84.9**	**(0.1)**
Net Current Liabilities	**(15.3)**	**(16.3)**	**(17.9)**	**(1.5)**
Debtors Due > 1 Year	0.98	0.98	0.98	0.00
Creditors Due > 1 Year	0.00	0.00	0.00	0.00
Loans > 1 Year	6.88	6.88	6.88	0.00
Finance Lease Obligations > 1 Year	12.29	12.29	12.31	0.03
Provisions - Non Current	4.04	4.04	4.04	0.00
Total Assets/(Liabilities)	**241.3**	**239.0**	**236.8**	**(2.2)**
TOTAL CAPITAL & RESERVES	**241.3**	**239.0**	**236.8**	**(2.2)**

Key Movements:

Current Assets

- Stock balances have increased slightly in month, this relates to an increase in audiology and theatre stock.
- Debtors have increased, United Lincs May block invoice is still outstanding, additional income has also been recognised for the pay award.
- The Trust cash balance has reduced in month, the movement relates to the payment of capital creditors.

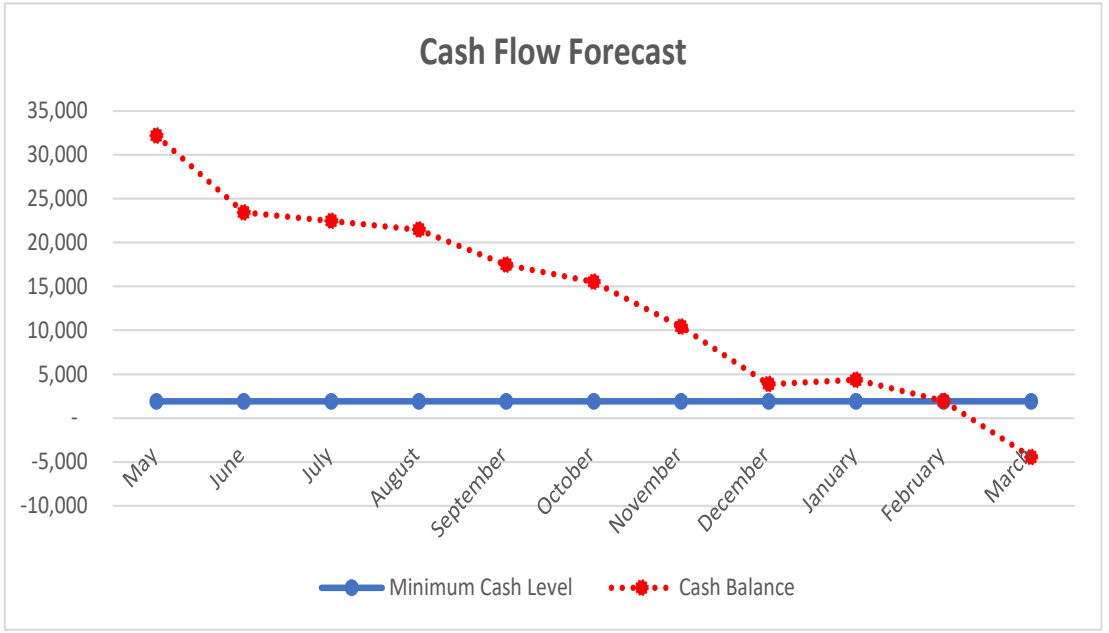
Current Liabilities

- The deferred income has reduced, the May income received in advance for Health Education has now been released.
- The Trust has also made a capital loan repayment this month.
- Trade and other creditors have increased in month, this relates to the additional 3% pay award.

The total BPPC figures for the Trust continue to be above 90%; year to date figures are, 96.5% for value of NHS invoices paid with 30 days and 94.4% for number paid. Non NHS invoices is 95.4% for value paid within 30 days and 94.1% for number paid. Monitoring of BPPC and communication to staff of the importance of authorising invoices will continue.

Cash Flow

Based on the current unmitigated forecast deficit of £23.8m, which includes the release of non-cash backed technical savings of £8.5m, the Trust would expect to require central cash support from February 2024.



£000's	May	June	July	August	September	October	November	December	January	February	March
Minimum Cash Level	1900	1900	1900	1900	1900	1900	1900	1900	1900	1900	1900
Cash Balance	32181	23415	22449	21462	17461	15523	10407	3857	4357	1945	(4450)

Northern Lincolnshire and Goole NHS Foundation Trust

Appendices

Appendix A – Divisional Financial Performance & Reserves Summary

£million	In Month			Year to Date		
	Plan	Actual	Variance	Plan	Actual	Variance
Operations						
Operations Directorate	(3.7)	(3.7)	0.0	(7.2)	(7.3)	(0.0)
Family Services	(3.1)	(3.0)	0.1	(7.3)	(7.7)	(0.3)
Surgery & Critical Care	(3.7)	(3.8)	(0.1)	(20.1)	(21.3)	(1.2)
Medicine	(10.4)	(11.0)	(0.6)	(20.6)	(21.7)	(1.1)
Therapy & Community Services	(10.1)	(10.6)	(0.5)	(6.2)	(6.1)	0.1
Total Operations	**(31.0)**	**(32.1)**	**(1.1)**	**(61.4)**	**(63.9)**	**(2.5)**
Corporate Directorates						
Trust Management	(0.1)	(0.1)	0.0	(0.2)	(0.2)	0.0
Chief Medical Officer Directorate	(1.9)	(1.9)	(0.0)	(3.9)	(3.9)	0.0
Chief Nurses Office	(0.5)	(0.5)	(0.0)	(0.9)	(0.9)	(0.0)
Finance	(0.4)	(0.3)	0.0	(0.8)	(0.7)	0.1
People Directorate	(0.4)	(0.4)	0.0	(0.9)	(0.8)	0.1
Estates & Facilities	(3.1)	(3.3)	(0.1)	(6.3)	(6.5)	(0.2)
Strategic Development	(0.1)	(0.1)	(0.0)	(0.2)	(0.2)	0.0
Digital Services	(0.9)	(0.8)	0.0	(1.7)	(1.7)	0.1
Central Income	40.6	40.3	(0.3)	81.2	80.5	(0.7)
Technical Central & Capital Charges	(2.2)	(1.8)	0.4	(4.4)	(3.6)	0.8
Central CIP	0.3	0.0	(0.3)	0.6	0.0	(0.6)
Trust Reserves	(3.3)	(1.1)	2.2	(7.0)	(2.7)	4.4
Total Corporate Directorates	**28.0**	**29.9**	**1.9**	**55.5**	**59.4**	**3.9**
Excluded Items	0.1	0.1	0.0	0.2	0.2	0.0
Trust Total	**(2.9)**	**(2.1)**	**0.8**	**(5.7)**	**(4.3)**	**1.4**

£million	Opening Allocation	Residual Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investments Reserve	11.0	6.7	0.5	0.0	**0.5**
Inflation Reserve	20.3	16.9	2.9	2.5	**0.5**
Agency Premium Reserve	12.7	6.1	2.4	0.0	**2.4**
Elective Recovery Reserve	12.0	10.6	1.2	0.2	**1.0**
TOTAL	**56.1**	**40.4**	**7.0**	**2.7**	**4.4**

Appendix B – Elective Recovery

Elective Recovery Funding baselines and profiling are still to be agreed with NHSI. Performance against plan is detailed in the following table.

	Elective Recovery Price (£'k)																	
	DAYCASE			ELECTIVE			OP FIRST ATTENDANCE			OP FIRST PROCEDURE			OP F/UP PROCEDURE			ALL ACTIVITY TYPES		
Specialty	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance	Plan	Actuals	Variance
Community and Therapies	56	19	-37	-	2	2	-	-	-	-	-	-	-	-	-	56	21	-35
Medicine	838	1,141	303	92	103	11	1,201	909	-292	28	17	-11	121	120	-2	2,281	2,290	10
Surgery and Critical Care	1,727	2,157	430	1,704	1,997	293	1,190	1,186	-4	240	289	49	462	685	223	5,323	6,314	991
Family Services	273	257	-17	341	341	-1	834	692	-142	291	283	-8	102	124	23	1,841	1,697	-145
Surgery Endoscopy	1,151	1,292	141	-	-	-	-	-	-	18	38	20	-	-	-	1,169	1,330	161
Grand Total	**4,046**	**4,866**	**821**	**2,138**	**2,443**	**305**	**3,225**	**2,787**	**-437**	**577**	**627**	**50**	**686**	**929**	**244**	**10,671**	**11,652**	**982**

	Spells/Attendances					
POD	2019/20	2020/21	2021/22	2022/23	2023/24	Variance to 2019/20
Elective	1,127	268	763	745	719	(408)
Daycase	9,022	2,959	8,015	8,737	8,880	(142)
OPD New	15,755	9,809	15,327	19,210	14,774	(981)
OPD New Procedures	4,496	1,030	3,460	3,696	3,947	(549)
OPD Follow Up	31,756	24,746	30,532	35,539	32,552	796
OPD Follow Up Procedures	8,935	2,734	6,529	8,178	8,712	(223)
Total	**71,091**	**41,546**	**64,626**	**76,105**	**69,584**	**(1,507)**

	Spells/Attendances												
POD	May-22	Jun-22	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23
Elective	400	353	399	417	426	482	476	357	389	455	397	377	342
Daycase	4,747	4,248	4,538	4,633	4,356	4,456	4,897	4,338	4,668	4,434	5,031	4,256	4,624
OPD New	10,146	9,682	9,304	9,048	9,847	9,491	9,538	7,949	8,940	7,846	8,935	6,665	8,109
OPD New Procedures	1,978	1,702	1,795	1,806	2,081	2,021	2,139	1,762	2,140	1,931	2,171	1,802	2,145
OPD Follow Up	18,993	18,350	16,929	17,418	18,173	18,738	20,669	16,334	19,741	17,632	18,266	15,237	17,315
OPD Follow Up Procedures	4,374	3,790	3,865	3,980	4,419	4,563	5,243	3,808	5,263	4,678	4,626	3,989	4,723
Total	**40,638**	**38,125**	**36,830**	**37,302**	**39,302**	**39,751**	**42,962**	**34,548**	**41,141**	**36,976**	**39,426**	**32,326**	**37,258**

Appendix C – Temporary Staffing Summary

Subjective Sub category	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Medical Staff	4,133	4,191	(58)
Nursing Staff	4,328	4,589	(261)
Scientific, Therapeutic & Technical Staff	409	437	(28)
Admin & Clerical Staff	424	355	69
Maintenance Staff	-	1	(1)
Other Staff	1	1	(0)
Support Staff	343	346	(2)
Grand Total	**9,637**	**9,918**	**(281)**

Division / Directorate	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Operations Directorate	523	556	(33)
Community + Therapy Services	576	513	63
Family Services	890	997	(107)
Medicine	4,614	4,795	(181)
Surgery + Critical Care	2,590	2,652	(63)
Sub Total Operations	**9,193**	**9,514**	**(321)**
Chief Medical Officer Directorate	2	3	(1)
Chief Nurses Office	19	15	5
Digital Services	87	36	51
Estates And Facilities	327	329	(2)
Finance	1	-	1
People Directorate	7	21	(14)
Strategic Development	-	-	0
Sub Total Corporate	**444**	**404**	**40**

Grand Total	9,637	9,918	(281)

Type	Subjective Sub category	2022/23 (£k)	2023/24 (£k)	Variance (£k)
Agency	Medical Staff	2,196	2,023	173
	Nursing Staff	2,221	2,568	(347)
	Scientific, Therapeutic & Technical Staff	282	274	7
	Admin & Clerical Staff	83	22	60
	Maintenance Staff	-	1	(1)
	Other Staff	1	1	(0)
	Support Staff	-	1	(1)
Agency Total		**4,781**	**4,890**	**(108)**
Bank	Medical Staff	1,937	2,167	(230)
	Nursing Staff	2,107	2,021	86
	Scientific, Therapeutic & Technical Staff	127	162	(35)
	Admin & Clerical Staff	341	332	9
	Maintenance Staff	-	-	0
	Other Staff	-	-	0
	Support Staff	343	345	(2)
Bank Total		**4,855**	**5,028**	**(173)**
Grand Total		**9,637**	**9,918**	**(281)**

Agenda Number: CoG (07/23) Item: 8.2

Name of the Meeting	**Council of Governors**
Date of the Meeting	13 July 2023
Director Lead	Helen Harris, Director of Corporate Governance
Contact Officer/Author	Helen Harris, Director of Corporate Governance
Title of the Report	**Board Assurance Framework (BAF) 2022-23, Quarter Four Report**
Purpose of the Report and Executive Summary (to include recommendations)	The purpose of the quarter four report is to present the BAF to the Council of Governors for information. The BAF is the key source of information that links the Trust's strategic objectives to risk and assurance. It brings together in one place all the relevant information on the risks relating to the Trust's strategic objectives. The Trust's BAF is based on the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Trust Board to resolve issues or concerns and improve control mechanisms. The Trust Board received the BAF at its meeting on 6 June 2023 where it reviewed the scoring of the strategic risks, noted the referenced high-level risks and received assurance that the BAF is operating as part of the Trust's overarching governance / control systems. It reviewed the highlights and lowlights of each of the principal risks and agreed revised target risk scores for four strategic risks. The Trust Board agreed to transfer all the strategic risks into the BAF 2023/24 and that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy. The Council of Governors is asked to receive the BAF for information.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	☐ TMB ☐ PRIMs ☐ Divisional SMT ✓ Other: Trust Board – 6 June 2023
Which Trust Priority does this link to	✓ Our People ✓ Quality and Safety ✓ Restoring Services ✓ Reducing Health Inequalities ✓ Collaborative and System Working ✓ Strategic Service Development and Improvement ✓ Finance ✓ Capital Investment ✓ Digital ✓ The NHS Green Agenda ☐ Not applicable

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

Board Assurance Framework – Quarter Four, 2022/23

1. Purpose of the Report

1.1. The Board Assurance Framework ('BAF') is the key source of information that links the Trust's strategic objectives to risk and assurance. It brings together in one place all the relevant information on the risks relating to the Trust's strategic objectives. The Trust's BAF is based on the identification of the Trust's strategic goals, the principal risks to delivering them, the key controls to minimise these risks, with the key assurances of these controls identified. These are monitored by the Trust Board to resolve issues or concerns and improve control mechanisms.

1.2. The purpose of the quarter four report is to present the BAF (see Appendix A) to the Council of Governors for information. The report outlines the risks, controls and assurances as well as the immediate and longer terms actions being taken to address the identified risks. It is an essential tool for the Boards seeking assurance against delivery of key organisational objectives.

1.3. The Trust Board received the BAF at its meeting on 6 June 2023 where it reviewed the scoring of the strategic risks, noted the referenced high-level risks (see Appendix B) and received assurance that the BAF is operating as part of the Trust's overarching governance / control systems. It reviewed the highlights and lowlights of each of the principal risks, noted the current risk scores and agreed revised target risk scores for:

SO1-1.1 = from 10 to 15
SO1-1.2 = from 10 to 15
SO1-1.6 = from four to eight
SO2 = from four to 15.

The Trust Board agreed to transfer all the strategic risks into the BAF 2023/24 and that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy.

1.4. The following Board Committees i.e. Workforce Committee, Quality and Safety Committee, and the Finance and Performance Committee reviewed the BAF at their respective committee meetings in May 2023.

