NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

2017/2018 ANNUAL REPORT & ACCOUNTS

Together
we care, we respect, we deliver

Northern Lincolnshire and Goole NHS Foundation Trust

2017/2018 ANNUAL REPORT & ACCOUNTS

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

Contents

Chair's foreword

This year has been one of facing up to challenges and striving for improvement following our special measures status in early 2017.

In August we welcomed our new Chief Executive Dr Peter Reading to the Trust. Peter is a very experienced leader who has overseen considerable organisational change previously. His leadership, knowledge and experience is exactly what we need here at Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) in order for us to make progress on our improvement journey.

I want to express my thanks to Richard Sunley, our previous Interim Chief Executive who stayed with the Trust to support Peter and provide continuity in leadership during a time of transition. Richard has been instrumental in leading the development of our operational capacity and in developing fresh and improved relationships with our partners and in engaging with our staff.

Our Council of Governors has been a constant source of support to me and the Trust at large. It is active in working to promote the organisation and its services and this year has taken its place on the national conference stage in representing the Trust.

NHS Improvement (NHSI), which is one of our regulators, has also been constant in its support to us as a very complex and challenged Trust, and for that I and the Board are very grateful indeed. Its teams have supported our staff in looking at new ways of delivering services and it has challenged us to think differently. In addition to NHSI we have had the practical support of East Lancashire NHS Trust as our 'buddy'. It is helping us at various levels to find new ways of working.

In thanking those who have helped us over the year and continue to do so I must pay tribute to our local partners, the local authorities and clinical commissioning groups for their unwavering help and support. We have some firm foundations for partnership on which we can build going forward.

Our volunteers continue to make a huge contribution in their varied roles such as acting as guides in our hospitals to patients or relatives who are trying to find their way through to wards and departments. They offer reassurance and help at a time of worry and stress. I and the Trust Board are very grateful to them for their continued support as it means a lot.

We have seen unprecedented demand for our services over the last quarter of the year, usually described as 'winter pressures'. Our staff have demonstrated great courage and commitment to the Trust and their patients in continuing to provide the best care they can in times of unrelenting pressure. I want to express my gratitude to each and every one of them for this and hope that we will all continue our improvement journey together.

I want to be clear; the Trust Board continue to keep quality and safety of care for patients our priority. This does mean however, that while seeing improvement in our financial position it is not as great or as swift as we might have liked because of this. But the care and safety of our patients comes first.

In tackling our service improvement we have established our overarching Improvement Programme – Improving Together. Improving Together has five key work steams – improving quality and safety, improving leadership and culture, improving access and flow, improving service strategy and improving finance, which address our areas of required improvement, including those related to the Care Quality Commission (CQC) inspection of 2016.

It must also be noted that during 2017 we continued to address the data quality

issues in connection with the information on the Trust waiting list which is used to manage delivery of the Referral to Treatment Waiting Times (maximum waiting time of 18 weeks) standard. Further information relating to this can be found within the Annual Governance Statement. We still have much to do in order to improve our position, work has undoubtedly been held up as we have had to focus on urgent care demands placed on the Trust.

Despite these challenges I firmly believe that our Trust values – 'together we care, we respect, we deliver' – underpins everything we strive to achieve across all our hospitals and good community services.

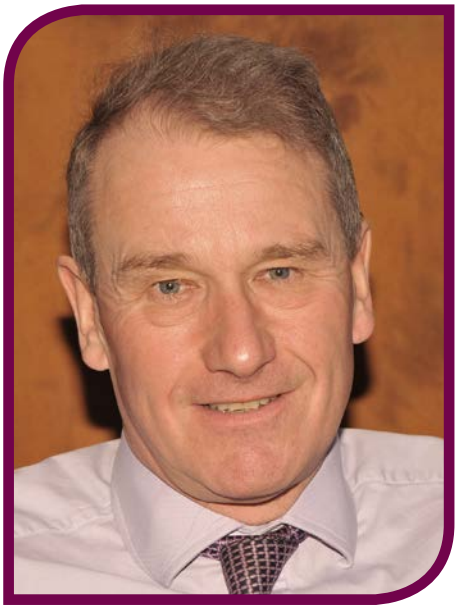
For our patients our values set out what they can expect from us at each contact, whether that is on the phone, in writing, or face-to-face. It says we care about more than just the treatment they receive, that we will respect them and will endeavour to provide safe, compassionate, individualised healthcare services through working with them, when they need us most.

For our staff it says that, together, working as a single team is the way forward. By everybody getting involved we can improve the quality of our patients' care and their experience when they are in our care. This is true for everyone from a frontline patient-facing member of staff to those within corporate directorates supporting clinical service delivery. We all have a stake and responsibility in contributing to our future and the services we provide to our local population. Improving Together is key to our success going forward.

During 2017/18 we also launched a new concept called Listening into Action (LiA). This is a mechanism by which staff can make suggestions and follow through with designing and implementing them in teams. This has provided the start for staff to drive forward changes to the ways in which we design systems and processes. I fully expect this to continue and evolve in the forthcoming year.

Anne Shaw
Chair

Chief Executive's foreword



I have not yet been in post 12 months but in that short space of time I feel as if I have got to know the organisation, its issues and more importantly, its staff.

2017/18 saw the Trust go through some substantial changes and some exceptionally challenging times, not least being placed in financial and quality special measures.

I came into post in August 2017 in the knowledge that there was a lot to do if we are to turn the organisation around and come out of double special measures.

We are on a journey to develop our future, and progress can only be made thanks to the 'can do' attitude and enthusiasm of our staff.

They have been working incredibly hard over the past year to ensure patient safety remains at the heart of everything we do.

Whatever has been thrown at the staff – from increasing numbers of acutely ill patients coming through our doors to the 'Beast from the East' bringing in wintry weather and snow drifts, they have risen to the challenge.

I want to embrace their commitment and harness their passion. Together I know we can make real, sustainable changes to services ensuring they are fit for the future. We already have a significant amount of work underway to improve quality, and to change the culture of the organisation through our Improving Together programme.

There are five workstreams which we are focusing on. These are: improving quality and safety; improving access and flow; improving leadership and culture; improving finances and developing a good service strategy.

We launched the Improving Together programme in response to the 2016 Care Quality Commission report in which we were rated as 'Inadequate' and placed into quality special measures. We have achieved much since then, but I am under no illusions that we still have a long way to go.

The results of our national staff survey, in which more than 2,000 members of staff responded, were disappointing but not entirely surprising. The key themes were around staffing levels, low morale, staff not feeling able to contribute to improvements and a lack of opportunities for training and development.

What was encouraging was that 69 per cent of staff said they were enthusiastic about their job and 85 per cent said their role made a difference to patients. I have introduced a clear focus on staff well being as I know that every member of staff from back office admin staff, to nurses, porters, doctors, pharmacists, community staff, allied health professionals, domestics, and consultants all have a part to play in turning round this organisation.

One thing I hope I have demonstrated so far is that their voice counts. I want to hear about their successes, and their concerns and issues as we have to work together if we are to make changes. One of our initiatives last year was Listening into Action, which aims to empower staff to make changes and bring their improvements ideas to life.

We have also appointed a Freedom to Speak up Guardian, Mr Makani Hemadri, to give staff a confidential route to raise concerns about anything at the Trust. It is essential they have someone they can confide in to raise matters that are important to them.

Mr Hemadri and I meet on a regular basis so that he can raise concerns with me. In addition to this we have also introduced our Pride and Respect project which provides an alternative way for people to raise concerns about people or

teams displaying unacceptable behaviours or poor professional standards. More than 100 staff have volunteered to help us shape and implement this project which will roll out across the Trust in 2018.

As with many other trusts across the country we are also having to think more innovatively about the way we recruit and retain our staff. The NHS as a whole is trying to appoint to posts from a diminishing pool of people, so we are having to look at new ways of ensuring we get the right staff, with the right skills and expertise delivering patient services.

We have to modernise our workforce to meet current and future challenges and one way we are doing this is by introducing new career pathways for non-medical practitioners, such as the advanced clinical practitioners. We have our first cohort currently studying for the Masters degree in Leadership and will be looking to extend this programme in the future.

Another way we are trying to 'grow our own' staff and retain existing people, is our wonderful apprenticeship programme. We have more than 160 people already signed up to courses ranging from business admin to cardiology physiology. I am immensely proud of the fact we are providing such a wonderful range of courses from GCSE level, all the way to degree level.