1.5. It is envisaged that through appropriate utilisation of the BAF, the Board can have confidence that they are providing thorough oversight of strategic risks. It is used to support the Board in receiving confidence about the likely achievement of each of its strategic objectives**.**

2. Strategic Objective Risk Ratings: 2022-23 Quarter Four

2.1. The table below illustrates the current risk rating of each Strategic Objective against the target risk rating by the end of March 2023:

2022-23						
Strategic Objective / Quarter	Risk Rating				Target Risk by 31/03/2023	Risk Appetite Score
	1	2	3	4		
SO1-1.1	15	15	15	15	15	4-6
SO1-1.2	20	20	20	20	15	4-6
SO1-1.3	12	12	12	12	8	4-6
SO1-1.4	20	20	20	20	20	4-6
SO1-1.5	12	12	9	6	6	4-6
SO1-1.6	16	16	12	12	12	4-6
SO2	20	20	20	20	12	4-6
SO3-3.1	15	20	20	5	20	8-12
SO3-3.2	12	15	15	15	15	8-12
SO4	12	12	12	12	8	8-12
SO5	12	12	12	12	8	8-12

2.2. Principal Risks – Highlights and Lowlights

2.2.1. **SO1-1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.**

The Quality and Safety Committee agreed the risk rating of 15 for the quarter four position and the target risk rating for 31 March 2024 should increase from 10 to 15 due to the strategic threats and the overall healthcare environment challenges. There is also a number of very high-level risks related to divisions and departments within the Trust, that may have an impact on the delivery of the strategic objective: i) No 3162 – quality of care and patient safety based on nurse staffing and, ii) No 3164 – nurse staffing (high number of registered nurse and support worker vacancies), both scored at 20.

However, positive external assurance has been received: improved ratings from the CQC inspection in December 2022 with good for Goole Hospital and the Safe domain improved from inadequate to requires improvement, and the maternity CNST standards compliance submission.

2.2.2. **SO1-1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets**

The Finance and Performance Committee agreed the risk rating for the quarter four position of 20 and that the target risk score for 31 March 2024 should be moved from 10 to 15. This is due to the completion of the new Same Day Emergency Centre and the Theatre refurbishment will support the delivery of the constitutional and other regulatory performance targets. However, a key gap in control is the high levels of staff

vacancies across registered nurses, doctors and allied health professionals in all service areas. This could impact on providing treatment, care and support which is as safe, clinically effective and timely as possible.

2.2.3. **SO1 - 1.3 The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy.**

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. The target risk score was not achieved due to the impact within the Integrated Care System, the future remit and responsibilities of the Collaborative of Acute Providers Board, the emerging ICS strategies and the delay in the consultation of the Humber Acute Services Programme.

2.2.4. **SO1-1.4: The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate**

The Finance and Performance Committee agreed the risk rating of 20 for the quarter four position. This is due to the Capital Programme funding for 2023-24 being impacted by the Critical Infrastructure Risk and BLM: the Six Facet total figure is £117M and the Backlog maintenance is £107M.

2.2.5. **SO1 - 1.5: The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care and/or use of resources.**

The Audit Risk and Governance Committee at its meeting on 23 February 2023 reviewed key elements of the strategic risk for the quarter three period, being IT Business Continuity / Disaster recovery programme, information governance and cyber. The Committee agreed the risk score of nine at its meeting.

Due to the disbanding of the Strategic Development Committee the risk to the delivery of the Digital Strategy has not been reviewed. An update on progress against the Digital Strategy will be presented to the Board in August 2023.

The Chief Information Officer undertook a review of the strategic risk for the quarter four period on 17 April 2023. All actions for 2022/23 were completed which resulted in the risk score reducing to six, with the target risk score by 31 March 2023 being met.

2.2.6. **SO1-1.6: The risk that the Trust's business continuity arrangements are not adequate**

The Finance and Performance Committee agreed that the target risk score for 31 March 2024 should be increased from four to eight. The quarter four risk score of 12 was agreed, due to two outstanding actions from 2022/23, being: i) major incident table top training and, ii) review of evacuation plan.

2.2.7. **SO2: The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients.**

The Workforce Committee agreed the risk rating for the quarter four position should remain at 20 for quarter one 2023/23 and the target risk score by 31 March 2024 be increased from four to 15. This is due to the number of High-Level Risks that could have an impact on the delivery of the strategic objective, in particular: i) No 2976, High registered nursing vacancy levels and ii) No 3015, Insufficient estate resources to

manage the workload demand. The implementation of the People Strategy is ongoing, with a target date of quarter four 2023/24.

2.2.8 SO3-3.1: The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities

The Finance and Performance Committee agreed the quarter four risk rating position of five and the target risk score for 31 March 2024 remaining at 20 due to financial challenges for 2023/24. The target risk score for 2022/23 was achieved due to the release of the balance sheet to support 2022-23 forecast outturn.

2.2.9 SO3 - 3.2: The risk that the Trust fails to secure and deploy adequate major capital to redevelop its estate.

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. There remains a significant risk with capital investment which is due to availability of capital funding to meet our requirements, impact of capital decisions on accessing new hospitals programme funding and impact of national reports (Ockenden) on potential capital investment requirements.

2.2.10 SO4: The risk that the Trust is not a good partner and collaborator.

The risk has only been reviewed by the Director of Strategic Development due to the disbanding of the Strategic Development Committee. The target risk score by 31 March 2023 of eight was not achieved due to the impact within the Integrated Care System, the future remit and responsibilities of the Collaborative of Acute Providers Board, the emerging ICS strategies and the delay in the consultation of the Humber Acute Services Programme.

2.2.10 SO5: The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

The Workforce Committee agreed the current risk score of 12 against a year-end target of eight by 31 March 2023. This is due to two outstanding actions remaining for 2022/23: refreshing the coaching model and refresh of the appraisal process. The Committee also agreed a risk rating of 12 for quarter one 2023/24 reducing to eight by 31 March 2024.

3. BAF Review

The Trust Board agreed to transfer all the strategic risks into the BAF 2023/24 and considered that a review of the BAF risks, structure and format are undertaken as part of the work relating to the Group Model and Strategy.

4. Recommendations

a) The Council of Governors is asked to receive the BAF for information.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Board Assurance Framework - 2022 / 23

Strategic Objective	Strategic Objective Description
1. To give great care	● To provide care which is as safe, effective, accessible and timely as possible ● To focus always on what matters to our patients ● To engage actively with patients and patient groups in shaping services and service strategies ● To learn and change practice so we are continuously improving in line with best practice and local health population needs ● To ensure the services and care we provide are sustainable for the future and meet the needs of our local community ● To offer care in estate and with equipment which meets the highest modern standards ● To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.
2. To be a good employer	● To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: - inclusive values and behaviours - health and wellbeing - training, development, continuous learning and improvement - attractive career opportunities - engagement, listening to concerns and speaking up - attractive remuneration and rewards - compassionate and effective leadership - excellent employee relations.
3. To live within our means	● To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse ● To keep expenditure within the budget associated with that income and also ensuring value for money ● To achieve these within the context of also achieving the same for the Humber Coast and Vale Health Care Partnership ● To secure adequate capital investment for the needs of the Trust and its patients.
4. To work more collaboratively	● To work innovatively, flexibly and constructively with partners across health and social care in the Humber 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 ● To make best use of the combined resources available for health care ● To work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally ● To work with partners to secure major capital and other investment in health and care locally ● To have strong relationships with the public and stakeholders ● To work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: - make best use of the human capabilities and capacities locally; - offer excellent local career development opportunities; - contribute to reduction in inequalities; - contribute to local economic and social development.
5. To provide good leadership	● To ensure that the Trust has leadership at all levels with the skills, behaviours and capacity to fulfil its responsibilities to its patients, staff, and wider stakeholders to the highest standards possible.

Risk Appetite Statement - 2022 / 23

The Trust's risk appetite is:

• For risks threatening the safety of the quality of care provided – low (4 to 6)

• For risks where there is the potential for positive gains in the standards of service provided – moderate (8 to 12)

• For risks where building collaborative partnerships can create new ways of offering services to patients – moderate (8 to 12)

Context

Healthcare organisations like NLaG are by their very nature risk averse, the intention of this risk appetite statement is to make the Trust more aware of the risks and how they are managed. The purpose of this statement is to give guidance to staff on what the Trust Board considers to be an acceptable level of risk for them to take to ensure the Trust meets its strategic objectives. The risk appetite statement should also be used to drive action in areas where the risk assessment in a particular area is greater than the risk appetite stated below.

NLAG is committed to working to secure the best quality healthcare possible for the population it serves. A fundamental part of this objective is the responsibility to manage risk as effectively as possible in the context of a highly complex and changing operational environment. This environment presents a number of constraints to the scope of NLAG's risk management which the Board, senior management and staff cannot always fully influence or control; these include:

• how many patients need to access our services at any time and the fact our services need to be available 24/7 for them whether we have the capacity available or not
• the number of skilled, qualified and experienced staff we have and can retain, or which we can attract, given the extensive national shortages in many job roles.
• numerous national regulations and statutory requirements we must try to work within and targets we must try to achieve
• the state of our buildings, IT and other equipment
• the amount of money we have and are able to spend
• working in an unpredictable and political environment.

The above constraints can be exacerbated by a number of contingencies that can also limit management action; NLAG operates in a complex national and local system where the decisions and actions of other organisations in the health and care sector can have an impact on the Trust's ability to meet its strategic objectives including its management of risk.

Operating in this context on a daily basis Trust staff make numerous organisational and clinical decisions which impact on the health and care of patients. In fulfilling their functions staff will always seek to balance the risks and benefits of taking any action but the Trust acknowledges some risks can never be eliminated fully and has, therefore, put in place a framework to aide controlled decision taking, which sets clear parameters around the level of risk that staff are empowered to take and risks that must be escalated to senior management, executives and the Board.

Risk Appetite Assessment

Risk Assessment Grading Matrix					
Likelihood of recurrence	Severity / Impact / Consequence				
	None / Near Miss (1)	Low (2)	Moderate (3)	Severe (4)	Catastrophic (5)
Rare (1)	1	2	3	4	5
Unlikely (2)	2	4	6	8	10
Possible (3)	3	6	9	12	15
Likely (4)	4	8	12	16	20
Certain (5)	5	10	15	20	25
RISK	Green Risk Score 1 - 3 (Very Low)	Yellow - Risk Score 4 - 6 (Low)	Orange - Risk Score 8 - 12 (Medium)	Red - Risk Score 15 - 25 (High)	

Risk Management

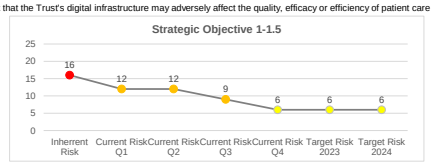
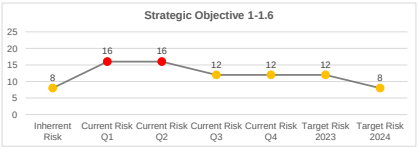
The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using the feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

The Trust will ensure 'risk management is everyone's business' and that staff are actively identifying risks and reporting adverse incidents, near misses or hazards. The Trust will look to create and sustain an open and supportive risk culture, seeking patients' views, and using their feedback as an opportunity for learning and improving the quality of our services. The Trust recognises it has a responsibility to manage risks effectively in order to:

• protect patients, employees and the community against potential losses;
• control its assets and liabilities;
• minimise uncertainty in achieving its goals and objectives;
• maximise the opportunities to achieve its vision and objectives.

Strategic Risk Ratings

Strategic Risk	High Level Risk Description and Risk Consequence / Likelihood Assessment	Risk Appetite	Owner	Committee
SO1 - 1.1	The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard 	Low	Medical Director and Chief Nurse	Q&SC
SO1 - 1.2	The risk that the Trust fails to deliver constitutional and other regulatory performance targets 	Low	Chief Operating Officer	F&PC
SO1 - 1.3	The risk that the Trust will fail to develop, agree, achieve approval to, and implement an effective clinical strategy 	Low	Director of Strategic Development	SDC
SO1 - 1.4	The risk that the Trust's estate, infrastructure and equipment may be inadequate or at risk of becoming inadequate 	Low	Director of Estates and Facilities	F&PC
SO1 - 1.5	The risk that the Trust's digital infrastructure may adversely affect the quality, efficacy or efficiency of patient care 	Low	Chief Information Officer	ARG
SO1 - 1.6	The risk that the Trust's business continuity arrangements are not adequate to cope 	Low	Chief Operating Officer	F&PC
SO2	The risk that the Trust does not have a workforce which is adequate to provide the levels and quality of care which the Trust needs to provide for its patients. 	Low	Director of People	WC
SO3 - 3.1	The risk that either the Trust or the Humber Coast and Vale HCP fail to achieve their financial objectives and responsibilities 	Moderate	Chief Financial Officer	F&PC
SO3 - 3.2	The risk that the Trust fails to secure and deploy adequate major capital 	Moderate	Director of Strategic Development	SDC
SO4	The risk that the Trust is not a good partner and collaborator 	Moderate	Director of Strategic Development	SDC
SO5	The risk that the leadership of the Trust will not be adequate to the tasks set out in its strategic objectives 	Moderate	Chief Executive	WC

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.1: To ensure the best possible experience for the patient, focussing always on what matters to the patient. To seek always to learn and to improve so that what is offered to patients gets better every year and matches the highest standards nationally.

Risk to Strategic Objective 1 - 1.1: The risk that patients may suffer because the Trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	5	5	5
Likelihood	3	3	3	3	3	3	3	3
Risk Rating Score	15	15	15	15	15	15	15	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 23 May 2023, January 2023, 10 October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Quality and Safety Committee

Risk Owners: Chief Medical Officer and Chief Nurse

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy, Risk Management Strategy, Nursing, Midwifery & Allied Health Care Professionals Strategy, Clinical Strategy, Medical Engagement Strategy

Current Controls

- Quality and Safety Committee (Q&SC)
- Operational Plan 2022/23
- Clinical policies, procedures, guidelines, pathways supporting documentation & IT systems
- Risk Management Group
- Trust Management Board
- Quality Board, NHSE
- Place Quality Meetings - N Lincs, N E Lincs, East Riding
- SI Collaborative Meeting with ICB, with Place Representatives
- Health Scrutiny Committees (Local Authority)
- Chief Medical Information Officer (CMIO)
- Council of Governors
- SafeCare Live
- Serious Incident Panel, Patient Safety Specialist and Patient Safety Champions Group
- Nursing Metric Panel Meeting
- OPEL Nurse staffing levels and short term staffing SOP
- Nursing and Midwifery Board
- NICE Guidance implementation monitoring and reporting processes
- Learning from deaths process
- Mortality Improvement Group

Assurance (internal & external)

Internal:
- Minutes of Committees and Groups
- Integrated Performance Report
- Annual Safe Staffing Report, Vulnerabilities report, Annual Complaints Report, Quality Improvement Report, Infection Control Annual Report, Maternity and Ockenden Report to Trust Board
- Non-Executive Director Highlight Report and Executive Director Report (monthly) to Trust Board
- Health Scrutiny Committees (Local Authority)
- NICE Guidance Assurance Report to Q&SC
- IPC - Board Assurance Framework and IPCC
- Inpatient surveys
- Nursing assurance safe staffing framework NHSI
- Audit Outlier Report to Quality Governance Group
- 15 Steps Accreditation Tool
- CQC action planning, monitoring and assurance of action completion processes

External (positive):
- Internal Audit - Serious Incident Management, N2019/16, Significant Assurance
- Internal Audit - Register of External Agency Visits, N2020/15, Significant Assurance
- NHSE External Review of Safe Staffing Establishment and Recommendations - February 2022
- Maternity Birth Rate Plus Review - 2022
- Internal Audit - CQC action plan compliance – Significant assurance
- Improved ratings in CQC inspection (Dec 2022 report) with Good for Goole Hospital and Safe domain improved from Inadequate to Requires Improvement
- Maternity CNST standards compliance submission

Planned Actions

Action	Quarter / Year	Assurance
Birthrate plus review	Q2 2024	Blue
Audit of stop and check safety huddle compliance	Q3 2022/23	Blue
Business case completed for Transition post	Q3 2022/23	Blue
Continue to develop metrics as data quality allows	Ongoing	Blue
Delivery of deteriorating patient improvement plan	Q4 2023/24	Amber
Implementation of End of Life Strategy (system-wide strategy)	Q4 2025/26	Amber
Annual establishment reviews across nursing, midwifery and community settings continue	Q4 2022/23	Blue
Update IPC BAF as national changes and requirements	Q4 2022/23	Blue
Review policy and embed supportive observation	Q4 2022/23	Blue
Review of Ward Assurance Tool and Web V pilot	Q4 2022/23	Blue
Pilot of 15 Steps Star Accreditation Programme	Q4 2022/23	Blue
Management of Influenza outbreaks	Q4 2022/23	Blue
Preparation for trust requirements for the newly proposed LPS	Q4 2022/23	Amber
Implementation of NLAG Patient Safety Incident Response Plan by Autumn 2023 (later due to national delays)	Q2 2023/24	Green
Implementation of the Learning From Patient Safety Events incident reporting requirements (we are in testing phase).	Q2 2023/23	Green
Review and implement changes to Audiology Service	Q2 2023/24	

Future Risks

- COVID-19 and Influenza surges and other infections which impact on patient experience
- National policy changes to access and targets
- Reputation as a consequence of recovery
- Additional patients with longer waiting times and additional 52 week breaches, due to COVID-19
- Generational workforce : analysis shows significant risk of retirement in workforce
- Many services single staff/small teams that lack capacity and agility
- Impact of IPC plans on NLaG clinical and non clinical strategies
- Changes to Liberty Protection Safeguards
- Skill mix of staff
- Student and International placements and capacity to facilitate/supervise/train.
- Transition from SI reporting framework to PSIRF approach.
- Resource for supporting improvement and delivery of Quality Priorities & CQUINS

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.