Our People and Organisational Effectiveness team has also been hard at work developing a new retention strategy to try and encourage people to stay in the organisation. There is no one solution to strengthening our workforce, but hopefully with a variety of building blocks we will start to see some improvements.

As well as focusing internally on how we can improve, we are also working closely with our commissioners, local tertiary centres, the Humber Acute Services Review and the Humber Coast and Vale Sustainable Transformation Programme.

There is much work to do around ensuring services are fit for the future, as we know there is fragility around some of them such as Ear, Nose and Throat (ENT), haematology and urology. We know we have further fragile services and these will come under the spotlight as we work with clinicians to ensure safe, sustainable services for the future.

Our finances also remain a challenge, but we are working closely with NHS Improvement to try and make savings where we can, as well as continue investment in our services and infrastructure.

NLaG has come a long way during 2017/18 in addressing the findings in the Care Quality Commission's inspection report which was published in April 2017, and our being placed in double special measures. I am confident that we have started our journey of improvement, however it would be remiss of me not to acknowledge that we still have a long way to go.

There are still challenges ahead of us such as our waiting times and our mortality position but we are getting a grip and we will see improvements as we drive forward change.

Finally, and most importantly of all, I wish to thank the staff for not only warmly welcoming me into the organisation, but standing by my side as we work together on our journey of improvement. It is a privilege to be their chief executive.

Dr Peter Reading
Chief Executive

Overview of performance

The purpose of this overview section is to set out: the purpose and activities of the Trust; the issues and risks which could affect the Trust in delivering its objectives; an explanation of the adoption of the going concern basis; and a summary of performance for 2017/18 against national standards.

CQC: Registration and Essential Standards of Quality and Safety

During November and December 2016, the Trust received announced and unannounced visits by the Care Quality Commission (CQC).

Arising from the visits, significant concerns were raised in respect of A&E including: lack of comfort rounds; lack of risk assessment and documentation; cleanliness; infection control; environment and data recording.

There were also concerns in maternity relating to: lack of fresh eyes; lack of escalation and issues in respect of interpretation of CTGs. There were also concerns with the waiting list (RTT and outpatient department follow-up) recovery.

The Trust subsequently received a Section 29A Warning Notice requiring immediate improvements. The full visit report was published on 6 April 2017 and the Trust received an overall rating of 'Inadequate'.

Arising from the outcome of the visit, the Trust was placed in quality 'special measures'. A support package from NHS Improvement (NHSI) was put in place including dedicated Improvement Director support to assist the Trust in the implementation of the 'Improving Together' programme and buddying support from East Lancashire NHS Trust.

Progress continues with the implementation, embedding and testing of agreed actions and the Trust Board receives a monthly 'Improving Together' progress report including compliance with key performance indicators (KPIs) intended to demonstrate the effectiveness and embedding of the improvements being put in place.

NHSI also introduced a System Improvement Board, which brings together all relevant stakeholders to support the Trust in the delivery of its improvement plan.

An announced re-visit to the Trust to test the improvement made was held between 8 to 11 May 2018. As part of the inspection process an unannounced visit was also carried out.

As the inspection and corroboration process is not complete and the outcome is unknown as at the date of finalising this report, the Trust is not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC).

Statement from Chief Executive on his perspective of the performance of the Trust

It's been a tough 2017/18 but our staff have continued to go the extra mile again and again. It has been humbling to be the Chief Executive for a workforce that is such a credit to the NHS.

When I first joined the Trust in

August 2017 I set out my five key priorities based on my first impressions.

These were safety, recruitment and retention, putting clinical leaders at the heart of the running the Trust, listening to staff and acting on what they tell us, and getting our spending under control. At the end of the financial year, those priorities remain the same.

Safety has, and always will, come top of our list of priorities. Specifically, we need to focus above all on four things; mortality, pressure ulcers, urgent, emergency and cancer care, and 52 week waiters. On mortality, in April 2018 we appointed two clinical leads and are redoubling our efforts around deteriorating patients and sepsis.

Last September we decided to focus on urgent, emergency and cancer care.

Despite the difficult winter we have achieved what we set out to as at the time of writing this report; the Trust's A&E system is now ranked the 12th most improved in the country, our cancer performance has improved and we are hoping to meet the national targets soon. In terms of our planned operations, 98.6 per cent of patients referred for an urgent procedure are operated on within six weeks.

Our vacancy rate continues to be a challenge, despite the best efforts of our recruitment team who are constantly looking at new and innovative ways to recruit. In medicine, we have a 24 per cent vacancy rate, it's nine per cent in nursing, and 10 per cent for allied health professionals.

It's not just a recruitment issue though, we need to also work hard to keep the staff we do have and to make NLaG an attractive place to work.

We have made some headway in reducing medical vacancies over the winter, and we recruited dozens of new nurses and healthcare assistants.

Sadly the impact of the latter was negated by too many people leaving so we are redoubling our efforts in a range of different ways.

I often talk about rebuilding the organisation, and that's what we are doing, slowly and bit by bit. Improving our culture is a major part of this.

Our staff are our greatest asset. Staff engagement is vital and over the past year we have introduced Listening into Action (LiA) to empower people to bring their quality improvement ideas to life.

We also launched Pride and Respect to tackle some of the underlying issues in the organisation and more than 100 staff stepped forward to volunteer to take this work forward.

We listened to people's feedback about the name, which some staff felt wasn't inclusive, and have now changed it to Pride and Respect (our anti-bullying campaign).

Putting clinicians, and particularly doctors, at the heart of running the Trust is something I have implemented elsewhere and seen the difference it can make.

In April 2018 we appointed five Divisional Clinical Directors (DCDs) to strengthen our divisions and put clinicians firmly in charge of how we plan and deliver clinical services.

Finally to the money; I have said before, and will say again, that getting a grip on our finances is essential, but it will not come at the cost of quality.

Although we still have a long way to go in terms of our deficit, we have stabilised what was a rapidly deteriorating position and we achieved £11m in savings last financial year.

We have been building trust and confidence with our regulator, NHS Improvement and have agreed a savings target of £15m for 2018/19.

This will be a very tough ask (four per cent of our budget) but it is comparable to most trusts in the country.

The Trust Board has also spent a lot of time over winter, with clinicians, looking at service strategy, supported by the Nuffield Trust.

We are now working closely with Hull and East Yorkshire Hospitals on the Humber Acute Strategy which see us moving towards having a one warmer acute site and one cooler acute site.

Who we are and what we do

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

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

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

In April 2011 we became a combined and community services trust for North Lincolnshire. As a result of this the name of the Trust, while acknowledging the geographical spread of the organisation, was changed during 2013 to reflect the trust does not just operate hospitals in the region.

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

Scunthorpe General Hospital (SGH)

The hospital was first built in the 1920's and occupies a 'land-locked' site surrounded by residential properties. The site has grown over time with expanded buildings attached to original structures.

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

The hospital has 370 overnight beds of which 95 are for surgery and critical care patients, 193 are for medical patients, with access to escalation beds when required, and 82 are for women and children.

Medical specialties on site include emergency ambulatory care and frail elderly assessment services, diabetes and endocrinology, cardiology (with facilities for cardiac catheterisation and pacing), respiratory

medicine, elderly care, dermatology, haematology and gastroenterology, stroke services including hyperacute, palliative medicine, rheumatology and neurology. Oncology, outpatient cardiothoracic surgery, plastic surgery and renal medicine are provided by visiting consultants from Hull.

There is a 22 bedded clinical decisions unit supported by ambulatory care and a short stay ward for acute medical emergency patients.

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

The hospital is equipped with eight main theatres; including two theatres dedicated to trauma and orthopaedic use (both with ultra-clean air facilities).

One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

Women and children services provide the entire maternity pathway using a more traditional service model comprising antenatal/postnatal clinics, a dedicated central delivery suite and a dedicated obstetric ward.

In addition gynaecology is provided through a range of outpatient clinics and an inpatient ward facility.

Acute/emergency paediatrics is provided by specialist nurses in A&E in conjunction with doctors.

The children's ward works closely with A&E assessing and receiving medical and surgical patients ensuring the pathway is seamless.

An inpatient paediatrics service is provided caring for children aged 0-16 years, supported by a community service.