Gaps in Controls

- Estate and compliance with IPC requirements B12- see BAF SO1 - 1.4
- Ward equipment and replacement programme see BAF SO1 - 1.4
- Attracting sufficiently qualified staff - see BAF SO2
- Funded full time Transition post across the Trust
- Paediatric audiology service

Gaps in Assurance

- Delays with results acknowledgement (system live, process not yet embedded)
- Progress with the End of Life Strategy
- Safety and delays on cancer pathways
- Patient safety risks increased due to longer waiting times. (Refer to SO1-1.2)

Links to High Level Risks Register

Divisional / Departmental Risks Scoring >15:
No 2347 Deteriorating patient risk, Surgery = 15
No 2992 Lack of Changing Places facility at SGH = 16
No 3036, Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS = 16
No 3158, Risk of not being able to view scans on Badgernet, patient safety risk to hgh risk pregnancies = 15
No 3161, Risk of patient deterioration not being recognised and escalated on NEWS = 15
No 3162, quality of care and patient safety based on nurse staffing position in Medicine = 20
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- International recruitment
- Shared clinical development opportunities
- Development of Integrated Care Provider with Local Authority

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.2: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.2: The risk that the Trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	5	5	5
Likelihood	4	4	4	4	4	4	3	3
Risk Rating Score	20	20	20	20	20	20	15	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, December 2022, 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan:
Quality Strategy, Patient Safety Strategy,Quality Improvement Strategy, Risk Management Strategy, Learning Strategy, Nursing and Midwifery Strategy, Clinical Strategy

Current Controls

- Operational Plan
- Operational Management Group (OMG)
- Performance Review Improvement Meetings (PRIMs)
- Trust Management Board (TMB)
- Waiting List Assurance Meetings
- Cancer Board Meeting
- Winter Planning Group
- A&E Delivery Board
- Policies, procedures, guidelines, pathways supporting documentation & IT systems
- Cancer Improvement Plan
- MDT Business Meetings
- Risk stratification
- Capacity and Demand Plans
- Emergency Care Quality & Safety Group
- Primary and Secondary Care Collaborative Outpatient Transformation Programme
- Divisional Executive Review Meetings
- System-wide Ambulance Handover Improvement Group
- Patient Flow Improvement Group (PFIG)
- Planned Care Improvement and Productivity (PCIP)
- Emergency Department and Medicine Specialties Quality & Safetly Groups

Assurance (internal & external)

Internal:
- Minutes of Finance and Performance Committee, OMG, PRIMS, TMB, Waiting List Assurance Meetings, Cancer Board Meeting, Winter Planning Group, A&E Delivery Board, MDT Business Meetings, System-wide Ambulance Handover Improvement Group, PCIP, PFIG
- Integrated Performance Report to Trust Board and Committees.
- Executive and Non Executive Director Report (bi-monthly) to Trust Board.

Positive:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- Benchmarked diagnostic recovery report outlining demand on services and position compared to peers presented at PRIM, October 2020. No significant differences identified, Trust compares to benchmarked peers.
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022
- Audit Yorkshire internal audit: Waiting List Management (including Clinical Harm): Significant Assurance, Q1 2022
- Completed job plans for relevant clinicians for 2022-23

External:
- Audit Yorkshire, Internal Audit, A&E Performance Indicators and Breach to Non-Breach Amendments, May 2021, Significant / Limited
- NHSE Intensive Support Team
- Independant Audit of RTT Business Rules following a number of RTT errors - all high risk areas identified and fully validated - work completed Q1 2022

Planned Actions

Action	Quarter / Year	Assurance
Further development of the ICP with HUTH	Q4 2021/22	Blue
Consultant led ward rounds, further development and implementation (ECIST)	Q4 2021/22	Blue
Winter Planning for 2022/23 - ongoing	Q2 2022/23	Blue
Review and relaunch of the Daily Operations Meetings - ongoing	Q2 2022/23	Blue
Establishment of pathway for YAS to access the North Lincolnshire SPA in the same way as EMAS	Q2 2022/23	Blue
Progress P1 of HASR Plan - Haematology, Oncology, Dermatology	Q2 2022/23	Blue
Implementation of the UCS Model (funding based on Business Case agreement) On hold - Review of South Bank Urgent Care Services taking place	Q3 2022/23	Blue
Outcome of the Urgent Care Services Review for South Bank of ICS agreed	Q3 2022/23	Blue
Introduction of Pathway to enable referrals into SPA from technology enabled care providers to reduce ambulance calls and conveyancing	Q3 2022/23	Blue
Further developemnt of the ICP with HUTH - Dermatology	Q3 2022/23	Blue
Introduction of LLoS reviews in Medicine Division	Q3 2022/23	Blue
Consultant job plans to be signed off for 2022-23	Q3 2022/23	Blue
Opening of new ED build at SGH	Q4 2022/23	Blue
Diagnostic and cancer pathways reviewed and implemented	Q4 2022/23	Blue
Progress with implementation of General Internal Medicine Model	Q2 2023/24	Yellow
Review of clinical pathways linked to HASR programme 1 ICP, 7 specialties	Q2 2023/24	Amber
Validation of all RTT Clock Stops back to 100%	Q2 2023/24	Amber
Develop divisional dashboards	Q2 2023/24	Yellow
Consultant job plans to be signed off for 2023-24	Q2 2023/24	Red
Completion of theatre refubishment programme	Q2 2023/24	Green
Implementation of 2023/24 Outpatient Clinic Configuration aligned to 2023/24 Activity Plan and NHS Operational Planning Guidance, reducing follow up activity and increasing capacity for new patients	Q2 2023/24	Green
Implementation of Gynaecology Service Review	Q3 2023/24	Green
Expansion of Community Discharge and Admission Alternative Development workstreams (Virtual Ward capacity, Short Term care capacity and OPAT capacity)	Q3 2023/24	Green
Implementation of Criteria to Admit within ED to support reduction in admissions and use of alternative pathways	Q4 2023/24	Green
Review of pathways for High Intensity Service Users	Q4 2023/24	Green
Implementation of Clinical Frailty Score in ED	Q4 2023/24	Green
Review Dementia pathways in ED	Q4 2023/24	Green
Implementation phase 3 of AAU business case	Q4 2023/24	Green

Future Risks

- Further COVID-19 surges and impact on patient experience and bed planning due to IPC guidance (including norovirus).
- National policy changes to emergency access and waiting time targets.
- Funding and fines changes.
- Reputation as a consequence of recovery.
- Additional patients with longer waiting times over 18 weeks, 52 weeks, 64 weeks, 62 days and 104 days breaches.
- Additional patients with longer waiting times across the modalities of the 6 week diagnostic target, due to inability to access scanner and reporting teams externally
- Generational workforce analysis shows significant risk of retirement in workforce.
- Many services single staff / small teams that lack capacity and agility.
- Staff taking statutory leave unallocated due to COVID-19 risk.
- Future requirement of Type 5 SDEC activity to be submitted as part ECDS requires significant system change. Early adopters from July 23, with mandatory submission from July 24
- Inability to staff UCS due to lack of support from Primary Care
- Impact of Mutual Aid work and increase in waiting times - not meeting constitutional standards and impact on diagnostic capacity
- Risk of no contracting for independent sector work
- Funding will not be approved to uplift weekend working for elective activity and support insourcing of theatre staff to backfill vacancy position.
- Replacement of ward A1

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of surgical and cancer pathways, poor flow and discharge, and increase in patient complaints.
Adverse impact of external events (ie. Continued Pandemic) on business continuity and the delivery of core service.

Gaps in Controls

- Evidence of compliance with 7 Day Standards.
- Capacity to meet demand for Cancer, RTT/18 weeks, over 64 weeks, over 52 week waits and Diagnostics Constitutional Standards.
- Diagnostic capacity and capital funding to be confirmed.
- Data quality - inability to use live data to manage services effectively using data and information - recognising the improvement in quality at weekly and monthly reconciliations.
- High levels of staff sickness
- High levels of staff vacancies across registered nurses, doctors and allied health professionals in all service areas.

Gaps in Assurance

- Quality of reports to board assurance committees
- Quality and timeliness of data
- Recruitment and development of Consultants, specialist nurses

Links to High Level Risks Register

No 1851, Shortfall in capacity with Ophthalmology service = 15
No 2244, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2245, Risk to Overall Performance : Non compliance with RTT incomplete target = 16
No 2562, Failure to meet constitutional targets in ECC = 20
No 2347, Risk to Overall Performance : Overdue Follow-ups = 15
No 2576, Paediatric Medical Support Pathway for ECC - 'Fastrack' = 16
No 2592, Risk to Overall Performance: Cancer Waiting / Performance Target 62 day = 16
No 2773, Lack of scanning capacity s leading to a risk of delayed diagnosis = 16
No 2949, Oncology Service = 20
No 3129, Overdue follow-up and new patients waiting lists for paediatric patients at SGH = 15
No 3131, Delay in paediatric assessment being carried out (multi-agency assessmenbt for under five years of age = 16
No 3168, Newborn hearing screening service cross-site (reduced management time / no management cover)

Future Opportunities

- Closer Integrated Care System working
- Humber Acute Services Review and programme
- Provider collaboration
- Collaboration with PCNs in NL / NEL to support full implementation of the UCS model

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.3: To engage patients as fully as possible in their care, and to engage actively with patients and patient groups in shaping services and service strategies. To transform care over time (with partners) so that it is of high quality, safe and sustainable in the medium and long term.

Risk to Strategic Objective 1 - 1.3: The risk that the Trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care which is high quality, safe and sustainable.

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4	4	4	4	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	12	12	12	12	12	8	8	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 Apriil 2023, 21 February 2023, 14/10/22, 23/6/22, 13 April 2022, 12 January 2022

Lead Committee: Strategic Development Committee

Risk Owner: Director of Strategic Development

Enabling Strategy / Plan: NHS Long Term Plan, Trust Strategy and Strategic Plan, Clinical Strategy, Integrated Care System

Current Controls

- NLaG Clinical Strategy 2021/25.
- Trust Priorities 2022/23
- Humber and North Yorkshire Health Care Partnership (HNY HCP).
- Integrated Care System (ICS) Leadership Group.
- Quality and Safety Committee.
- Acute and Community Care Collaboratives (ACC).
- Humber Cancer Board.
- Humber Acute Services - Executive Oversight Group (HAS.
- Health Overview and Scrutiny Committees (OSC).
- Trust Membership
- Council of Governors.
- Primary Care Networks (PCNs).
- Place Boards
- Clinical and Professional Leaders Board.
- Hospital Consultants Committee (HCC) / MAC
- Joint Development Board (JDB)
- Committees in Common (CIC)
- Strategic Development Committee (SDC)
- Patient Safety Champions

Assurance (internal & external)

Positive:
- NHSE Assurance and Gateway Reviews.
- OSC Engagement.
- Clinical Senate formal review
- The Consultation Institute (assurance on the engagement process)

Internal:
- Minutes from Committees and Executive Oversight Group for HAS, JDB, CiC, SDC
- Humber and North Yorkshire Health Care Partnership.
- ICS Leadership Group.
- OSC Feedback.
- Outcome of public, patient and staff engagement exercises.
- Executive Director Report to Trust Board.
- Non-Executive Director Committee Chair Highlight Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- Citizens Panel (Humber).
- The Consultation Institute (assurance on the engagement process)

Planned Actions

Action	Quarter / Year	Assurance
CIC / SDC / NED / Governor reviews	Q4 2022/23	Green
Evaluation of the models and options with stakeholders	Q4 2022/23	Green
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
Citizens Panel reviews	Q4 2022/23	Green
To undertake continuous process of stocktake and assurance reviews NHSE/I and Clinical Senate review	Q1 2023/24	Green
Joint OSC - reviews	Q1 2023/24	Green
To undertake continuous engagement process with public and staff	Q1 2023/24	Green
Stakeholder Mapping	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
NHSEI Gateway review	Q4 2023/24	Green
ICB Executive Assurance Board / ICBoard Approval	Q4 2023/24	Green
Final report from Clinical Senate review (due Q1)	Q1 2023/24	Green
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Green

Future Risks

- Change in national policy
- Delays in legilsation.
- Operational pressures and demand affecting opportunity to engage.
- Uncertainty / apathy from staff.
- Lack of staff engagement if not the option they are in favour of.
- Out of Hospital enablers and interdependencies
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- Government legislative and regulatory changes.
- Change in local leadership meaning priority changes.
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users.
- Creation of Placed based partnerships
- Strategic Capital allocation

Gaps in Controls

- A shared vision for the HAS programme is not understood across all staff/patients and partners
- Link to SO3 - 3.2 re: Capital Investment

Gaps in Assurance

- Feedback from public, patients and staff to be wide spread and specific in cases, that is benchmarked against other programmes.
- Partners to demonstrate full involvement and commitment, communications to be consistent and at the same time.
- Alignment of strategic capital
- Alignment to a System wide Out Of Hospital Strategy and ICS Strategic workforce planning

Links to High Level Risks Register

Future Opportunities

- Clinical pathways to support patient care, driven by digital solutions.
- Closer ICS working.
- Provider collaboration.
- System wide collaboration to meet control total.
- HAS Programme
- Joint workforce solutions inc. training and development Humber wide

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.4: To offer care in estate and with engineering equipment which meets the highest modern standards.

Risk to Strategic Objective 1 - 1.4: The risk that the Trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high quality care and/or a safe and satisfactory environment for patients, staff and visitors.

	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	5	5	5
Likelihood	4	4	4	4	4	4	4	4
Risk Rating	20	20	20	20	20	20	20	20

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Finance and Performance Committee

Last Reviewed: 24 May 2023, January 2023, October 2022, July 2022, 12 April 2022, 11 January 2022

Risk Owner: Director of Estates and Facilities

Enabling Strategy / Plan: Estates and Facilities Strategy, Clinical Strategy, Digital Strategy

Current Controls

- Audit Risk & Governance Committee
- Finance and Performance Committee
- Capital Investment Board
- Six Facet Survey - 5 years
- Annual AE Audits
- Annual Insurance and External Verification Testing
- Estates and Facilities Governance Group
- Trust Management Board (TMB)
- Project Boards for Decarbonisation Funds
- BLM Capital Group Meeting
- PAM (Premises Assurance Model)
- Specialist Technical Groups

Assurance (internal & external)

Positive:
- External Audits on Estates Infrastructure, Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- PAM

Internal:
- Minutes of Finance and Performance Committee, Audit Risk & Governance Committee, Capital Investment Board, Estates and Facilities Governance Group, TMB, Project Board - Decarbonisation
- PAM
- Non Executive Director Committee Chair Highlight Report (bi-monthly) to Trust Board
- Executive Director Report (6 monthly) to Trust Board
- Specialist Technical Groups

External:
- External Audits on Water, Pressure Systems, Medical Gas, Heating and Ventilation, Electrical, Fire and Lifts
- Six Facet Survey, AE Audit, Insurance and External Verification Testing (Model Health Benchmark)
- ERIC (Estates Return Information Collection)

Planned Actions

Action	Ouarter / Year	Assurance
Continue to explore funding bids to upgrade infrastructure and engineering equipment - Action date; ongoing	Ongoing Actions	Green
Secure sufficient Core Capital Funding to ensure the infrastructure, engineering and equipment needs identified in the 6 facet survey can be managed appropriately.	Ongoing Actions	Red
Completed Backlog Maintenance programme fiscal year	Q4 2022/23	Blue
Completed Core Capital Programme	Q4 2022/23	Blue
Complete refurbishment of old DPOW ED (prgramme slipped - new completion date Dec 2023)	Q3 2023/24	Red
Completed Ward 25 defects	Q4 2022/23	Blue
Commenced refurbishment of SGH ED (completion end of Q3)	Q3 2023/24	Green

Future Risks

- COVID-19 future surge and impact on the infrastructure
- National policy changes (HTM / HBN / BS); Ventilation, Building Regulation & Fire Safety Order
- Regulatory action and adverse effect on reputation
- Long term sustainability of the Trust's sites
- Clinical Plan
- Adverse publicity; local/national
- Workforce - sufficient number & adequately trained staff
- Without significant investment future BLM will increase (BLM figures for 2019/20 = £97M circa, and BLM figures for 2020/21 increased to circa £107M, 2022/23 Six Facet = £117m)

Strategic Threats

- Integrated Care System (ICS) Future Funding
- Failure to develop aligned system wide clinical strategies and plans which support long term sustainability and improved patient outcomes. This could prevent changes from being made
- The above prevents changes being made which are aligned to organisational and system priorities
- Government legislative and regulatory changes

The Critical Infrastrucutre Risk (CIR) is 74% of the total BLM. The breakdown of the CIR % per site is detailed below:
- Grimsby 21% CIR of the BLM
- Goole 11% CIR of the BLM
- Scunthorpe 42% CIR of the BLM

Gaps in Controls

- Lack of ICS Funding aligned for key infrastructure needs/requirements i.e. equipment, BLM, CIR
- Insufficient Capital funding

Gaps in Assurance

- Integrated Performance Report - Estates and Facilities (development in progress)

Links to High Level Risks Register

No 1620, Medical Gas Pipeline System = 20
No 2038, Fire Compliance = 20
No 2623, Failure of windows - Trustwide = 20
No 2088, Building Management Systems (BMS) Controller failure/upgrade = 20
No 2719, Water Safety Compliance:Oversized water distribution pipes = 20
No 2951, Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide = 20
No 2655, SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers = 20
No 3015 Insufficient estate resources to manage the workload demand - Trustwide = 20
No 1774, Poor condition of Fuel Oil Storage Tanks - SGH = 16
No 2035, Equality Act 2010 compliance - Trustwide = 16
No 2272, EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide = 16
No 2905, Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW = 16
No 2952, Water Safety Compliance: Fire ring main - Trustwide = 16
No 2953, Water Safety Compliance: Sensor taps - Trustwide = 16
No 2959, Replacement/Repairs of flat roof - Trustwide = 16
No 2036, Ventilation and Air Conditioning - HVAC - Trustwide = 15
No 2955, Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide = 15

Future Opportunities

- Closer ICS working.
- Humber Services Review and programme.
- Provider and stakeholder collaboration to explore funding opportunities.
- Expression of Interest submitted for New Hospital Programme (NHP)
- PSDS 4 submission
- Feasibility of District Heating network for DPOW

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.5: To take full advantage of digital opportunities to ensure care is delivered as safely, effectively and efficiently as possible.

Risk to Strategic Objective 1 - 1.5: The risk that the Trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the Trust vulnerable to data losses or data security breaches.

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	3	3	3	3	3
Likelihood	4	3	3	3	2	3	2	2
Risk Rating	16	12	12	9	6	9	6	6

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: April 2023**,** January 2023, October 2022, July 2022, 11 April 2022, 11 January 2022

Lead Committee: Audit, Risk and Governance Committee

Risk Owner: Chief Information Officer

Enabling Strategy / Plan: Digital Strategy

Current Controls

- Strategy and Development Committee
- Finance and Performance Committee
- Up to date Digital / IT policies, procedures and guidelines
- Digital Strategy Board
- Digital Solutions Delivery Group
- Data Security and Protection Toolkit, Data Protection Officer and Information Governance Group to ensure compliance with Data Protection Legislation.
- Audit Risk & Governance Committee (including external Auditor reports)
- Annual Penetration Tests
- Cyber Security Monitoring and Control Toolset - Antivirus / Ransomware / Firewalls / Encryption / SIEM Server / Two Factor Authentication
- Trust Management Board (TMB)

Assurance (internal & external)

Internal:

- A Digital Strategy Board reviews progress of the plans to achieve the strategy
- Highlight reports to Trust Board, Audit Risk and Governance Committee, Strategic Development Committee, Finance and Performance Committee and TMB
- Digital / IT Policies all current
- CIO/Executive Director Report (6 monthly) to Trust Board
- Digital / IT Policies all current
- Consolidated digital services leadership team (Chief Technology Officer, Deputy CIOs and Chief Medical Information Officer, Chief Nurse Information Officer, Chief AHP and Nursing Info Officer)

External:

- Limited Assurance: Internal Audit Yorkshire IT Business Continuity April 2021.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Positive Assurance:

- The Integrated Performance Report (IPR) has been revised and updated. This was done with NHSE/I who have stated it is now among the leading models for reporting.
- Significant Assurance: Audit Yorkshire internal audit: Data Security and Protection Toolkit: Significant Assurance, 2021

Planned Actions

Action	Quarter / Year	Assurance
Completed IT BC / DR Programme initiation with Gap Analysis report outline required vs. current capabilities approved at Digital Strategy Board in March 2023..DSPT Ref: IA-20724	Q4 2022/23	Blue
Meet the DSPT toolkit standards for Cyber Security with a goal to meet Cyber Essentials Pkus Accreditation. Work is being undertaken to target specific gaps which were undelivered by Q4 2022/23.	Q3 2023/24	Yellow
IPR - further review of current IPR for adding Digital, Finance and Estates KPI. S, Review in April 2023 (this may be deferred) - report to the Board, defer being put into IPR, Divisional IPRs being developed.	Q3 2023/24	Yellow
Secure resources to deliver Digital Strategy and annual priorities (PAS; EPR; Data Warehouse; RPA; Document management; Infrastructure upgrades). Digital Aspirant Funds £5 M secured with additional internal Capital to deliver projects 21/22 & 22/23. Depending on when NHSX releases funds for the Unified Tech Fund, we work with the ICS to bid for funds to continue our "levelling strategy" across the ICS	Q1 2023/24	Green
The Data Warehouse with core activity data sets will be completed and running on the new platform by May 2023 due to the rescheduling of the Lorenzo PAS go-live. (Undelivered by Q1 2023-24).	Q2 2023/24	Yellow
Review recently submitted Digital Maturity Assessment when published as part of WGLL framework factor in any revision to strategic plans based on findings.	Q1 2023/24	Green
Completed IT Business Continuity Policy and Procedure	Q1 2023/24	Green

Future Risks

- National policy changes in some cases in short notice, requiring revisions to work plan
- Regulatory action and adverse effect on reputation if there is a perception that NLaG is not meeting Cyber Security standards
- IT infrastructure and implementation of digital solutions that not only support NLaG but also the Integrated Care System (ICS), may delay progress of NLaG specific agenda
- Ongoing financial pressures across the organisation

Strategic Threats

- Capital funding to deliver IT solutions and establish a 5 yr plan
- Government legislative and regulatory changes shifting priorities as the ICS continues to evolve

Gaps in Controls

- Modernize Data Warehouse to address data quality issues associated with Patient Administration System and ability to produce more real time dashboards for business decisions.
- Develop policy and procedure to address the gaps noted in the IT Business Continuity audit in April 2020.
- Achieve DSP Toolkit compliance - in progress

Gaps in Assurance

- Implementation of PAS and connection to Data Warehouse
- DSP Mandatory Training

Links to High Level Risks Register

- No 2300, Insufficient processes in place to ensure records management /quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards. = 16

Future Opportunities

- Humber and North Yorkshire ICS, system wide collaborative working
- Clinical pathways to support patient care, driven by digital solutions
- Collaborative working with HAS, the Acute Care Collaborative and Integrated Care Partnership

Strategic Objective 1 - To give great care

Description of Strategic Objective 1 - 1.6: To provide treatment, care and support which is as safe, clinically effective, and timely as possible.

Risk to Strategic Objective 1 - 1.6: The risk that the Trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure).

	Inherent Risk	Current Risk				Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
		Q1	Q2	Q3	Q4			
Consequence	4	4	4	4	4	4	4	4
Likelihood	2	4	4	3	3	4	3	2
Risk Rating	8	16	16	12	12	16	12	8

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, 18 January 2023, December 2022, 13 October 2022, July 2022, 11 April 2022, 24 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Operating Officer

Enabling Strategy / Plan: NLAG Winter Planning and Potential COVID-19 Wave, Business Continuity Policy

Current Controls

- Winter Planning Group.
- Strategic Planning Group.
- A&E Delivery Board.
- Director of People - Senior Responsible Owner for Vaccinations.
- Ethics Committee.
- Clinical Reference Group.
- Influenza vaccination programme.
- Public communications re: norovirus and infectious diseases.
- Chief Operating Officer is the Senior Responsible Officer for Executive Incident Control Group.
- IPC protocols implemented including mask wearing and rapid testing process
- COVID-19 Executive Incident Control (Gold Command).
- Patient Flow Improvement Group (PFIG)
- Discharge System Improvement Group
- Planned Care Improvement and Productivity (PCIP)
- Industrial action planning
- Emergency Preparedness, Resilience and Response Steering Group
- Bank Holiday Planing Group

Assurance (internal & external)

Internal:

- National and Regional exercises testing emergency plans, business continuity and planning assumptions (e.g. Artic Willow, Mighty Oak)
- Business continuity management system and business continuity plans
- Minutes of Winter Planning Group, Strategic Planning Group, Ethics Committee, Executive Incident Control Group, A&E Delivery Board, Clinical Reference Group, PFIG, Discharge System Improvement Group, PCIP

Positive:

- Half yearly tests of the Major incident response cascades
- Annual review of business continutiy plans.
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance

External:

- Emergency Planning self-assessment tool and peer review against the NHSE EPRR Core Standards rated substantial compliance
- NHSE review of emergency planning self-assessment 2021/22 rated substantial compliance
- Internal audit of emergency planning and business continuity compliance 2022/23 rated substantial compliance
- EMAS Audit of Trust CBRNe/HAZMAT arrangements with no recommendations (2022/23)

Planned Actions

Action	Quarter / Year	Assurance
Lateral flow testing staff is ongoing	Ongoing	Blue
Business Intelligence monitoring re: pandemic	Ongoing	Blue
Rolling Schedule of annual business continuity plans	Ongoing	Green
Winter Planning for 2022/23	Ongoing	Blue
Planning for and response to industrial action (multiple unions)	Ongoing	Green
Inclusion of details of BC plans tested/implemented duirng exercises/incidents documented in reports.	Ongoing	Blue
CBRN training aligned to New DPOWH ED transition plan	Q4 2022/23	Blue
Relaunch of loggist training and provision	Q4 2022/23	Green
Major incident table top training	Q4 2022/23	Yellow
National Exercise Mighty Oak (national power outage)	Q4 2022/23	Blue
Review and update of Escalationand Surge Policy	Q4 2022/23	Blue
Review of Evacuation Plan	Q4 2022/23	Yellow
Review of Major Incident Plan and Critical Incident Plan	Q1 2023/24	Green
Roll out of new Major Incident Triage Tool (MITT)	Q4 2023/24	Green

Future Risks

- COVID-19 surge.
- Availability of clinical consumables, equipment and some medications post EU Exit.
- Costs and timeliness of deliveries due to EU Exit.
- Additional patients with longer waiting times RTT, Cancer and Diagnostics due to COVID-19.
- Increase in seasional outbreaks (influenza, norovirus) impacting on bed capacity.
- National industrial action within healthcare and other sectors impacting on workforce levels.
- Increased risk of cyber attacks due to sanctions imposed on Russia.
- Risk of energy supply disruptions over winter period.

Strategic Threats

A widespread loss of organisational focus on patient safety and quality of care leading to increased incidence of avoidable harm, exposure to 'Never Events', higher than expected mortality, and significant reduction in patient satisfaction and experience. Increase in patients waiting, affecting the effectiveness of cancer pathways, poor flow and discharge, an increase in patient complaints.

Gaps in Controls

- Capacity to meet demand (workforce).
- Bed Capacity challenges in Northern Lincolnshire, East Riding and Lincolnshire due to ASC workforce challenges being seen and likely to continue into 2022/23
- Lower than expected uptake of influenza vaccination.

Gaps in Assurance

- BC Plans that are tested or implemented during exercises/incidents are not specifically named or captured within reports to evidence testing.
- Challenge in releasing workforce to attend specialist training (e.g. CBRN/HAZMAT).
- Recruitment pipeline to address medical staffing shortfalls and reduce reliance on agency.
- Recruitment pipeline to address nurse staffing shortfalls and reduce reliance on agency.

Links to High Level Risks Register

- No 2562, Constitutional A&E targets = 20
- No 3164, Nurse staffing = 20
- No 2976, Registered nursing vacancies = 25
- No 3063, Doctor vacancies = 16

Future Opportunities

- Closer Integrated Care System working.
- Provider collaboration.
- Participation in national, regional and ICS/LRF exercising and testing of emergency plans.

Strategic Objective 2 - To be a good employer

Description of Strategic Objective 2: To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce, including by promoting: inclusive values and behaviours, health and wellbeing, training, development, continuous learning and improvement, attractive career opportunities, engagement, listening to concerns and speaking up, attractive remuneration and rewards, compassionate and effective leadership, excellent employee relations.