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

All the diagnostic and service departments are based on site including endoscopy, radiology with plain film, ultrasound, CT and MRI.

The hospital also hosts the Path Links laboratory for pathology and immunology.

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

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

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

Diana, Princess of Wales (DPoW)

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

The hospital has 410 overnight beds of which 135 are for surgery and critical care patients, 191 are for medical patients, 84 are for women and children.

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

The medical floor of the hospital has a 32 bedded medical assessment unit supported by ambulatory care and a short stay ward for acute medical emergency patients.

Surgical specialties on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, breast services, urology,

ophthalmology, ENT and maxillo-facial and orthodontics and pain services.

The surgical floor of the hospital has a 28-bedded surgical assessment unit and short stay ward dedicated to the assessment and care of acute surgical emergency patients.

The theatre suite provides eight fully equipped theatres each with its own anaesthetic room, with two theatres dedicated to orthopaedic use (both with ultra-clean air facilities). One theatre is dedicated to emergency work, staffed at all times.

A separate session for acute trauma cases is reserved each day, including weekends.

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

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

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

Four designated beds are provided for babies requiring transitional care within the maternity unit.

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

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

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

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

Goole and District Hospital

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

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

The hospital has 44 overnight beds, 15 for surgical inpatients, 15 for medical inpatients and 14 dedicated neuro-rehabilitation beds.

Surgical services provided include general surgery, orthopaedics, ophthalmology, ENT and audiology, gynaecology, urology and pain services. There is also a surgical day case unit complete with a theatre incorporating endoscopy services.

Two further main theatres are equipped for major orthopaedic work and other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre and an outpatient department. Internationally renowned specialist laser treatment is provided at Goole in collaboration with the Yorkshire Laser Centre.

Women and children services provide outpatient consultant-led gynaecology clinics, colposcopy services, hysteroscopy services and a purely midwife led 'Home from Home' unit for low risk deliveries. A reduced level of consultant-led paediatric outpatient activity happens in Goole to try and provide care closer to home.

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

The hospital also provides a neurological rehabilitation centre. We are continuing to develop the hospital-based services focusing on expansion of elective care services and dedicated inpatient rehabilitation services.

Community services

The Trust also provides a wide range of community services across the region.

Key information about the Trust:

In 2017/18:

- There were 150,370 attendances to our emergency centres (A&Es)
- There were 108,504 admissions, including daycases
- Patients attended 373,470 outpatient appointments
- Around 4,323 babies were born.

With an operating income of £346,496k NLaG delivers services by working in partnership with three local authorities, three clinical commissioning groups, and a range of other providers including voluntary organisations and the private sector, as well as patients, their carers and the public.

It employs around 5,803 staff.

It delivers its services through six clinical groups:

- Clinical support services
- Community and therapy
- Path Links
- Surgery and critical care
- Women and children
- Medicine

There are also eight enabling ones:

- Chief Nurse
- Estates and Facilities
- Finance
- Governance and Assurance
- Operations
- People and Organisational Effectiveness
- Medical Director's office
- Strategy, Planning and Performance.

As a foundation trust NLaG also benefits from a membership of more than 6,122 staff and members of public, and has a Council of Governors which supports the Trust Board of Directors and holds them to account.

The annual report and accounts for 2017/18 have been prepared under the direction issued by NHS Improvement under the National Health Service Act 2006.

Our headquarters are at Diana, Princess of Wales Hospital:

Chief Executive's Office

Diana, Princess of Wales Hospital

Scartho Road

Grimsby

North East Lincolnshire

DN33 2BA

Tel: 01472 874111.

Our vision, mission, values and strategy

Working together we will deliver the high quality, innovative, safe and compassionate healthcare services.

Our values

Together we care – we care about providing safe, compassionate and attentive services for patients

Together we respect – we respect the dignity and individuality of each person in our care, and the professionalism and skills of our team members

Together we deliver – we will deliver forward thinking services, through listening to, learning from, and empowering those we work with.

Our aim is to provide accessible healthcare which meets the needs of the local population.

Our aim and objectives

Our aim is to provide accessible healthcare which meets the needs of our local population. Our objectives are grouped into five specific areas as part of the Improving Together Programme which focuses on those areas in most of need of improvement. They are:

1. Improving Quality

- To continuously focus on improving the quality of care provided to our patients, from the perspective of clinical effectiveness, patient safety and the patient experience
- The Board will continue to ensure that quality forms an integral part of its philosophy, practices and business plans and will drive the quality agenda across all levels and all areas of the business with all staff.

2. Patient Access and Flow

- To improve patient flow through our hospitals, better flow through A&E, reduce out of hours bed transfers, increased capacity and improve the trust performance targets and waiting lists
- To ultimately achieve an improved patient experience

3. Service Strategy

- Through clinical leadership, to continuously review the services we offer to determine where best they can be provided whether they be in traditional hospital settings or in the community setting
- To effectively work with commissioners and, where appropriate, other providers to secure facilities and support services for delivery of the very best healthcare in an accessible way to our local population.
- Improved sustainability via clinical networks delivering scale and workforce opportunity
- To work within the Sustainability and Transformation Plan (STP) as part of the Humber Coast and Vale Network to support the wider opportunities for providing joint effective and efficient use of resources.

4. Improving Organisational Development and Culture

- To invest on our staff ensuring they are fully equipped to deliver now and in the future effective local

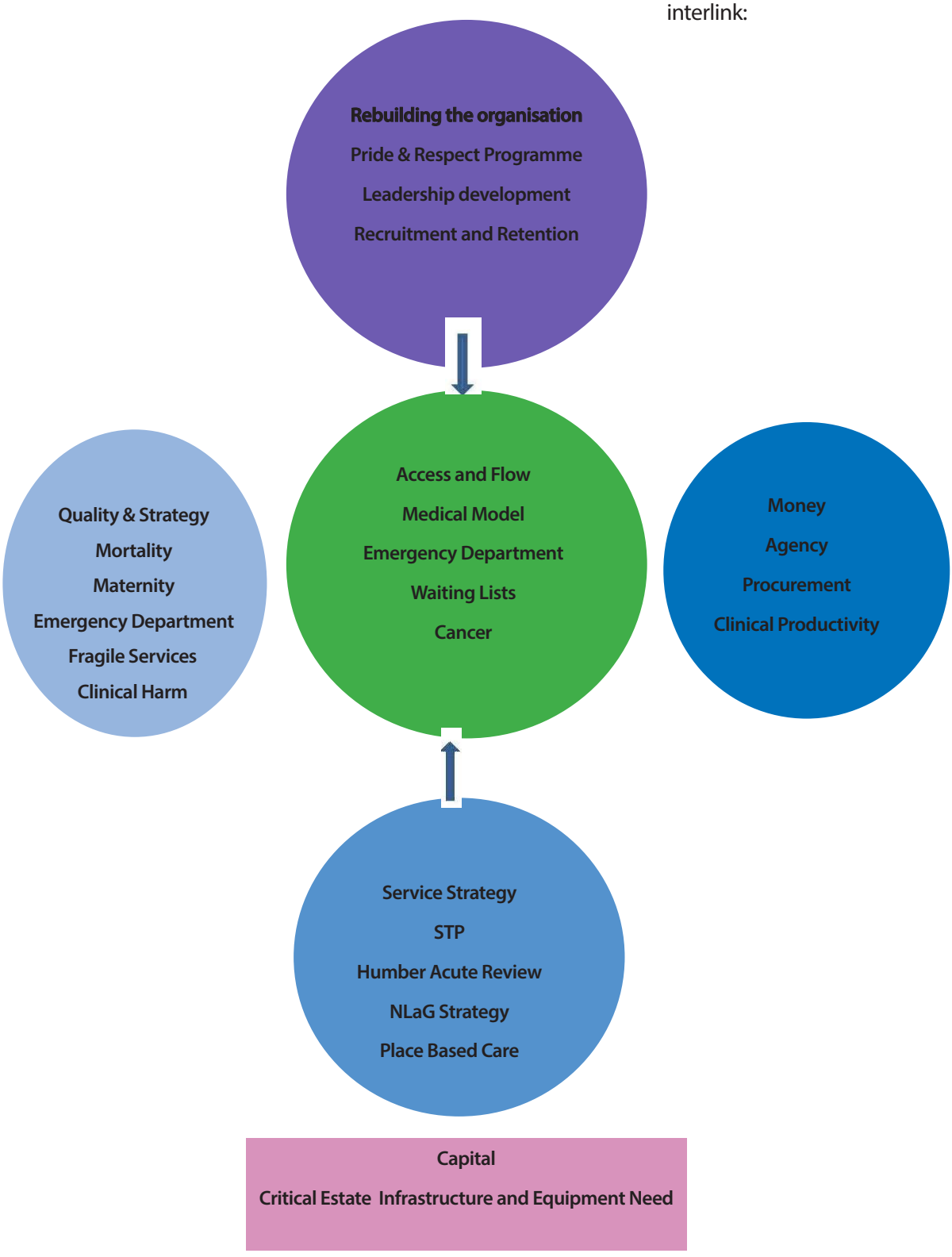
healthcare

- To invest in innovative ways of working with local teaching and training centres to identify the doctors, nurses and other professional leaders of the future locally.
- To ensure the Trust is an attractive place to work and focus on retaining our staff

5. **Finance**

- To continuously strive to improve the financial position focusing on key areas in increased efficiencies and reduction in premium rate workforce spend.
- Optimising our resources to ensure best use of every pound and reducing our current financial deficit position through identified work programmes

The graph below depicts how each of the above elements interlink:



Key developments during 2017/18

We have put in place a range of developments during the year to improve patient safety and enhance the quality of care. These include:

Endoscopy at Scunthorpe hospital

The new endoscopy unit which commenced in 2016/17 was opened in July 2017 following a £1.6million build to create a purpose built endoscopy and lower gastrointestinal (GI) suite.

The size and layout of the unit needed to be improved to ensure we could provide the timely access much needed by our patients.

The new layout of the unit provides a smooth transition for patients in a dedicated confidential and comfortable environment.

We have increased treatment rooms from to two to three which will allow us to expand our services for patients participating in the national bowel screening programme.

Theatre D upgrade at Scunthorpe hospital

A theatre within the main theatre suite was upgraded to provide improved ultra-clean air facilities and redesign to incorporate a dedicated orthopaedic room to prepare the equipment for major surgeries.

This is part of a wider programme to upgrade all theatres within the main suite over the coming years.

New CT Scanner at Grimsby hospital

The existing CT scanner was in need a new replacement and the end of 2017/18 an upgraded CT scanner was installed into the radiology department. This is part of the diagnostic strategy to increase and improve both MRI and CT facilities for the Trust.

GP Streaming

Attendances to Emergency Departments continue to increase, and a proportion of these patients have conditions or symptoms that could have been dealt with by services other than Emergency Medicine.

Streaming these patients away from or out of highly pressured A&E departments, to co-located GP led primary care services, ensures patients receive the care that they need and performance against the four hour standard improves.

As part of the wider transformation of urgent and emergency care services, all systems now need to ensure they have a robust streaming service in place.

To support these developments, the Trust has been successful in securing £900,000 to enable the development of GP Streaming within the A&E Departments.

The funding will improve streaming services, ensuring patients are seen by the most appropriate clinician and reduce the time they wait to be either treated and discharged or admitted into hospital for further care. Improving access and flow in this way is a key part of the trust's long-term strategy.

Ambulatory Care – Medicine and Surgery

The Trust has introduced ambulatory emergency care in both medicine and surgery for appropriate emergency patients to be diagnosed and treated on the same day and sent home with ongoing clinical support and supervision as needed.

Evidence has shown that this approach has improved both clinical outcomes and patient experience, and reduced costs and pressures in the urgent care system.

Clinical teams adopting this new way of working have indicated managing significant numbers of emergency patients on the same day will avoid the need for full admission into hospital without affecting the quality or safety of their clinical care.

It is anticipated that the following benefits will be achieved:

- Positive impact on patient experience by reducing waiting times for patients attending the hospital on the urgent care pathway
- Improves quality service to emergency patients
- Support achievement of the A&E 4 hour wait times
- Positive impact on staff experience

Key issues and risks that affected the Trust in 2017/18

Risk type	Nature of risk	What we are doing
Insufficient capacity	Negative risk. Within key areas of resource the Trust does not have sufficient capacity to meet the demand.	Following a robust external validation of Trust data, the specialty teams have adopted the National Intensive Support model to enable greater clarity and depth of understanding of the challenge. Working as a system, on a specialty basis, actions are being taken which will either increase capacity or reduce demand. These actions are varied and reside either within the Trust or within the wider system.
Lack of sufficiently skilled and volume of workforce	Negative risk. The high vacancy rate across the spectrum of clinical staff is impacting upon capacity to deliver good care, consistently.	• Commenced a rolling programme of recruitment for Advanced Clinical Practitioners • Introduction of Physician Associates with a clear remit on where they will be able to offer the most impact and support • Introduction of Doctors Assistant and Nursing Associates post to support the doctors and maximise efficiency • Nursing and midwifery pre-registered apprenticeships to 'grow our own' • Investment in upskilling current staff as part of the workforce development.
Culture of the organisation	Negative risk. Through the results of national and local surveys, morale across our workforce needs to be improved.	• Rebuilding the organisation through: - Pride & Respect Programme - Clinical Engagement - Leadership Development - Recruitment & Retention - Listening into Action (LiA).

We temporarily moved Urology emergency inpatient services and all of the ENT inpatient care to one of our main sites. Haematology complex day case care transferred to our region's cancer centre in Hull. All these service moves were due to a reduction in clinical workforce and need to temporarily ensure the services were safe.

Our clinical leaders continue to develop the clinical strategy to ensure our services are sustainable for the future.

Going concern

1 Introduction

1.1 The accounting concept of going concern is fundamental in the way that the assets and liabilities of an organisation are recorded and included within the accounts. Under this concept the organisation is usually viewed as continuing in business for the foreseeable future to allow the accounts to be drafted. If the organisation could not continue to operate in the way it has been operating, the assets and liabilities would be recorded in the accounts on a different basis reflecting their value on the winding up of the entity. As a result, the assets would be recorded at a much lower break-up value and medium and long-term liabilities would become short term.

1.2 NHS Foundation Trusts are required to prepare their accounts in accordance with the relevant accounting rules, which are set out in the International Financial Reporting Standards (IFRSs) and International Accounting Standards (IASs) as interpreted by the NHS Foundation Trust Annual Reporting Manual (ARM). The requirement to prepare accounts on a going concern basis is set out in IAS 1: Presentation of Financial Statements which states:

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

(a) The entity is being liquidated or has ceased trading; or

(b) The directors have no realistic alternative but to liquidate the entity or to cease trading,

in which circumstances the entity may, if appropriate, prepare its financial statements on a basis other than going concern."

"When preparing financial statements, directors should assess whether there are significant doubts about the entity's ability to continue as a going concern."

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

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

2 Required action for North Lincolnshire and Goole NHS Foundation Trust

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

2.2 In making this assessment, management should take into account all information about the future that is available at the time the judgment is made. As a minimum, this assessment should cover at least a 12 month period from the date of approval of the accounts, although this period will need to be extended where management is aware of events and related business risks further in the future that may cast doubt on the going concern assumption.

2.3 The Trust is required to consider performance against the finance use of resources theme under the regulator's Single Oversight Framework.

3 Financial and Quality Special Measures

3.1 The Trust delivered a financial deficit of £37.9m in 2017/18, based on draft accounts. This clearly represents a significant variance from the original planned control total deficit for the year (excluding STF) of £23.5m.

3.2 In light of the deterioration NHSI Improvement formally placed the Trust in Financial Special Measures on the March 2017. This was shortly followed by the Trust being placed in Quality Special Measures, following the November 2016 inspection by the CQC. Through this process, NHSI will set specific financial and service objectives.

3.3 Financial and Quality Special Measures do not represent a requirement to cease trading within the next 12 months, or face regulator action to cease or modify our trading status in that period.

They are designed to support recovery of quality standards and financial and operational performance, supported by regulators.

4 Single Oversight Framework – Finance Use of Resource

4.1 The Finance Use of Resources metric aims to support providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure.

When assessing the Trust against this metric NHS Improvement considers the financial metrics shown below to assess financial performance by:

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

4.2 Where providers have a score of 4 or 3 in the financial and use of resources theme, this will identify a potential support need, as will providers scoring a 4 (ie significant underperformance) against any of the individual metrics. Providers in financial special measures will score a 4 on this theme.