Risk to Strategic Objective 2: The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training, motivation, health or morale) to provide the levels and quality of care which the Trust needs to provide for its patients.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	4	4	5
Likelihood	3	4	4	4	4	2	3	3
Risk Rating	15	20	20	20	20	8	12	15

Risk Appetite Score: Low (4 to 6)

Initial Date of Assessment: 1 May 2019

Lead Committee: Workforce Committee

Last Reviewed: 22 May 2023, January 2023, 14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Risk Owner: Director of People

Enabling Strategy / Plan: People Strategy, NHS People Plan, Leadership Development Strategy

Current Controls

Locally
- Workforce Committee
- Audit Risk & Governance Committee
- Trust Management Board (TMB)
- PRIMS
- Nursing,midwifery & AHP recrutiment and retention group
- Nursing Apprenticeship task and finish group
- International recruitment programme Task & Finish group
- Remuneration and Terms of Service Committee (RATS)
- Culture Transformation Board (CTB) & Culture Transformation Working Group (CTWG)
- Workforce Systems Group (Finance, HR and Operations)
- NLAG People Strategy approved by the Board June 2020
- People Directorate - People Strategy Annual Delivery Implementation Plan 2022-23 (Workforce Committee approved July 2022 and TMB September 2022)
- Annual NHS staff survey and quarterly People Pulse

Regional and ICB
- Humber and North Yorkshire (HNY) – ICB Strategic Workforce Group
- Humber Workforce Group
- ICB People Strategy
- HNY ICB HRD Group
- Yorkshire and North East – HRD Group

National
- National HRD Forum
- NHS People Plan and People Promise
- NHS Employers Forum

Assurance (internal & external)

Internal:
- Minutes of Workforce Committee, Audit Risk & Governance Committee, Trust Management Board, PRIMS, Recruitment and Retention Group, Nursing Apprenticeship Group, Internal Recruitment Programme Group, Culture Transformation Board, Workforce Systems Group, Remuneration and Terms of Service Committee.
- NHS People Plan, NLAG People Strategy and Implementation Plan reported to Workforce Committee.
- Recruitment Plans signed off divisionally
- Workforce Integrated Performance Report
- Annual staff survey and people pulse results
- Medical engagement survey 2019
- Non Executive Director Highlight Report to Trust Board
- Executive Director Report to Trust Board

Positive:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance

External:
- Audit Yorkshire internal audit. Establishment Control: Significant Assurance, April 2020.
- Audit Yorkshire internal audit: Sickness Absence Management N2020/13, Significant Assurance
- Minutes of Regional and ICB workforce groups
- Minutes of National HRD Forum and NHS Employers Forum

Planned Actions

Action	Quarter / Year	Assurance
Development and Sign off of Performance Metrics to support roll out of Leadership Strategy and Culture Transformation	Q2 2022/23	Blue
Continued implementation of People Strategy by 31 March 2024	Q4 2023/24	Green
Delivery of people priorties with the Trust priorites 22/23	Q4 2022/23	Blue

Future Risks

- Staff morale and turnover
- COVID-19 & FLU winter surge and impact on staff health and wellbeing.
- National policy changes.
- Generational workforce : analysis shows significant risk of retirement in workforce.
- Impact of HASR plans on NLaG clinical and non clinical strategies.
- Provide safe services to the local population.
- Succession planning and future talent identification.
- Visa changes / EU Exit.
- Staff retention and ability to recruit and retain HR/OD staff to deliver people agenda

Strategic Threats

- ICS Future Workforce
- Integrating Care: Next Steps
- Future staffing needs / talent management

Gaps in Controls

- Slower international recruitment of clinical staff due to visa backlogs

Gaps in Assurance

- Increase in nurse staff vacancies and conversion of the 50 overseas nursing recruits

Other Significant Risks & Links to High Level Risks Register

No 1851, Shortfall in Capacity within the Ophthalmology Service - 15
No 2550, Pharmacy Staffing = 15
No 2898, Medical Staff - Mandatory Training Compliance = 16
No 2960, Risk of inability to safely staff maternity unit with Midwives = 16
No 3015, Insufficient estate resources to manage the workload demand = 20
No 3045, Medical Workforce Vacancies in Gastroenterology = 16
No 3048, Challenges to recruitment of acute care physician vacancies in Acute = 16
No 3063, Doctors Vacancies within Medicine Division = 16
No 2976, High registered nursing vacancy levels = 25
No 3164, Nurse Staffing, high number of registered nurse and support worker vacancies = 20

Future Opportunities

- Closer ICS working
- Provider collaboration
- International recruitment

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.1: To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value for money for the public purse. To keep expenditure within the budget associated with that income and also ensuring value for money. To achieve these within the context of also achieving the same for the Humber Coast and Vale HCP.

Risk to Strategic Objective 3 - 3.1: 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.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	5	5	5	5	5	5	5
Likelihood	2	3	4	4	1	1	4	4
Risk Rating	10	15	20	20	5	5	20	20

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 24 May 2023, 9 January 2023, 19 July 2022, 18 May 2022, 31 January 2022

Lead Committee: Finance and Performance Committee

Risk Owner: Chief Financial Officer

Enabing Strategy / Plan: Trust Strategy, Clinical Strategy, ICS

Current Controls

- Capital Investment Board, Trust Management Board (TMB), PRIMs, Model Hospital.
- National benchmarking and productivity data constantly reviewed to identify CIP schemes.
- Engagement with Integrated Care System on system wide planning
- Monthly ICS Finance Meetings
- Operational and Finance Plan 2022/23
- Counter Fraud and Internal Audit Plans
- Trustwide Budgetary Control System

Assurance (internal & external)

Internal:
- Minutes of Audit Risk & Governance Committee, Trust Management Board, Finance and Performance Committee, Capital Investment Board, PRIMs, Monthly ICS Finance Meetings
- Non-Executive Director Highlight Report (bi-monthly) to Trust Board

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan. On track to deliver the requirements set out by NHSE
- Internal Audit Reports - Internal Control - significant assurance

External:
- Financial Special Measures Meeting - Letter from NHSE related to financial special measures and achievement of action plan
- Approval received at ICS Level for 2022-23 capital plan
- Internal Audit Reports - Internal Control - significant assurance
- Agreed Financial Plan at ICS Level for 2022/23

Planned Actions

Action	Quarter / Year	Assurance
Work with system partners, specifically community and local authorities to ensure that our local systems are working in unison to tackle the issues of system flow	2022/23	Blue
Agree financial recovery plan to meet 2022/23 year-end target	Q4 2022/23	Blue
Release of balance sheet flexibility to support 2022/23 forecast outturn	Q4 2022/23	Blue
Number of planned initiatives in 2023-to help facilitiate improvement with medical staffing		
There is specific workforce planning ongoing - linked to Workforce committee (refer to SO2)		

Future Risks

- COVID-19 further surges and impact on finance and CIP achievement
- Savings Programme not sufficient and deteriorating underlying run rate which is execerbated by the elective recovery programme
- Impact of external factors such as problems with residential and domicilary care, causing hospitals to operate at less than optimum efficiency and cause financial problems
- Vacancy levels in medical and nursing driving an unplanned level of spend
- Inability to transform planned care pathways, including outpatient follow-ups and theatre productivity

Strategic Threats

- ICS Future Funding
- Integrating Care: Next Steps
- System wide control total

Gaps in Controls

- Clinical strategy required to inform Finance Strategy
- As we progress, the emerging uncertainty around the financial implications of decisions from the HAS process
- Month on month adverse variants against operational budgets
- Fully formed CIP
- Fully formed transformtion planned care
- Inability to recruit and retain staff to meet financial plannnig assumptions
- Have we systems in place to facilitate level of recruitment
- Systems and processes in place to facilitate reduction in turnover rate
- Uncertainty of existing systems to recruit and retain staff.

Gaps in Assurance

- Trustwide Budgetary Control System, not working to deliver financial balance with current plans
- Recurrent delivery of Cost Improvement Programme Plan
- Management of financial risks arising from the lack of flow
- Individual organisational sustainability plans may not deliver system wide control total

No assurnce recruitment or retention will iprove

Links to High Level Risks Register

No 3074, Financial Risk - Medicine CIP 2022/23 = 16
No 3162, quality of patient cae and patient safety based on nurse staffing position and increase in use of bank and agency nurses and escalation beds = 20
No 3174, Trust doesnot receive SystmOne information to be able to submit costs at a patient level as per mandatory requirements of NHSE.

Future Opportunities

- Closer ICS working
- Provider collaboration and formation of the Group
- System wide collaboration to meet control total

Strategic Objective 3 - To live within our means

Description of Strategic Objective 3 - 3.2: To secure adequate capital investment for the needs of the Trust and its patients.

Risk to Strategic Objective 3 - 3.2: The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	5	5	5	5	5	5
Likelihood	3	3	3	3	3	3	3	3
Risk Rating	15	12	15	15	15	15	15	15

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 12 April 2023, 21 February 2023**,** 9 January 2023, 14/10/22**,** 23/6/22, 13 April 2022 (DoSD), 14 February 2022

Lead Committee:
Strategic Development Committee

Risk Owners:
Chief Financial Officer and
Director of Strategic Development

Enabling Strategy / Plan: Trust Strategy, Clinical Strategy, Humber Acute Services Programme/ Capital Investment EOI and potential SOC for NHP

Current Controls

- Capital Investment Board (Internal Capital)
- Trust (Internally) Agreed Capital programme and allocated budget - annual/three yearly
- Trust Strategic Development Committee
- Trust Board
- Trust Committee(s) in Common
- ICS Strategic Capital Advisory Group
- NHSE - HAS Assurance Reviews
- NHSE Financial Special Measures Assurance Reviews

Assurance (internal & external)

Internal:
- Minutes of Internal Trust Meetings

External:
- Financial Special Measure Meeting with NHSE/I
- NHSE attendance at AAU / ED Programme Board
- NHSE Assurance Review Feedback
- CiC Minutes

Planned Actions

Action	Quarter / Year	Assurance
Develop Capital Investment Strategic Outline Case for development of SGH/DPoW	Q3 2022/23	Green
Agree forecast spend for current year as part of wider ICS capital planning exercise	Q4 2022/23	Blue
Develop strategic capital plan as part of comprehensive service planning exercise - to be completed by end March 2023	Q4 2022/23	Green
Develop integrated bid across N and NE Lincs for implementation of CDH aligned to ICS Core Programme	Q4 2022/23	Blue
Review and seek if there are ways of applying for future rounds of PSDS funding	Q4 2022/23	Green
Present Strategic Capital to Joint Trust Board 4 April 2023)	Q1 2023/24	Blue

Future Risks

- National policy changes - implications of three year capital planning
- Lack of investment in infrastructure through Targeted Investment Fund (TIF)
- Inability of Trust to fund capital through internal resource - potential lack of external funding sources
- Inability of Trust to gain Capital Departmental Resource Limit (CDEL) cover for strategic capital investment if not on New Hospital Programme (NHP)
- Not gaining a place on the NHP
- Challenges with existing estate continue and significant issues remain with Backlog Maintenance (BLM), Critical Infrastructure Risk (CIR)

Strategic Threats

- ICS Capital Funding Allocations
- Inability to gain national strategic capital through NHP
- Inability to offset CDEL if non NHS funding sources used for capital investment

Gaps in Controls

- Comprehensive programme of Control and Assurance - potential inherent risk on ability of Trust to afford internal capital for major spend
- Control environment whilst comprehensive may not have ability to influence availability of Strategic Capital - investment funding/affordability
- Control environment may not be able to eliminate or reduce risk of estates condition in the short term

Gaps in Assurance

- Assurance review process does not create a direct link to sources of strategic capital investment
- ICS CDEL may not be sufficient to cover infrastructure investment requirement of Trust in short term - when split across other providers

Links to High Level Risks Register

Future Opportunities

- Provider collaboration and use of Place based funding
- Use of TiF, CDH and Towns Centre funds to support capital spend
- System wide collaboration to major capital development needs.
- Announcement of multi year, multi billion pound capital budgets for NHS
- Gaining a place on the NHP

Strategic Objective 4 - To work more collaboratively

Description of Strategic Objective 4: To work innovatively, flexibly and constructively with partners across health and social care in the Humber Coast and Vale (HCV) Health Care Partnership (HCP) (including at Place), and in neighbouring Integrated Care Systems, and to shape and transform local and regional care in line with the NHS Long Term Plan (LTP): to make best use of the combined resources available for health care, to work with partners to design and implement a high quality clinical strategy for the delivery of more integrated pathways of care both inside and outside of hospitals locally, to work with partners to secure major capital and other investment in health and care locally, to have strong relationships with the public and stakeholders, to work with partners in health and social care, higher education, schools, local authorities, local economic partnerships to develop, train, support and deploy workforce and community talent so as to: make best use of the human capabilities and capacities locally; offer excellent local career development opportunities; contribute to reduction in inequalities; contribute to local economic and social development.

Risk to Strategic Objective 4: The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment.

Risk Rating	Inherent Risk	Current Risk Q1	Current Risk Q2	Current Risk Q3	Current Risk Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	5	4	4	4	4	4	4	4
Likelihood	3	3	3	3	3	2	2	2
Risk Rating	15	12	12	12	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 21 April 2023, 21 February 2023, October 2022, 23/6/22, 13 April 2022, 12 January 2022

Lead Committee: Strategic Development Committee

Risk Owner: Director of Strategic Development

Enabing Strategy / Plan: NHS Long Term Plan, Trust Strategy, Clinical Strategy, Humber Acute Services Programme, Communications & Engagement Strategy

Current Controls

- Audit Risk & Governance Committee (ARGC).
- Trust Management Board (TMB).
- Finance and Performance Committee (F&PC).
- Strategic Development Committee (SDC).
- Capital Investment Board (CIB).
- HAS Executive Oversight Group.
- HNY HCP.
- ICS Leadership Group.
- Wave 4 ICS Capital Committee.
- Executive Director of HAS and HAS Programme Director appointed.
- NHS LTP.
- ICS LTP.
- NLaG Clinical Strategy.
- NLaG Membership of ICP Board NE Lincs.
- Committees in Common (Trust Board approved 1/6/2021)
- Acute and Community Collaborative Boards
- Clinical Leaders & Professional Group
- Council of Governors.
- Joint Overview & Scutiny Committees
- MP cabinet and LA senior team briefings
- Primary/Secondary Interface Group (Northbank&Southbank)

Assurance (internal & external)

Positive:
- HAS Governance Framework.
- HAS Programme Management Office established.
- HAS Programme Plan Established (12 months rolling).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Clinical Senate review approach and process

Internal:
- Minutes of HAS Executive Oversight Group, HNY HCP, ICS Leadership Group, Wave 4 ICS Capital Committee, ARGC, F&PC, TMB, SDC, CIB, CoG
- Non Executive Director Committee chair Highlight Report to Trust Board
- Executive Director Report to Trust Board

External:
- Checkpoint and Assurance meetings in place with NHSE (3 weekly).
- Clinical Senate Reviews.
- Independent Peer Reviews re; service change (ie Royal Colleges).
- NHSE Rolling Assurance Programme - Regional and National including Gateway Reviews.
- Councillors / MPs / Local Authority CEOs and senior teams

Planned Actions

Action	Quarter / Year	Assurance
CIC / SDC / NED / Governor reviews	Q4 2022/23	Blue
Citizens Panel reviews	Q4 2022/23	Blue
Clinical Senate reviews (final review held 27 Feb 2023)	Q4 2022/23	Blue
To undertake continuous engagement process with public and staff	Q4 2022/23	Blue
Evaluation of the models and options with stakeholders	Q4 2022/23	Blue
Finalise Pre-Consultation Business Case and alignment to Capital Strategic Outline Case	Q4 2022/23	Green
HAS Programme:		
Options appraisal for HAS Capital Investment to be approved	Q4 2022/23	Green
Clinical Senate Final Report due Q1	Q1 2023/24	Blue
Stakeholder Mapping	Q1 2023/24	Blue
To undertake continuous process of stocktake and assurance reviews	Q1 2023/24	Blue
NHSE and Clinical Senate review		
Joint OSC - reviews	Q1 2023/24	Green
NHSE Gateway review	Q1 2023/24	Green
ICS Board approval	Q1 2023/24	Green
Public Consultation	Q2/Q3 2023/24	Green
HAS Risk Workshop with ICB Executives (18 April 23)	Q1 2023/24	Green

Future Risks

- National policy changes
- Delays in legislation
- Long term sustainability of the Trust's sites.
- Change to Royal College Clinical Standards.
- Capital Funding.
- ICS / Integrated Care Partnership (ICP) Structural Change.
- Ockenden 2 Report
- Combined winter pressures and cost of living impacts

Strategic Threats

- ICS Future Funding.
- Failure to develop aligned system wide strategies and plans which support long term sustainability and improved patient outcomes.
- Government legislative and regulatory changes.
- Integrated Care: Next Steps and Legislative Changes.
- Strategic capital.

Gaps in Controls

- Clinical staff availability to design and develop plans to support delivery of the ICS Humber and Trust Priorities.
- Local Authority, primary care and community service, NED and Governor engagement / feedback (during transition)
- ICS, Humber and Trust priorities and planning assumptions, dependency map for workforce, ICT, finance and estates to be agreed.

Gaps in Assurance

- Project enabling groups, finance, estate, capital, workforce, IT attendance and engagement.
- Lack of integrated plan and governance structure.
- Alignment with Out of Hospital strategies and programmes

Links to High Level Risks Register

Future Opportunities

- HNY ICS, system wide collaborative working.
- Clinical pathways to support patient care, driven by digital solutions.
- Strategic workforce planning system wide and collaborative training and development with Health Education England / Universities etc.
- Acute and community collaborative.

Strategic Objective 5 - To provide good leadership

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

Risk to Strategic Objective 5: The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives.

Risk Rating	Inherent Risk	Current Risk Q1	Q2	Q3	Q4	Target Risk by 31 March 2022	Target Risk by 31 March 2023	Target Risk by 31 March 2024
Consequence	4	4	4	4	4	4	4	4
Likelihood	4	3	3	3	3	2	2	2
Risk Rating	16	12	12	12	12	8	8	8

Risk Appetite Score: Moderate (8 to 12)

Initial Date of Assessment: 1 May 2019

Last Reviewed: 22 May 2023, January 2023,14 November 2022, September 2022, July 2022, 6 April 2022, March 2022

Lead Committees: Workforce Committee and Trust Board

Risk Owner: Chief Executive

Enabing Strategy / Plan: Trust Strategy, NHS People Plan, People Strategy, Leadership and Development Strategy

Current Controls

- Trust Board, Trust Management Board, Workforce Committee, PRIMS
- CQC and NHSE Support Teams
- Board development support programme with NHSE support.
- Significant investment in strengthened structures, specifically (a) Organisational structure, (b) Board structure, (c) a number of new senior leadership appointments
- Development programmes for clinical leaders, ward leaders and more programmes in development
- Communication with the Trust's senior leaders via the monthly senior leadership community event
- NHSI Well Led Framework
- PADR compliance levels via PRIM as part of the Trust's focus on Performance improvement
- Joint posts of Trust Chair and Chief Financial Officer, with HUTH
- Collaborative working relationships with MPs, National Leaders within the NHS, CQC, GPs, PCNs, Patient, Voluntary Groups, Humber and North Yorkshire Health and Care Partnership.

Assurance (internal & external)

Internal:
- Leadership Strategy signed off by Trust Board - May 2022
- Minutes of Trust Board, Trust Management Board, Workforce Committee and PRIMS
- Trust Priorities report from Chief Executive (quarterly)
- Integrated Performance Report to Trust Board and Committees.
- Letter from NHSE related to financial special measures and achievement of action plan.
- Chief Executive Briefing (bi-monthly) to Trust Board
- Board and Commiteee meeting structures
- Workforce Implementation Plan report (includes development and leadership programmes) to Workforce Committee
- Senior Leadership Community presentation
- Trust Board - Well-Led assessments at Board Development

Positive:
- Letter from NHSE related to financial special measures and achievement of action plan.

External:
- CQC Report - 2020 (rated Trust as Requires Improvement).
- Financial and Quality Special Measures.
- NHS Staff Survey.
- Minutes of Collaborative Working Relationship groups

Planned Actions

Action	Quarter / Year	Assurance
Refreshing of the coaching model with the move towards a Coaching and Mentoring Bureau, offering staff at all levels, opportunities for coaching and mentoring. All participants on leadership development programmes will have a coach for the duration of their development course. We aim to introduce mentoring, both peer to peer, role and career, and reverse, during 2023 with some small scale pilot programmes including a pilot EDI-centric reverse mentoring programme to further strengthen inclusion.	Q2 2022/23	Yellow
Refresh of our PADR process referred to in the Training & Development submission, will include process components and skills training to enable identification of talent, development of potential, and proactive planning for succession. Refer to the Leadership and Career development draft schematic in the Appendices for concept. December 2022.	Q3 2022/23	Green
Introducing a managerial core skills programme for newly appointed managers 2022 and beyond - February 2023	Q3 2022/23	Blue

Future Risks

- COVID-19 third surge and impact on finance and CIP achievement.
- National policy changes.
- Impact of HASR plans on NLaG clinical and non clinical strategies.

Strategic Threats

- Non-delivery of the Trust's strategic objectives
- Continued quality/financial special measures status
- CQC well-led domain of 'inadequate'
- Inability to work effectively with stakeholders as a system leading to a lack of progress against objectives
- Failure to obtain support for key changes needed to ensure improvement or sustainability
- Damage to the organisation's reputation, leading to reactive stakeholder management, impacts on the Trust's ability to attract staff and reassure service users

Gaps in Controls

- No investment specifically for staff training / courses to support leaders work within a different context and to be effective in their roles as leaders within wider systems

Gaps in Assurance

- Financial Special Measures
- Quality Special Measures

Links to High Level Risks Register

None

Future Opportunities

- Closer Integrated Care System working
- Provider collaboration
- System wide collaboration to meet control total
- HAS

Key to Assurance	
Red	Action rated red means the action is off track, with no mitigation and pose a significant risk to the delivery of the strategic objective
Amber	Action rated amber mean it is in progress, but off track with, no mitigation and could pose a risk to the strategic objective being delivered
Yellow	Action rated yellow - in progress, off track, with mitigation, and could pose a risk to the strategic objective being delivered
Green	Actions rated green mean they are on track to deliver.
Blue	Closed action which supports the progress towards the delivery of the strategic objective

HIGH LEVEL RISK REGISTER (22-May-2023)

No	Risk Opened Date	Risk Target Date	Risk Type	Risk Category	Title of Risk	What is the Risk?	Assessor	Owner	Site	Directorate	Division	Specialty	Risk Rate Score	Review Frequency	Next Review Date	Control Details	Gaps In Controls	Control Assurance
1620	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas: Medical Gas Pipeline System, Mark 4 bedhead terminal outlets - Trustwide	There is a risk of losing bed head medical gases due to Mark 4 medical wall terminals outlets (Oxygen, Vacuum Medical Air, Nitrous Oxide) being obsolete with limited spare parts due to damage caused through clinical activity. The loss of medical gas pipeline behind the bedhead terminal outlets at SGH & GDH, could result in loss of oxygen supply and suction ability to an entire ward for an extended period time.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Med Gas	20	1 Monthly	28/05/2023	Ongoing monitoring of alarms.	Limited spares availability.	Approved ISO9001 contractor and QC pharmacist and access to limited terminal spares through approved spares supplier.
1774	05/06/2014	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Poor condition of Fuel Oil Storage Tanks - SGH	If the Trust lost gas supplies to the SGH site the boilers would have to be fuelled by oil. The material state of the oil storage tanks has resulted in the oil being contaminated and if called upon, could damage the boilers. The strategic risk are the boilers failing to provide heat and hot water due to main hospital site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	16	1 Monthly	28/05/2023	Emergency generator fitted with own fuel supply.	No replacement plan for SGH.	External condition report.
1851	28/04/2015	30/09/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Shortfall in Capacity within the Ophthalmology Service	The current risk, is the capacity does not meet the demand and the service is unable to meet this. Therefore, this impacts on ability to see patients within the clinical time scales.	Tom Foulds	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Ophthalmology	15	1 Monthly	15/06/2023	Work with the ICB to secure additional capacity in the independent sector.	Recent investment will not mitigate the shortfall in capacity	
2035	22/08/2016	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Equality Act 2010 compliance - Trustwide	The Trust has received numerous claims for slips, trips and falls from the state of the Trust's roads, pathways and corridors. These both damage the Trust's reputation and lead to financial loss. A number of facilities (lifts, toilets) are non-compliant with current regulations which may result in patients and staff being unable to move through the hospital sites safely and with dignity and respect.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	16	1 Monthly	28/05/2023	Estates continually monitor the condition of the roads and pathways, repairing potholes as required. Larger resurfacing scheme are limited to BLM or other capital works funding when available.	Currently none, funding is required to provide adequate assurances. Staff to be made aware of the hazards of parking and moving around this area, as the site is not designated a car park.	The current control measures are not effective, it would need the "car park" to be closed to prevent further incidents.
2036	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ventilation and Air Conditioning - HVAC - Trustwide	There is a risk of failure of the heating and ventilation system due to aged infrastructure resulting in a negative impact on the effective delivery of patient care and pose a risk to the Trusts elective recovery plan in critical areas; theatres, ITU etc...	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	15	1 Monthly	28/05/2023	Planned preventative maintenance (PPM) in place for inspection and maintenance of all ventilation plants.	Limited BLM funding resulting in no long term replacement plan. Capital plan 22-25 capture theatre upgrades	Validation and flow checks carried out by 3rd party accredited contractor.
2038	23/12/2022	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Fire Compliance	There is a risk failure of the fire alarm resulting in failure to detect fire/smoke leading to fire taking hold and hence possible serious harm and/or loss of life of patients and staff.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Fire Safety	20	1 Monthly	28/05/2023	Panels are being replaced. DPoW ward replacement programme includes updated detection loops.	Fire detection - Mixture of analogue and digital which increases the risk of failure. Closed protocol system at SGH. Drawings - Establishment and confirmation of existing fire compartments.	Automatic fire detection - current panels to be replaced. A review of existing drawings is near completion.
2088	28/02/2023	31/03/2024	To provide care which is as safe, effective, accessible and timely as possible	Buildings, Land and Plant	Building Management Systems (BMS) Controller failure/upgrade	There is the risk of failure of elements of the Building Management Systems (BMS). The BMS is the trusts advanced warning system which adjusts and controls the sites ventilation, heating and hot water services, therefore, temperature control of both the hospital environment and water systems could become significantly compromised.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Building Management	20	1 Monthly	28/05/2023	Continued monitoring of the system for operation (by Estates Staff).	Reactive to ongoing BMS failures. Current BMS runs on outdated windows 7 support system. Cyber security risk and patch update	There are limited assurances on controls highlighted by continued BMS failures.
2244	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within tWT (62 days) will result in poor patient experience and may have the potential for clinical harm in some specialties. The Trust consistently achieves the 14 day and 31 day standards. The likelihood of continuing to not achieve the 62 day standards is high due to some elements of the diagnostic or staging pathway being outside of the control of NLAG and sitting with the tertiary provider. Risk register also relates to Risk ID 2008.	Denise Gale	Abolfazl Abdi	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Cancer Services	16	1 Monthly	06/10/2021	(1) Weekly Cancer RTT waiting time meeting to challenge and review all cancer PTLs (62 day 1st, screening, consultant upgrade, 31 day 1st, subsequent surgery, subsequent drugs) (2) Automated RAG rated PTL (updated twice daily to reflect current position and available to all Divisional Managers). (3) 62 day Cancer Improvement Plan has translated into the Cancer Transformation Programme (2 year programme commencing 2021) (4) Cancer performance/ backlog is reported weekly to Operational Management Group (5) Improved visibility on all aspects of cancer pathways through the Cancer Power BI Performance report (which is updated daily and available to all Divisional Managers/clinicians. (6) Cancer Trackers attend Divisional Huddles in some specialties (Colorectal/Gynae) as a point of escalation. (7) A trust-wide clinical harm review process is in progress	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm	62 day backlog and 104+ days waits monitored weekly at Operational Management Group
2245	20/06/2017	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Overall Performance : Non compliance with RTT incomplete target	Given our current operating models, there is a risk that there is insufficient capacity to meet demand in a number of specialities which risks the RTT position and potential for adverse patient impact. Potential for 52 week breaches and potential to not meet current 40 week maximum RTT target This could result in clinical harm	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Surgery (All)	16	1 Monthly	14/06/2023	(1) Capacity & demand plans have been developed for all specialties as part of the business planning 22/23 which highlight our risk specialties and gap between capacity and demand, use of the IST tool working with NHSI and strategy and planning.	Data quality and validation of clock stops.	Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published.
2272	25/09/2017	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Environmental	EHO Compliance with Ward Based Kitchen surfaces and storage areas - Trustwide	There is a risk that the EHO could instruct that the ward based kitchen is unfit for food preparation and issue a prohibition notice which would prevent food/drink being prepared on ward areas. This would result in a delay to patients receiving food and drink.	Keith Fowler	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Catering	16	1 Monthly	28/05/2023	1) Food preparation boards, minimal ward based food preparation of low risk food. Hazard Analysis of Critical Control Points HACCP. 2) Ward refurbishment programme 3) Quality Matron Environmental Audits 4) Flo-audits	Funding for major ward refurbishments.	Funding for major ward refurbishments. EHO currently assess each site and awards cleanliness standard up to and including 5*, these outcomes are for public communication and awareness.
2300	07/12/2017	31/12/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Information Governance	Insufficient processes in place to ensure records management /quality against national guidance	The Trust has insufficient processes in place to ensure records management / quality against national guidance. Gaps include: Limited application of a corporate records audit, not fully implemented IGA retention standards.	Susan Meakin	Christopher Evans	Trustwide - All Sites (DPoW, S	Digital Services	Digital Services	Information Governance	16	1 Monthly	15/06/2023	Oversight by Trust's IG Steering Group and is managed via the Group's Action Log which is reviewed monthly.	None	The IG Steering Group monitor the progress of this actions