4.3 As NLAG is in Special Measures, it has a rating of 4 as a default – though it would in any case qualify for this rating based upon performance against the core metrics

The Finance Use of Resources metric aims to support providers in improving financial sustainability, efficiency and compliance with sector controls such as agency staffing and capital expenditure.

When assessing the Trust against this metric NHS Improvements considers the financial metrics shown below to assess financial performance by:

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

Each of the results for the Trust at the end of 2017/18 are shown below, however the Trust will score a 4 across all measures while under financial special measures.

Financial use of resource	Metric	Rating
Capital service cover	(6.116)	4
Liquidity	(19.718)	4
I&E Margin	(12.56%)	4
I&E variance from plan	(8.89%)	4
Agency	45.42%	3
Overall rating		4
Financial special measures override		4

5 Financial Sustainability – Going Concern

5.1 The Trust is currently tasked with delivering financial improvement in 2018/19, rather than being expected to meet the control total regime set by NHS Improvement. This reflects the supportive approach taken by the regulator, and the recovery based nature of Financial Special Measures.

5.2 Delivery of this level of improvement will require material improvement in productivity (averaging around 4 per cent), to support income projections, a savings programme of approximately 4 per cent of expenditure, and also some degree of progress on strategic redesign of services, delivering verifiable improvement.

5.3 These are objectives which have been delivered in similar circumstances elsewhere, and reflect a reasonable recovery timeline anticipated by the regulator.

5.4 In addition to the savings programme the Trust has also identified planned risks to income driven by restrictions on CCG allocations. The Trust will need to engage in a comprehensive income and contract review process to ensure that all contracted services are appropriately priced and paid for by commissioners. Work is underway to take this forward.

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

5.6 Any judgment on going concern status should be made in the context of the ongoing dialogue with the regulator, and the absence of any indication from them of a need to consider any substantial ceasing of current operations within 2018/19. At this point there is no indication of any degree of pressure to cease service delivery to the point at which the Trust's existence would be materially threatened within the 12 month timescale.

5.7 The Trust remains dependent upon central loan support to maintain cashflow. The experience of the Trust and

other providers since 2014/15 is that this means of liquidity support is now established as a critical element of the central provider management system. There are no grounds to expect such a system to be substantially altered during 2018/19.

5.8 The terms of loans are critical. At the point of maturity, the lender (the DH) is obliged to look at the affordability for the position of the organisation before deciding on the next step to take – conversion to PDC support, extension of the loan, or repayment. The Trust Board has stated its reliance upon this clause in the regulations when approving loan agreements.

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

6 Basis of Assessment

6.1 When concluding whether or not the accounts for 2016/17 should be prepared on a going concern basis, IAS 1 requires that the Board will need to consider which of the following three basic scenarios is the most appropriate:

(i) The body is clearly a going concern and it is appropriate for the accounts to be prepared on the going concern basis

(ii) The body is a going concern but there are uncertainties regarding future issues which should be disclosed in the accounts to ensure a true and fair view

(iii)(iii)The body is not a going concern and the accounts will need to be prepared on an appropriate alternative basis.

7 Conclusions

7.1 Given the evidence presented in sections 3, 4 and 5 above, and the criteria stated in paragraph 1.2 above, it is clear that the Trust is a going concern and it is appropriate for the 2017/18 annual accounts to be prepared on this basis.

7.2 It should be noted that, as stated above, there remain a number of risks attached to the Trust's financial and service plans. These are subject to active management through the Special Measures process, and as such do not represent a fundamental threat to operations through 2018/19. As such the risks outlined do not affect the decision to prepare accounts on a going concern basis.

8 Recommendation

8.1 The Trust Board is asked to consider the evidence presented above and to approve the recommendation that the 2017/18 annual accounts are prepared on a going concern basis (6.1 (ii) above).

Performance analysis

The Well-led Framework used by NHS Improvement identifies effective oversight by Trust Boards as essential to ensuring trusts consistently deliver safe, sustainable and high quality care for patients.

This includes robust oversight of care quality, operations and finance.

At the Trust an Integrated Performance Report is submitted monthly to the Board for assurance. For the purpose of reporting, indicators are grouped into the five domains of quality (caring, safe, effective, responsive and well led) identified by the Care Quality Commission.

Data is reported using a scorecard approach and performance is assigned a Red or Green (RAG) rating based on achievement against pre-defined thresholds. Under these assessments the ratings are:

RAG status	Performance Description
Red (R)	Not Achieved – the required standard has not been met and performance is not within an agreed tolerance
Green (G)	Achieved – the required standard has been met for this indicator

The monthly report to the Trust Board identifies performance against: key operational and quality requirements mandated nationally; activity against planned levels; and finance.

The purpose of this approach is to ensure the Board is provided with robust and timely information on organisational and operational performance.

Further information is provided to the Board on an exception basis where under performance in a particular area or against a specific target is identified.

Performance against targets

The Trust's performance during 2017/18 is summarised below. These figures are based on the year end position reported to the Trust Board in its April 2018 Integrated Performance Report.

Responsive access and flow: unplanned care

Performance indicator	Threshold	Apr 17	March 17	April 17	May 17	June 17	July 17	Aug 17	Sept 17	Oct 17	Nov 17	Dec 17	Jan 18	Feb 18	March 18
Patients admitted, transferred or discharged within 4 hours of arrival A&E	95%	Not yet applicable to NLaG as within a category 4 system													
Patients admitted, transferred or discharged within 4 hours of arrival A&E		90%	78.8 %	85.2 %	82.8 %	83.8 %	89.2%	87.4%	91.6%	92.4%	87.9%	86.2%	83.4%	79.5%	83.4%	79.5%

Responsive access and flow: planned care

Performance indicator	Threshold	Apr 17	May 17	June 17	July 17	August 17	September 17	October 17	November 17	December 17	January 18	February 18	February 18
Cancer care													
2 week wait – urgent GP referrals	93%	95.3%	97.2%	95.7%	95.5%	97.42%	96.1%	96.94%	97.48%	96.81%	94.61%	97.1%	96.47%
2 week wait – urgent symptomatic breast referrals	93%	90.7%	94.%	95.3%	94.9%	96.12%	88.1%	96.88%	95.96%	96.20%	86.21%	88.46%	94.29%
Patient waiting <31 days from diagnosis to first definitive treatment	96%	99.2%	98.0%	99.2%	99.3%	100.00%	97.9%	99.3%	100.00%	100.0%	94.61%	98.5%	99.2%
Patient waiting <31 day for subsequent treatment (surgery)	94%	100.0%	100.0%	100.0%	86.7%	100.0%	100.0%	100.0%	92.31%	100.0%	82.35%	100.0%	100.0%
Patient waiting <31 days for subsequent treatment (anti-cancer drug regiment)	98%	100.0%	97.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.97%
Patient waiting <62 days from urgent GP referral to first definitive treatment	85%	72.7%	70.5%	57.1%	77.9%	62.16%	54.4%	63.10%	69.94%	73.55%	62.09%	76.10%	65.93%
Patient waiting <62 days referral from an NHS screening service to first definitive treatment	90%	77.8%	57.1%	86.7%	83.3%	100 %	88.2%	77.78%	75.0%	71.43%	82.4%	80.8%	88.89%

Financial performance

2017/18 was a difficult year for the Trust, and the challenges facing the organisation through the year are reflected in the financial performance.

Financial Special Measures

The Trust Board had signed up to its plan for the year with NHSI in November 2016, with a deficit forecast of £13m. However, the financial position deteriorated rapidly in the latter part of 2016/17.

Activity delivery was slowed, affecting income, and temporary clinical staffing costs and expenditure on outsourced treatment capacity increased sharply. As a result the Trust was placed in Financial Special Measures in March 2017, and entered 2017/18 in a position that made delivery of the financial targets set for the year impossible.

Due to changes in the Trust's leadership team, the Financial Special Measures process truly commenced in August 2017.

The Trust put in place a Turnaround Director, and a Service Transformation expert to support the rebuilding of management teams and to support the tightening of controls. The Trust also appointed Ernst Young (EY) as partners.

A financial Recovery Plan was agreed with NHS Improvement through the autumn, which set the Trust a target of £40.0m deficit, with recognition that delivery risks were such that £3m to £4m of shortfall on this target was likely.

Financial outturn 2017/18

At the end of the year, the Trust reported a final deficit of £37.9m, significantly ahead of the £40.0m target. However, this position included two exceptional items:

1. The Trust received a final cash support payment of £2.3m;
2. The Trust's assets are revalued each year, and the upward valuation in 2017/18 supported the Trust's Income and Expenditure position by £2.8m.

These exceptional items are normally excluded form target comparisons. The realistic comparator therefore is a deficit of £43.0m. This was within the risk range agreed with NHS Improvement for the year.

Through 2017/18, the Trust has continued to struggle to make progress financially, with many of the issues that caused the problems in 2016/17 continuing to make life difficult both operationally and financially.

Income and contracting

The Trust had experienced difficult contractual relationships with its commissioners, and this made it difficult to establish clear plans for the year.

The Trust also struggled to improve on the number of elective, daycase and outpatient treatments delivered, particularly during the winter period.

The Trust followed national guidelines to ensure priority was given to urgent patients, with an impact on routine activity, which affected income.

Through the later part of the year, the Trust has been able to re-establish much improved relationships with commissioners, and agreed a robust financial framework for the remainder of the year, which supported the Trust. Together, Trust and commissioners have started to build more effective forward plans. The Trust is also now more effectively engaged with the task of improving productivity and capacity in key services. Next year should therefore show significant further improvements.

Expenditure and savings delivery

In expenditure terms, the vacancy rates in the Trust's clinical workforce continued to have a financial impact. Recruitment and retention have remained difficult, given the Trust's geography and the nationwide shortages of key clinical staff groups. Temporary staff have been vital in maintaining safe services, but this has come at a continuing cost.

The Trust has also struggled to keep momentum across its savings programme, though through the second part of the year significant improvements have been made in key areas of control – expenditure on additional ad hoc clinical sessional work has been sharply reduced, and management teams have been effective at controlling avoidable expenditure.

The Trust has mapped out more clearly its forward plans for services through the year, and has been working with local partners to develop robust service and workforce arrangements. This work will be critical in delivering further

improvements next year.

Financial and Quality Special Measures bring their own financial burdens, with increased costs for management support and consultancy, and also increased interest charges for support loans. Work is ongoing with NHSI to limit these burdens in 2018/19.

Capital and infrastructure

The Trust has been able to set out a much more robust capital programme, rebuilding key infrastructure. In 2017/18, Scunthorpe's endoscopy suite, the new CT scanner in Grimsby, and the new staff residences at Grimsby have been major schemes, which will deliver benefits in 2018/19.

The Trust has also secured the first £4m of additional capital to support its modernisation plans for ward environments and diagnostic scanning capacity. There is a wide recognition that NLAG's recovery journey will require further investment in infrastructure.

NHSI has been extremely supportive of the Trust throughout the year, and will continue to provide assistance in 2018/19, as the Trust continues to rebuild, focussing on the clinical workforce and the quality of services.

The Trust will continue to ensure that patient safety cannot be compromised by financial constraints, a line fully supported by the Trust's Regulators.

Single Oversight Framework – Finance Use of Resources

The Finance Use of Resources metric aims to support providers in improving financial sustainability, efficiency and compliance with sector controls

such as agency staffing and capital expenditure.

When assessing the Trust against this metric, NHS Improvement considers the financial metrics shown below to assess financial performance by:

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

Each of the results for the Trust at the end of 2017/18 are shown below.

Financial use of resource	Metric	Rating
Capital service cover	(6.116)	4
Liquidity	(19.718)	4
I&E Margin	(12.56%)	4
I&E variance from plan	(8.89%)	4
Agency	45.42%	3
Overall rating		4
Financial special measures override		4

With the Trust being in Special Measures, and automatic overall rating of 4 is applied.

Looking Forward to 2018/19

The Trust faces significant and ongoing service challenges, and the financial position reflects the extent of these difficulties.

Next year will be important in the Trust recovery journey. A plan has been agreed with NHSI to deliver a deficit of £43.7m, with further work required to work up comprehensive service improvement plans to improve efficiency and effectiveness.

This will be challenging work, but will improve the quality of services for patients.

As the Trust's management teams are renewed to better support clinical leaders, NLAG will be able to deliver significant improvements in 2018/19.

Social, community and human rights

Maintaining strong relationship with our local communities is an important priority for our organisation.

Our Chief Executive holds regular meetings with our local MPs to keep them informed of our progress and performance.

Representatives from the Trust regularly attend meetings of the local Health and Wellbeing Boards and our performance is monitored by the overview and scrutiny committees of North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire councils.

Regular communication takes place with our Trust members in the form of email updates, and invitations to attend our Trust Board meetings and governor events including drop-in sessions and discussion groups.

Our Trust magazine, News@ NLaG is aimed at staff, members, as well as the general public and includes a wealth of information about our services and our performance.

We also continue to engage with local education establishments to recruit healthcare and other students, and this has helped with our nurse cadet, traineeship and apprenticeship schemes.

Further information about our equality and diversity policy can be found within the report in the Equality section on page 125.

Details of any overseas operations

The Trust does not have any overseas operations.

Volunteers

The enormous contribution made by our volunteers continues to humble us as they dedicate their time for free.

We are truly grateful to the 500 volunteers who helped out across our three hospital offering support and help to our patients and staff.

They tirelessly work in our hospitals providing a range of services from 'meet and greet' which sees them escorting patients and visitors around our sites, to assisting patients at mealtimes and helping in clinics.

Many more opportunities for volunteering are available and we endeavour to place each individual in the most appropriate area to suit their skills and expertise.

Volunteers from external agencies including the League of Friends and Hospital Radio also provide services that enhance our patients' hospital experience.

Information about environmental matters

The Trust's sustainability report can be found on page 127.

News from across the Trust during 2017/18

Health and wellbeing of our staff

We know that our staff are pivotal to everything we do as a Trust. Their health and wellbeing is critical to delivering high quality services for our local patients.

The Trust signed up to Listening into Action (LiA) which is designed to empower frontline staff from the grass roots upwards. LiA is not a 'project', 'programme' or 'initiative' but more of a movement that galvanises and re-engages staff. It gave them permission to act on their good ideas, with leaders and support teams collaborating with them, removing obstacles and enabling them to 'just do it'.

LiA is about championing working differently and empowering people to make the 'patient first' changes that they have always wanted to. A series of 'Crowdfixing' events were held inviting staff to share their ideas and frustrations out of which a number of 'quick wins' were implemented. These included:

- A number of training sessions were held to increase the number of volunteers with expanded skills to provide assistance to ward staff by supporting patients at mealtimes, assisting with caring for dementia patients and answering phones at peak times
- The introduction of 40 new wheelchairs for patients visiting the hospitals, as sometimes they had been missing appointments/ investigations slots due to mobility issues
- Staff on the intensive care unit at Grimsby devised a new survey specific to their department to collect feedback from patients, families and carers to help them continually improve their service
- Doctors in the medicine group have reduced the time in handover each morning, allowing them more time to spend with their patients
- The high dependency unit at Grimsby focused on improving its patient flow and are now using an electronic discharge system. It has not only helped with flow but also patient safety and clinical governance compliance.

Also aimed at empowering staff is our Pride and Respect project which we launched in February 2018. Its aim is to change the culture of the organisation and has more than 100 staff members signed up to it who have volunteered to help.

We want to make sure that every single person who works for the Trust understands how they their behaviour may affect colleagues, and that they feel empowered to hold others to account if their behaviours or professional standard fall below what is expected.

In addition to this we appointed our first ever Freedom to Speak-Up Guardian (FTSU) Mr Makani Hemadri, who is a consultant in general surgery. Acting in a genuinely independent and impartial capacity, his role is to work alongside the board and executive team to help support the organisation to become a more open, transparent place

to work.

He is supported by a national network of guardians who all share best practice in supporting members of staff who speak up and a local network of associate guardians at the Trust. His aim is to make sure that staff feel comfortable about speaking out when they need to, so we can not only improve the working lives of our staff but also the quality of care we provide to our patients.

Development of our staff

Our training and development department works closely with our recruitment team, as well as our workforce analysts, to ensure we have a skilled and competent workforce across our services.