2347	24/11/2022	31/03/2023	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance : Overdue Follow-ups	There is a risk that there is insufficient capacity to meet demand in a number of specialities which risks overdue follow up position deteriorating Failure to review patients in clinically specified timescales.	Jennifer Orton	Mathew Thomas	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Surgery (All)	15	1 Monthly	14/06/2023	Specialties have developed recovery plans in all areas	Potential clinical harm due to lack of appointment capacity.	Cap & demand plans for the trust top 8 specialities are reviewed by the Planned Care board. Currently covering all clinics and wards with the use of agency and locums to mitigate the risk of rota gaps. North East Lincs and N Lincs council of members routinely review the data published. Clinical harm review progress report to S&CC Board; Planned Care Board and Trust Board. Fail safe officers in post to ensure Wet AMD patients are on a separate PTL. Risk stratification of outpatient follow up PTL, No harm from risk stratification.
2550	27/01/2023	30/09/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Staffing Levels & HR	Pharmacy staffing	Due to the number of vacancies and maternity leave at this time, the clinical pharmacy service is unable to maintain its current level of service delivery. The impact on service delivery is likely to be in effect for a number of months. The service has been recruiting to posts and continues to do so. Within the pharmacy workforce the applicants have been primarily from pharmacists due to qualify in August therefore resulting in a short term gap as staff have left now and will be replaced in August. With the pharmacy technician workforce multiple attempts have been made to recuruit to fixed term and permanent posts with little success.	James Hargraves	Simon Priestley	Trustwide - All Sites (DPoW, S	Chief Operating Officer	Chief Operating Officer	Pharmacy	15	1 Monthly	03/05/2023	We are trying to source locum cover for both pharmacists and technician posts but have had minimal response from locum agencies. We are working with existing staff to offer bank contracts and additional shifts, again with minimal uptake.	Difficulty recruiting permanent and locum staff. Difficulty retaining staff. Difficulties continue with finding and appointed appropriately experienced locum pharmacists. Situation not helped by current high cost locum rates (£40-£50 per hour) in community making hospital work financially unattractive)	We will have 1x locum pharmacist commencing on the Scunthorpe site in August 2022 for minimum of 3 months.
2562	13/01/2023	08/09/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Failure to meet constitutional targets in ECC	Due to a high level of demand at the front door and challenges with patient flow through the hospital, ED waits are a challenge which has an adverse effect on patient safety. Risk that the Trust's 4 hour A&E performance target may not be achieved and that 12 hour trolley breaches may occur. Due to a high level of demand at the front door and challenges in patient flow through the hospital, ED waits are an ongoing challenge, which has an adverse effect on patient safety.	Nicola Glen	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	20	1 Monthly	27/05/2023	- Daily Operations Centre Meetings - Establishment for medical staffing in ECC increased to 14 Consultants, 12 Middle Grades, 10 Juniors - Additional consultant coverage up to midnight on shop floor 7 days a week to ensure compliance with RCEM guidance - Additional 3rd middle grade shift overnight 7 days a week to support operational pressures - Daily analysis of challenges and performance Update: 18.06.21 * ECIST support provided and action plan produced * Implemented NHS 111 First Initiative * EMAS direct streaming to SDEC now providing an alternative to going through ED and improving the patient experience * EMAS patient self-handover protocol now in place allowing ambulance crews to leave appropriate patients at ED reception to end the handover and avoid delays * Frailty service at DPOWH went live on 12th May to reduce frail patients within ED and provide an improved pathway for the patients Update: 20.07.2021 * Senior Medicine Management oversight tiers implented to improve support to ED and timely escalation Update: 09.11.2021 * New Urgent Care Service (UCS) model implemented at SGH from 18th October 2021 - phased approach to implementation due to need to build workforce numbers and clinical skills * Newly revised and relaunched IAAU/SDEC SOP to reduce barriers for patient pathway from ED and reduce patient wait times Update: 10.01.2022 * UCS model due to be implemented at DPOWH from 18th January 2022 Update: 10.03.2022 * UCS model implemented at DPOWH and sustaining 100% performance for this cohort of patients, with improved patient care and experience	- Exit block from ED for admission due to lack of patient flow causing long delays for patients in ED - Medical staffing vacancies, sickness, and isolation resulting in over reliance on locum/agency doctors and junior skillmix - Nurse staffing vacancies, sickness and isolation resulting in unfilled nursing shifts and over reliance on agency nurses with less ED experience - Inappropriate attendances to ED due to lack of access to alternative, more appropriate services - Update = 02.03.2021 = COVID 19 has had and is continuing to have a significant impact on the Trust's ability to maintain its constitutional A&E targets, primarily due to maintaining the flow of patients requiring isolation beds, additional PPE and social distancing requirements and delays in diagnostics - Lack of physical capacity within the ED to see patients when exit block occurs resulting in long patient waits in ED and ambulance handover delays	- Emergency Care Quality and Safety Meeting oversight - Medicine Governance Meeting oversight - Agenda item on PRIM - Recruitment plans to recruit to medical staffing vacancies through new ED specific recruitment strategy - Additional medical staff booked by Trust to support covid implications and delayed patient stays within the ED - Additional HCA staff booked by Trust to support covid implications and delayed patient stays within the ED - Implementation of phase 1 of AAU in Nov 2019, followed by phase 2 of integrated AAU in Oct 2020 has improved SDEC provision and patient flow * D2A - audits. Update: 10.01.2022 * 12hr DTA Breach Validation to identify root cause of breach and to check whether patient harm occurred Update: 08.02.2022 * UCS pilots at each site are showing improvements in patient care, exeperience and performance against the 4 hour target
2576	10/03/2022	30/09/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Paediatric Medical Support Pathway for ECC - 'Fastrack'	There is a risk that children and young people are not triaged and assessed within the 15 minute standard as a result of acuity and activity within the Emergency Depratments which may lead to prolonged wait times for nursing and medical assessment within the Emergency Departments which may lead to a sick child not being recognised thus causing a level of harm	Deborah Bray	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Paediatrics	16	1 Monthly	20/05/2023	>Fast track pathway in place across both ED's	Limited paediatric medical workforce on duty out of hours and overnight which could limit ability to respond and pose a risk to care delivery across the paediatric and neonatal areas.	Incidents monitored via Ulysses and RCA's conducted where appropriate.
2592	17/09/2019	31/10/2021	To work with partners across health and social care in the Humber Coast and Vale Health Care Partnership (including at Place), and neighbour	Clinical	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	Failure to treat patients within the cancer waiting times may result in poor patient experience and potential clinical harm. Risk register also relates to Risk ID 2244.	Jennifer Orton	Jennifer Orton	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Cancer Services	16	1 Monthly	14/06/2023	Weekly Cancer RTT waiting time meeting to challenge and review the PTL.	Failure to treat patients within Cancer Waiting / Performance Target 62 day may result in poor patient experience and potential harm.	104+ waits are reducing week on week, clinical harm review being undertaken on all 104+ patients.
2623	28/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Health & Safety	Failure of windows - Trustwide	There is the risk of patient harm due to failing aged windows and window restrictors supported by DoH Alert EFA/2013/002. Many of the windows are the original windows installed (in excess of 40 years) and do not meet HBN 00-10 Part D: Windows & associated hardware requirements, which is retrospectively applied.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Buildings	20	1 Monthly	28/05/2023	Periodic planned maintenance.	Due to the windows been in poor state it is difficult in determining when these could fail.	Labour management system
2655	11/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	SGH - Replacement of primary heat source and associated infrastructure and equipment to include the Steam Raising Boilers	Risk is loss of heating and hot water on site. The steam raising boilers are 31 years old and could fail. Boiler failure would result in SGH closing down all clinical services until temporary boilers could be connected to site.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Heating/Ventilation	20	1 Monthly	10/06/2023	The management of the energy centre (steam boilers) is outsourced to Equans.	Equans contract has expired. Renewing annually.	Adhoc repairs are effective. No significant loss of service.
2719	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety - Oversized water distribution pipes	There is the risk of micro bacterial water infections from under utilised water services due to legacy oversized water distribution pipework which could result in patient(s) contracting infections whilst in hospital.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	20	1 Monthly	28/05/2023	Risk assessments undertaken at two yearly intervals by external competent specialist contractors.	Lack of funding for infrastructure upgrading.	Hydrop defect portal giving real time data on progress of defects.
2773	21/04/2023	31/08/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Clinical Harm	Cause - Lack of scanning capacity is leading to a risk of delayed diagnosis Impact - inability to deliver timely diagnostics for patients on diagnostic pathways, and lack of clinical capacity & agreed pathways is impacting on ability to perform harm reviews. The impact of this is failure to meet waiting times standards, leading to an increased risk of clinical harm.	Ruth Kent	Ruth Kent	Trustwide - All Sites (DPoW, S	Directorate of Operations	Surgery, Critical Care & Clini	Radiology	16	1 Monthly	21/05/2023	Risk stratification process agreed with groups. Escalation process reiterated to clinical administration staff Monitored via activity meetings and updated via RMT Close working with operational management team, heads of service and clinical leads where appropriate to agree booking priorities Wiating lsits recovering since new scanners opened, CT & MRI not triggering waiting list validation according to national guidance. Non obs ultrasound has become a concern - separate risk has been added for this.	Clinical framework for appointing within current capacity	Monitored and update via COVID-19 management meeting. Added to action plan and risk log of above meeting. Discussed at Trust level Recovery plans and increasing capacity to support reduction of waiting lists

2898	14/03/2023	01/12/2022	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Staffing Levels & HR	Medical Staff - Mandatory Training Compliance	Mandatory Training compliance for medical staff. There is a risk to patient safety if medical staff do not complete their mandatory training before each element has expired. Due to the volume of doctors demonstrating low compliance across all grades, this has impacted upon the divisional CQC improvement plan.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	16	1 Monthly	13/04/2023	* Feb Data - Core: 63% Role Specific: 52%. * Rota Coordinators providing more directed support to all level doctors across Medicine to allocate/support training time for them to complete MT * MT raised at SMT, Board Meetings, Workforce SMT and separately at AGM/Speciality/Clinical Lead/Line Manager Level * Workforce Development plans are being developed for each Speciality within Medicine which is being supported by the Medicine Quad, HRBP and AGM down to Clinical Leads. * Reviewed at Divisional Workforce Meeting Updated - 14.03.22 Identification of 2 least compliant staff members in each area each month and target set for compliance to be met HRBP meeting monthly with the rota co-ordinators to identify 10 least compliant doctors and allocate time on the roster to complete Divisional Clinical Leads to work with divisional SMT to develop recovery plans for their specialities Training incorporated at the Quality & Safety meetings Individuals with low compliance being contacted and targets for completion set on-going at ward review meetings Linking in with course leads to look at prioritisation and alternative ways of completing training e.g. targeted cohorts New rotational doctors commenced training prior to starting in post	Potential failure to meet CQC requirements Staff not adequately trained with potential to impact on patient care and staff H&WB	* Report collated by HR Business Partner. * Improvement plan led by AMD / ACOO. * Compliance monitored at Divisional Board / Divisional Governance Meetings. * Reviewed at Divisional Workforce Meeting * Reported via Performance Review Meetings.
2905	07/04/2021	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Ageing Diesel Powered Generator Sets - CSSD1 - Secondary Power Source Failure - DPoW	There is a risk that the following areas may not be able to receive essential supply of electricity in the event of a power failure due the age of generator (1979). This will affect clinical procedures and potential persons within the lifts becoming trapped, therefore directly affecting patient safety. - Ramp Plant Room (Med Gas Compressors +) - Theatre Plant Room (All Theatres) - Lifts - I.T and I.T Server - X-RAY - Theatres - Pathology If this risk materialises, the hospital would need to close	James Lewis	Simon Tighe	Diana, Princess Of Wales Hospi	Estates and Facilities	Estates and Facilities	Estates - Electrical	16	1 Monthly	28/05/2023	Monthly test to start and run Diesel Generator for a period of 90mins	Non-compliant with HTM 06-01;17.88 Maintenance programmes should include a longer test run to establish the generator Engine's mechanical performance. A test to prove the generator engine's condition up to 110% full load should be carried out annually. The period of the test should be not less than 3 hours and ideally 4 hours. The Trust is currently only able to conduct an 80% max load test. Tests can currently only be ran for a period of 90 minutes. Potential frailty of equipment was highlighted in the 2019 Load Bank Test as it damaged a Cooling Pump & Radiator on a similar set. Non-compliant with BS7671:2018;414.2.1 Live parts shall be inside enclosures or behind barriers providing at least the degree of protection IP2X	Minor and major equipment services logged in compliance folders.
2949	12/05/2023	31/03/2023	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Oncology Service	As part of the ongoing Oncology HASR work, a joint risk register has been created to capture all potential risks and their mitigating actions. The below are jointly reviewed at the weekly NLaG & HuTH Oncology meeting: 1)NLaG Waiting times for Oncology patients are longer than expected due to absence of Consultant Oncologists at HUTH. Concerns escalated by Surgery Division at NLaG regarding Urology Cancer waiting times and delays to treatment of patients. 2)NLaG Matron has flagged as a serious risk, that inpatient chemotherapy can no longer be delivered on Amethyst due to a shortage of chemotherapy nurses at DPoW and difficulties in training new chemotherapy nurses.	Angela Lamming	Jill Mill	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Oncology	20	1 Monthly	11/06/2023	1)Currently looking for locum consultants to back fill some of the work, and a locum SpD has been secured, starting week commencing 30/11/2020. Interviewing for a further 5 SpDs. 2)Ongoing work around the management of clinics including clinic redesign, telephone clinic management, practitioner support, adequate time slots etc. Support offered to all staff from management. 3)Covid19 steering group in place, with CSS Health Group and SS Division input into command structure. 7no. Covid19 + beds still in place on C30 and position monitored closely to establish requirements into the future. 4)Liaison between HUTH and NLaG Senior Management Leads to ensure oversight of the waiting times and actions to mitigate avoidable delays. Plan is to develop a single joint activity / waiting times report whc will be produced monthly and reviewed at the joint Oncology meetings. 5)Very small number of patients affected, who could be admitted at HUTH to receive inpatient chemotherapy delivery. 6)Where clinically appropriate, SACT delivery from Lloyds community infusion clinic to reduce demand on SGH dat unit. Consider reducing the number of days SGH day unit opens to consolidate staffing. Continue to access external Level 6 SACT training for RN on Amethyst Unit at DPOW to increase chemo trained workforce.		* Risks reviewed weekly at the joint NLaG & HuTH Oncology meeting and updated accordingly.
2951	23/03/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Electrical: Age and resilience of Low Voltage Electrical Infrastructure - Trustwide	There is the risk of failure of aged (40 years plus) Electrical and/or mechanical LV components which could cause power interruptions to key areas. The impact of such failure is for clinical departments to experience reduced capacity or ability to treat and/or carry out diagnostic investigations on patients, leading to possible harm. This risk became a tangible issue on Dec 22 when a power cable failed causing widespread power interruptions.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Electrical	20	1 Monthly	28/05/2023	Monitoring switch gear regularly to ensure the situation is not deteriorating.	Lack of annual switching.	Periodic inspections carried out annually.
2952	04/08/2021	07/12/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Fire ring main - Trustwide	The fire ring main is legally required to serve only water services for fire fighting, the ring main has a number of building fed from it thus making it non-compliant with regulations and could lead to enforcement action by Humberside Fire and Rescue Service.	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	16	1 Monthly	28/05/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.		Hydrop defect portal giving real time data on progress of defects.
2953	22/02/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Water Safety Compliance: Sensor & Spray taps - Trustwide	Due to the installation of sensor and spray taps and the inability to flush for the required time period, there is the risk of legionella which could impact on the health of the building occupants (patients/staff).	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Estates - Water	16	1 Monthly	28/05/2023	Risk assessments undertaken at three yearly intervals by external competent specialist contractors.	Linked to on-going refurbishment works.	Hydrop risk assessment report which identifies location of taps.
2955	12/04/2023	30/06/2023	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Med Gas; Insufficient Oxygen pressure available due to VIE and pipework configuration and sizing - Trustwide	There is the risk of failure of the oxygen delivery system if the demand exceeds design capacity, which could result in loss of oxygen supply to patients causing the Trust to divert patients to neighbouring hospitals.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Med Gas	15	1 Monthly	28/05/2023	Daily monitoring of the oxygen consumption.		Medical Gas Policy DCP026