As well as ensuring our staff undertake their necessary mandatory training such as challenging behaviours, information governance, antimicrobials, and dementia awareness they are also rolling out new apprenticeships.

The Trust has embraced the national apprenticeship levy and has surpassed its required number of apprentices which is 148. As of March 31 2018, there were 166 on an apprenticeship programme.

NHS Employers was so impressed with the work the Trust has done, that they showcased it as part of National Apprenticeship Week as a best practice model. There is range of clinical and non-clinical courses on offer ranging from level two to level six, which is GCSE to degree level.

It is not just those people coming into the organisation on an apprenticeship; we are also developing our existing staff to upskill them so they grow and develop their own expertise in the area they work.

Safety of our staff

The Trust signed a joint working agreement with Humberside Police and the Crown Prosecution Service for Yorkshire and Humberside strengthening partnership arrangements in tackling violence and antisocial behaviour against our staff.

The Trust takes the stance that violence against any member of staff is unacceptable and will not be tolerated. The signing of this agreement shows the commitment of the parties to reduce the risks and the ongoing work together to achieve this.

In addition to this, the Trust's security provider ISS UK Healthcare invested £2,000 in new high-tech body cameras to be worn by their staff.

The shoulder-worn cameras – which record digital images and sound - will deter people from lashing out verbally or physically at members of NHS staff and the security team.

Investing in new staff

Our midwifery team appointed its first ever bereavement midwife Nick Kerry who is focusing solely on providing support and care for women who lose their babies. She has a wealth of experience and is on hand for women across the area providing vital care and compassion.

She is on hand for people who suffer the devastation of miscarriage, stillbirth, neonatal death or sudden infant death syndrome. When not caring for patients she is hard at work providing an education programme for doctors, midwives and students.

Nick has also been instrumental in establishing rainbow clinics. These are a first for the area and are aimed at those women who have lost a baby/babies and are pregnant again.

The Trust saw not one but two new orthopaedic consultants join the Trust during the year.

Mr Mustafa Javed saw his career come full circle when he joined the team at Scunthorpe and Goole as he had previously worked on our wards as a surgical junior doctor. Specialising in upper limb surgery he is providing care for patients with shoulder and elbow problems, including sports injuries and trauma to the upper limbs.

Mr Aravind Desai joined the team at Grimsby hospital. He has a special interest in sports injuries of the shoulder and elbow.

We also saw the appointment of a new stroke consultant who joined the team at Scunthorpe hospital. Dr Mohamed Soliman who has worked at hospitals across the UK – including world famous Kings' College, Guys' and St Thomas' and Addenbrooke's – was attracted to NLaG after coming to visit the team. He was so impressed with the multidisciplinary working between all of the teams that he decided to take the post.

A former heart surgeon returned to the Trust

bringing with him a wealth of knowledge on how to transform the way information systems in the hospitals work.

Dr Steven Griffin, who is no stranger to the area having worked at Scunthorpe hospital as a visiting consultant for nearly 20 years, was appointed as the Trust's first digital and informatics associate medical director. His focus is to work towards a paperless hospital with the long-term goal being the roll out of electronic referrals, electronic notes and electronic prescribing.

A brush with royalty

Two members of staff from Grimsby hospital had a brush with royalty when they were invited to attend a special event highlighting the advances in communication aids and voice banking for motor neurone disease patients.

Jennifer Benson, clinical expert speech and language therapist, and Mandy Edwards, therapy rehabilitation technical instructor, were privileged to meet HRH The Princess Royal.

The event, which was organised by the Motor Neurone Disease (MND) Association, put the spotlight on the ongoing work in providing a voice to people living with the disease.

Jennifer has previously been recognised nationally for her work. She was a finalist in the compassionate patient care category of the HSJ awards in 2016. She has been helping patients with motor neurone disease and other neurological conditions, preserve their voices and was the first in the region to offer voice banking to her patients.

Our stars Awards

A fabulous night of glitter, glamour and celebration was held when the Trust came together to reward its staff as part of its annual Our Stars. More than 400 staff, volunteers and fundraisers turned out to see 16 winners pick up a variety of awards.

There was even a special 'Patients Choice Award' which went to consultant breast surgeon Jenny Smith.

Meanwhile the Rotary Clubs of Scunthorpe district picked up the Health Tree Foundation Charity Champion Award for their contribution to the Maternity Bereavement Suite at Scunthorpe hospital.

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

- Compassion in Practice Award – Staff Nurse Isabel Lamb, ward 18, Scunthorpe
- Unsung Hero Award – James Wilson, Medical Engineering, Grimsby
- The Achiever Award – Garry Cowling, Ward 24 manager, Scunthorpe
- The Innovator Award – Consultant Anaesthetist Dr Namita Singh, Scunthorpe
- Rising Star Award – FY1 doctor Dr Wuraola Odunlami

- Sparkle Award for volunteers – chaplaincy volunteers at Grimsby
- Team of the Year Award (non-clinical) – linen team, Scunthorpe
- Team of the Year Award (clinical multidisciplinary team) – podiatry team, Grimsby
- Clinical Supervisor of the year – Consultant Paediatrician Dr Jailosi Gondwe, Scunthorpe
- Safety First Award – Consultant Miss Mariyah Mohammed, Scunthorpe
- Quality Improvement Award – Christopher Best, Scunthorpe theatres
- Apprentice of the Year Award – Georgia Whitelaw, payroll, Scunthorpe
- The Flying the Flag Award – Helen Yewdall, clinical development team, community and therapy services
- Chief Executive's Shining Star – Ward sister Sarah Rushby, C1 Holles, Grimsby.

Investment in services

Work got underway on a new £16.4million staff accommodation block at Grimsby hospital. It will provide accommodation for 'key workers' – they are hard-to-recruit staff including doctors and nurses. The block will consist of 96 student units and 124 studio apartments. Work began on the build in the summer of 2017 and completion is expected in late 2018 with staff moving in early in 2019.

In March we saw a new £600,000 state-of-the-art CT scanner become operational at Grimsby hospital. It was a replacement for the old scanner which had been installed back in 2009.

In addition, the Trust has successfully secured capital monies for a second CT scanner to be installed at Scunthorpe hospital which is planned to be operational during the spring of 2019. Having two scanners at the hospital will allow for more patients to be seen.

Investment in pharmacy also came to fruition with the opening of a newly refurbished £1.5million aseptic unit at Grimsby hospital. The unit was completely refurbished and new equipment was installed. It is used to prepare treatments in an environment that is free from bacteria. Products are prepared within a pharmaceutical isolator which has its own sterile airflow. Intravenous chemotherapy and nutrition products are prepared in the unit for patients across both Scunthorpe and Grimsby hospitals.

Work on a £1.6million development at Scunthorpe hospital was also completed in August when the doors to a new endoscopy unit at Scunthorpe hospital opened. Located on the Church Lane side of the hospital, close to the main entrance, the unit also houses the lower gastrointestinal (GI) unit and stoma care services. The new unit will provide dedicated outpatient and day case facilities.

The Trust has invested in new handheld devices – smartphones and tablets – to help staff spot deteriorating patients. The devices have been issued to acute care wards and departments allowing staff to record vital patient observations at the bedside.

This is helping staff to quickly recognise any patient whose condition may be deteriorating, so swift action can be taken. The devices, which use the latest NEWS 2 - national early warning score – record such things as blood pressure, pulse, temperature, respiration rate, oxygen levels and levels of consciousness/or confusion. Some of the new tablet devices will also be used to undertake sepsis screening, so that those patients requiring treatment can be identified quickly.

The work was undertaken as part of the deteriorating patient project. This is part of the Trust's wider Improving Together programme. The devices integrate with the Trust's existing electronic WebV system which is a bespoke 'virtual ward' system designed alongside clinicians. It is used by a range of staff including nurses, doctors, therapists and pharmacists to help improve the way patients are managed on hospital wards.

The system alerts staff when observations are due and overdue, gives access to test results and allows staff to view a whole ward or even an entire hospital virtually as a bed management system. Staff can see at a glance which patients are on which ward, under which consultant and whether they have any particular health needs such as diabetes or requiring

support with eating and drinking.

As the devices are mobile, staff can record observations quicker meaning patients who are deteriorating can be picked up faster and given the care intervention they need more quickly. The Trust has also rolled out a new escalation policy and process using the SBAR tool. This is a structured method for communicating critical information about patients who require immediate attention and action.