2959	12/04/2023	31/03/2024	To offer care in estate and with equipment which meets the highest modern standards	Buildings, Land and Plant	Replacement/Repairs of flat roof - Trustwide	There is the risk of failure of flat roofs across the sites. A number of roofs have failed across the site. Roofs of note include the SGH IT roof which houses trustwide servers and a roof over a new £1m MRI unit. A roof failure in either of these areas would result in significant risk to trustwide infrastructure and service delivery impacting elective recovery.	James Lewis	Simon Tighe	Scunthorpe General Hospital (S	Estates and Facilities	Estates and Facilities	Estates - Buildings	16	1 Monthly	28/05/2023	Staff report any roof leaks to the facilities department when they occur.	Limited BLM funding prevents full replacement of flat roofs and only enables patch repairs.	Document will provide targeted spend profile to minimise roof failure.
2960	27/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk of inability to safely staff maternity unit with Midwives	The risk is the potential inability to safely staff the maternity unit in order to provide care and treatment to a defined establishment due to sickness, Covid isolation and vacancies. If the staffing levels are reduced, this will impact on the ability to provide safe care to women and their babies, resulting in increased incidents and potential poor outcomes.	Jane Warner	Preeti Gandhi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Obstetrics / Maternity	16	1 Monthly	25/05/2023	Daily staffing meetings for oversight of issues Thrice daily Operational meetings to escalate staffing issues SafeCare Live Process to escalate short staffing - request for bank staff / agency staff 24/7 theatre access is managed by surgery division Maternity Services Escalation Policy	Challenges in acquiring midwives via agencies due to limited numbers and trust location Acuity of unit changes requires demand for additional staff and difficult to plan	Any incidents relating to staffing compromise are monitored via weekly incident review meeting and any issues relating to safety being compromised are escalated at time of event.
2976	01/11/2022	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Staffing Levels & HR	Registered Nursing Vacancies	High Registered Nursing vacancy levels - a lower number in the UK market impacting upon the delivery of patient service, travel and accommodation issues causing some difficulties for international recruits.	David Sprawka	David Sprawka	Trustwide - All Sites (DPoW, S	People and Organisational Effe	People & Organisational Effect	Recruitment	25	1 Monthly	21/06/2023	Funding accessed through NHSi to facilitate international recruitment providing additional pipelines.		
2992	18/11/2021	31/03/2022	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Equipment	Changing Places facility at Scunthorpe General Hospital	There is a risk of emotional harm and distress to patients and families who visit the trust and unable to use appropriate toilet facilities. This is due to no adapted Changing Places facility at Scunthorpe General Hospital. This could result in reputational damage from complaints, safeguarding section 42 Care Act enquiries and patient harm due to psychological distress and deterioration in skin integrity.; breaches in the Human Rights Act could lead to reputational and cost implications.	Victoria Thersby	Victoria Thersby	Scunthorpe General Hospital (S	Chief Nurse	Chief Nurse	Safeguarding Adults	16	1 Monthly	01/06/2023	There are disabled toilet facilities within the Trust	Complaints by members of the public and patients attending the outpatient department	
3015	11/04/2023	31/03/2023	To offer care in estate and with equipment which meets the highest modern standards	Staffing Levels & HR	Insufficient estate resources to manage the workload demand	Failure to recruit technical capital project team members to support current major capital project delivery programme which is impacting on the estates operational teams ability to deliver service level compliance, statutory requirements, and provide an environment that is fit for purpose. Compounding the risk is the limited (11 personnel) number of staff holding the duties of an Authorised Person (AP) for specialist engineering fields. Additionally, there has been an increase in claims being lodged in relation to areas where slips, trips and falls and statutory compliance is not being met. It is anticipated that this risk will be reduced in 24/25 when capital funding reduces. The impact to the Trust if not actioned; inability to meet statutory compliance, leading to potential prosecution for statutory non-compliance, lack of Engineer resource to complete mandatory work and project works, ineffective management of Pre-Planned Maintenance, ineffective management of water systems due to shortage of water APs (SGH), inability to complete emergency testing across main estates disciplines (electrical system emergency testing, ventilation multi-disciplinary emergency testing), ineffective management of the estates leading to reactive maintenance (firefighting), inability to implement proactive management systems (MICAD helpdesk), impact to patient safety, loss of workforce due to on-going work pressure and employee market shortage (supply/demand), reduced staff morale, inability to support wider project delivery, durther degradation and serious incidents within the estates, loss of financial resources due to settlement of claims (mainrity of	James Lewis	Simon Tighe	Trustwide - All Sites (DPoW, S	Estates and Facilities	Estates and Facilities	Health & Safety	20	1 Monthly	28/05/2023	Resources prioritized in a reactive manner	Minimal controls in place, competing priorities for both capital and operational compliance work, resulting in poor ability to manage both within either a safe or responsive realm.	Internal policies and procedures in place
3036	17/03/2022	30/06/2022	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Risk to Patient Safety, Quality of Care and Patient Experience within ED due to LLOS	There is a risk to patient safety, quality of care and patient experience due to delayed admission to ward beds due to challenges with patient flow throughout the Trust.	Simon Buckley	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Emergency Care	16	1 Monthly	08/06/2023	LLoS is monitored on an ongoing basis through the following meetings; Medicine Divisional Board Medicine Governance Daily Operation meetings Deprtmental Board rounds and Huddles ED 95% standard compliance		
3045	16/03/2023	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Medical Workforce Vacancies in Gastroenterology	Following departure of 2 consultants in Gastroenterology there is insufficient workforce to deliver the range of services. Resulting in: - Failure to meet constitutional targets (RTT &Cancer) - Delays in patients being seen both as inpatient & outpatients - Increased waiting times - Increase LOS - Failure to fulfil emergency GI Bleed Rota - Lack of training and supervision - Unable to provide a Barrett's oesophagus service and registry in the Trust for appropriate follow up of these patients. The patients with Barrett's are being managed by gastroenterology, surgery and even some patient's are with primary care.	Simone Woods	Simone Woods	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Gastroenterology	16	1 Monthly	02/06/2023	Staff on the GI bleed rota will travel to the opposite site where needed to attend a patient with a GI bleed or patient will be transferred to the alternate site for treatment if feasible.	When short notice leave applies this puts additional pressure on the current provision for the service	

3048	13/04/2022	30/11/2022	To provide care which is as safe, effective, accessible and timely as possible	Operational	Challenges to recruitment of acute care physician vacancies in Acute	This risk is to highlight the difficulties in workforce recruitment and the increased pressures on staff, which has been exacerbated by the Covid-19 We have vacancies for acute care physicians (ACP) Trust-wide and it is proving very challenging to fill these posts. The cause has been due to a national shortage of ACPs and lack of applicants for the posts when we have advertised them. The impact would result in failure to recruit the required ACPs and this will delay the planned expansion of acute medicine service with extended hours with senior clinician presence on the shop floor and could result in failure to launch phase 3 of the IAAU development plan for 2023. There is a risk that due to the pressures created by having less workforce and increased demands placed on services as a result of not having a balanced workforce, this may result in the current ACPs becoming exhausted, leading to gaps in rotas and therefore not sufficient senior medical staff to ensure quality and safety of patients. In addition, this may also result in doctors withdrawing from our hospitals, exacerbating staffing issues.	Lynsey Chessman	Anwer Qureshi	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	General Medicine	16	1 Monthly	14/06/2023	Actively trying to recruit more clinicians through networks		
3063	14/03/2023	31/03/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Doctors Vacancies within Medicine Division	1.lack of substantive practitioners as a result of difficulties recruiting may lead to patient safety issues (lack of continuation of care due to the number of locums who may choose the leave at any time). 2. an increased financial burden for the Trust due to higher costs for locums (circa double the cost of Consultants on Trust contract). 3. There are fluctuating but significant number of vacancy posts required in Medicine.	Sarah Smyth	Asem Ali	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Medicine (All)	16	1 Monthly	13/04/2023	weekly workforce panel workforce SMT specialty business meetings review and oversight if data	development of specialty workforce plans	workforce panel workforce SMT Div Board workforce improvement plan
3074	29/06/2022	31/12/2022	To secure income which is adequate to deliver the quantity and quality of care which the Trust's patients require while also ensuring value	Financial	Financial Risk - Medicine CIP 2022/23	Non delivery of divisional financial objectives for financial year 2022/2023.	Darren Marshall	Sarah Smyth	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Finance	16	1 Monthly	28/04/2023	General budgetary Financial Management - Includes reporting, variance analysis and actions / recommendations.		
3129	23/02/2023	/ /	To provide care which is as safe, effective, accessible and timely as possible	Clinical	Overdue follow-up and new patients waiting lists for Paediatric patients at SGH	There is a risk of possible delays in diagnosis and treatment for Paediatric patients who have been waiting for a long time, as a result of a backlog from the Covid 19 pandemic (clinics being cancelled and staff shortage/ sickness). This may lead to complications and side effects which can be avoidable if patients are seen on time.	Nicki Chatterton	Umaima Aboushofa	Scunthorpe General Hospital (S	Directorate of Operations	Family Services	Paediatrics	15	1 Monthly	30/03/2023	To risk stratify the cases overdue by 20 weeks and try to priorise these patients.	Ensure patients are seen and safe.	Feeding into weekly performance and activity meetings. This is also being discussed / reviewed within the Teams. Discussed at PRIM.
3131	30/12/2022	/ /	To ensure the services and care we provide are sustainable for the future and meet the needs of our local community	Operational	Delay in assessments being carried out for children with health and educational needs (under 5 years of age)	There is a risk that children are not diagnosed in a timely manner to be able to put the appropriate support package in place due to the delay in assessment being carried out (currently a wait of 2 years).	Deborah Bray	Vijayalakshmi Hebbar	Diana, Princess Of Wales Hospi	Directorate of Operations	Family Services	Paediatrics	16	1 Monthly	20/05/2023	Working collaboratively with the ICB to put a plan in place to ensure the health assessments are carried out as quickly as possible and that parents are sign-posted to healthcare professional, GPs and health visitors.	Unable to proceed with increased capacity due to limited resources across health and education.	Issues are incident reported and specific issues will be addressed depending on the issue raised at the time of the incident. Complaints and PALS management.
3158	02/05/2023	30/06/2023	To provide care which is as safe, effective, accessible and timely as possible	Clinical	(EPR) Badgernet - ability to view scans	There is a risk that Obstetricians will not have access to electronic scan reports when the new maternity services EPR (Badgernet) is implemented, as a result of the systems incompatibility with the current Viewpoint package, which may lead to an adverse impact on patient safety in terms of potential for high risk pregnancies.	Nicola Foster	Anthony Rosevear	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Obstetrics / Maternity	15	1 Monthly	01/06/2023	MITS Project Board in place MITS Data Migration and Warehousing Strategy in place Digital Midwife and CNIO in place providing oversight EPR project management and digital projects development monitoring systems in place	Current incompatibility of procured IT systems	MITS Project Board
3161	05/04/2023	31/05/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Clinical	There is a risk of patient deterioration not being recognised and escalated appropriately.	There is a risk that patients deterioration is not recognised and the recording and monitoring of NEWS is not consistently completed to guide further actions appropriate to the trust Deteriorating Patient Policy, including the use of risk assessments (Sepsis screening tool) to identify required clinical responses in a timely way.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)	15	1 Monthly	11/06/2023	1.Divisional progress against targets is monitored via the Deteriorating Patient & Sepsis Group.		
3162	08/02/2023	31/05/2023	To provide care which is as safe, effective, accessible and timely as possible	Operational	Quality of Care and Patient Safety based on Nurse Staffing Position	The Registered Nursing vacancy position in Medicine, against current, agreed establishment creates significant issues with producing a robust nursing roster. Reliance upon a pipeline of Newly Registered Nurses and Internationally Educated Nurses creates skill mix issues when set against numbers of leavers. The Nurse vacancy position within Medicine has a direct impact on quality of care and patient safety. There is a finance risk associated with the use of Bank & Agency Nurses in order to fill the gaps in the rosters. Service developments and new build areas (IAAU/SDEC/ED's) and investment in the establishments required have increased demand for Bank/Agency and vacancy in substantively funded posts. Medicine are also staffing escalation beds which adds further risk. Patient harm, increased sickness, staff retention are possible outcomes as a result.	Joanne Foster	Simon Buckley	Trustwide - All Sites (DPoW, S	Directorate of Operations	Medicine	Nursing (All Specialties)	20	1 Monthly	11/06/2023	1.Recruitment pipeline for Internationally Educated Nurses Recruitment pipeline and engagement with newly registered nurses	Inability to safely redeploy	
3164	21/02/2023	31/03/2024	To develop an organisational culture and working environment which attracts and motivates a skilled, diverse and dedicated workforce	Staffing Levels & HR	Nurse Staffing	There is a risk that the Trust will be unable to maintain safe nurse staffing levels as a result of the high number of registered nurse & support worker vacancies and ongoing requirement to support unestablished escalation beds, which may impact on the ability to maintain patient safety and delivery of high quality care, leading to poor patient and carer experience and reputational damage.	Jennifer Hinchliffe	Eleanor Monkhouse	Trustwide - All Sites (DPoW, S	Chief Nurse	Chief Nurse	Nursing (All Specialties)	20	1 Monthly	08/06/2023	SNCT acuity data collected twice a year with formal Chief Nurse establishment reviews undertaken annually	High number of nurse vacancies leading to shortage of nursing staff available to cover required shifts and reliance on bank and agency staff. Increased RN and HCSW turnover rates. Diversity of IEN pipeline and ability of ward to support high numbers of IENs due to impact on skill mix.	Nurse staffing dashboard accessible and contains KPIs re vacancy position, agency usage, nurse sensitive indicators etc.

3168	26/04/2023	28/07/2023	To provide care which is as safe, effective, accessible and timely as possible	Corporate Business	Newborn Hearing Screening Service cross-site (reduced management time / no management cover)	There is a risk that, when the local hearing screening manager is on leave or absent, there is no-one to carry out local hearing screening manager tasks which could result in a lack of service provision as there is no-one within the team who is trained to cover these duties. There is a risk that babies' screening may be missed or escalations may not be followed, if not managed timely, which may result in a late diagnosis of hearing loss. Management tasks for the QA / Public Health England will not be completed which could result in a delay in picking up gaps in the service and screener performance. If there is reduced capacity within the team, this also reduces the amount of time the local screening manager has for managerial tasks. There is also a risk of burnout to the team.	Alison Hilder	Vijayalakshmi Hebbar	Trustwide - All Sites (DPoW, S	Directorate of Operations	Family Services	Newborn Hearing Screening	16	1 Monthly	26/05/2023	Escalating to matrons (including the Antenatal and Newborn Screening Manager).	Escalation to highlight increasingly prominant risk. This has also been highlighted in the QA visit in September 2022.	
3174	22/03/2023	30/06/2023	To learn and change practice so we are continuously improving in line with best practice and local health population needs	Financial	National Cost Collection - patient level community data	Trust doesn't receive system one information to be able to submit costs at a patient level as per the mandatory requirements of NHSE/I.	Damian Kitchen	Lee Bond	Trustwide - All Sites (DPoW, S	Finance	Finance	Finance	15	1 Monthly	16/06/2023	regular contact with information department for progress updates		escalation to internal digital management

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Agenda Number: CoG (07/23) Item: 8.3

Name of the Meeting	**Council of Governors**	
Date of the Meeting	13 July 2023	
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

Mar 2023 – v8.4

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 (CCGs) were NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in each of their local areas in England. On 1 July 2022 they were abolished and replaced by Integrated Care Systems as a result of the Health and Care Act 2022.

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

Committees in Common (CiC) - NLaG and HUTH are implementing a governance structure which will ensure that they have single focussed discussions on major areas of service change. These discussions would take place in the Committees in Common

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.

ICB – Integrated Care Board

ICP – Integrated Care Partnership

ICP – Interim Clinical Plan

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