There were changes for women accessing midwifery services at Louth hospital. The service went on the move in May and for the first time is now able to offer antenatal and consultant-led clinics all under the same roof.

There was further good news for local woman as the Trust is helping lead the way in improving bereavement care nationally around baby loss. Sands – the stillbirth and neonatal death charity – is working with a number of partners on the National Bereavement Care Pathway (NBCP) for pregnancy and baby loss.

The Trust is working with them on a pioneering project which aims to improve the overall quality of bereavement care. In addition to this, bereavement midwife Nick Kerry has introduced new rainbow clinics for women who have suffered the heartbreak of losing a baby. A rainbow baby is a child that is born to a mum who has previously suffered a late miscarriage (over 20 weeks), neonatal death, stillbirth or infant loss.

They are in addition to routine midwife appointments, and provide tailor-made individual care and delivery plans. Women are seen at clinic at 16, 31 and 34 weeks although they will be able to contact the bereavement midwife in between for that little extra bit of support.

Neuro rehabilitation centre at Goole

The Trust took over the management of the brain injury unit at Goole hospital. The unit had been previously been operated in a joint partnership between NLaG and the Braun Injury Rehabilitation Trust. From September 1 all staff in the centre, which changed its name to the Neuro Rehabilitation Centre at Goole, were employed by NLaG. The centre provides specialist neurological rehabilitation for patients referred from across the country. Patients have continued to receive the same high quality, person centred care they have always received, with the same consultants leading on their rehab programme.

Developments in patients care

There have been numerous developments in patient care across the Trust with wards and departments always striving to improve what they do on a daily basis. Here are just a few examples:

A new patient screening tool was rolled out across the Trust which has helped to spot sepsis. Adele Lloyd, sepsis specialist nurse, has been working with staff to embed the tool in acute care areas. It is quick and easy to use and identifies patients quickly so that the 'sepsis six' care bundle can be started. The screening tool can also now be accessed on tablet devices.

Also aimed at improving care was a pilot scheme aimed at reducing A&E visits at Scunthorpe hospital by mental health patients. NLaG and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH) teamed up to work on the scheme which also aimed to reduce unnecessary A&E attendances. The Great Oaks mental health unit in Scunthorpe, which is run by RDaSH, treats patients who are suffering with their mental health. Around ten patients a week attend Scunthorpe A&E from the unit. Under the pilot scheme Great Oaks staff could refer patients to the NLaG unscheduled care team (UCT) who visited the patient on the unit, preventing a visit to A&E.

The UCT usually works with patients in their own home or care home during an episode of acute illness. The team includes registered nurses or paramedics who are able to assess, diagnose and treat a range of medical conditions. They are supported by healthcare assistants. The service operates 24/7 with staff assessing and treating medical conditions including chest infections, urinary tract infections, minor skin tears, injuries and assessments following a fall.

One of the key priorities for NLaG as part of its Improving Together programme has been to improve access and flow through its hospitals.

Awards and accreditation

Our maternity and neonatal services across North Lincolnshire and North East Lincolnshire were awarded the prestigious level three 'baby friendly' accreditation from UNICEF.

We were commended for the 'very high' standards of care pregnant women and new mothers receive, for taking every opportunity to initiate a discussion around feeding and for the 'effective support' given to breast feeding mothers.

Stage three is about the outcomes for pregnant women, new mothers and their babies, that is; parents have had informative conversations regarding infant feeding, that they are able to make an informed choice about the method of feeding and that they receive consistent support and advice on their breastfeeding journey.

Our career confidence programme, which aims to get young people into full time employment, was shortlisted for a national award. The scheme, which is run in partnership with Job Centre Plus and Interserve Employment and Skills, was a finalist in the Health Education England's awards programme.

The scheme has successfully seen young people in the area equipped with the skills and knowledge needed to get on the first rung of the career ladder. Those on the course spend two weeks preparing for their new roles then four weeks of work experience out on wards and in support services. They learn about using IT systems, the importance of infection control and other training which helps them apply for a position in the NHS in the future.

At the end of the programme students receive an accredited Level 1 qualification in customer service, health and safety and equality and diversity as well as a sought after place in the Trust's apprentice talent pool ready for a position on the apprentice programme.

The team behind the career confidence scheme were finalists at the National Widening Participation Awards 2017.

Signed: Dr Peter Reading

Date: 24 May 2018

Accountability Report

Directors' report

Composition of the Board

Name	Position	Term of office	Attendance at board meetings
Anne Shaw	Chair (appointed as a Non-Executive Director 12.8.13; appointed as Chair 15.9.16)	3 years	8 out of 8
Sue Cousland	Non-Executive Director (appointed 10.8.16)	3 years	5 out of 8
Neil Gammon	Non-Executive Director (Resigned 31.7.17)	3 years	2 out of 2
Linda Jackson	Non-Executive Director and Deputy Chair (appointed 30.9.14)	3 years	7 out of 8
Stan Shreeve	Non-Executive Director (appointed 7.6.12)	3 years	8 out of 8
Anthony Bramley	Non-Executive Director (appointed 3.1.17)	3 years	7 out of 8
Sandra Hills	Non-Executive Director (appointed 3.1.17)	3 years	6 out of 8
Dr Peter Reading	Chief Executive (appointed 14.8.17)	n/a	6 out of 6
Karen Jackson	Chief Executive (seconded to NHS Improvement from 3.1.17)	n/a	0 out of 0
Richard Sunley	Deputy Chief Executive and Director of Operations (from 31.8.17)	n/a	5 out of 8
Dr Karen Dunderdale	Deputy Chief Executive and Director of Operations (left the Trust 14.7.17)	n/a	1 out of 1
Wendy Booth	Director of Performance Assurance and Trust Secretary (appointed August 2012)	n/a	7 out of 8
Pam Clipson	Director of Strategy and Planning (appointed 13.6.14)	n/a	2 out of 2
Tara Filby	Chief Nurse (appointed 9.10.15)	n/a	7 out of 8
Karen Griffiths	Chief Operating Officer (resigned 3.7.17)	n/a	0
Mr Lawrence Roberts	Medical Director (appointed 2015)	n/a	3 out of 8
Dr Kate Wood	Acting Medical Director (from 1.10.17)	n/a	5 out of 5
Marcus Hassall	Director of Finance (appointed 1.8.14)	n/a	8 out of 8
Robert Toole	Acting Director of Finance (resigned 7.7.17)	n/a	1 out of 1
Jayne Adamson	Director of People and Organisational Effectiveness (appointed 1.8.16)	n/a	8 out of 8
Jug Johal	Director of Estates and Facilities (appointed 14.8.14)	n/a	2 out of 2
Claire Phillips	Interim Chief Operating Officer (17.7.17 to 30.7.17)	n/a	0 out of 0

Registers of interest

All Directors and Governors are required to declare their interests, including company directorships, on taking up appointment and as appropriate Board of Governors and Board Directors meetings in order to keep the register up to date.

The Register of Directors' Interests and the Register of Governors' Interests are available on the Trust website at www.nlg.nhs.uk

Brief details of all directors who served during 2017/18 are below:

Anne Shaw

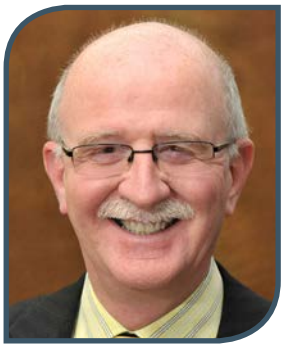
Chair

Anne heads up both our Board of Directors and Council of Governors. Anne is from the East Riding of Yorkshire but began her professional career as a staff nurse working in the A&E department at John Radcliffe Hospital, Oxford. She then to work as a staff nurse and ward sister in Hull. Her career took a different route when she moved to teaching nurses which opened new doors for her as she joined The Open University, teaching within the health and social care department. Over the years Anne has also been a secondary school governor, a public sector director for the Doncaster Learning and Skills Partnership and Director of Aim Higher Humber. Anne was a non-executive director at the Trust for three years before taking up the role as chair in September 2016.

Sue Cousland

Non-executive director

Sue Cousland trained in the Grimsby School of Nursing and qualified as a State Registered Nurse in 1981. During her 38 years' experience in the National Health Service she has worked in a wide variety of clinical roles across the north of the country, before returning to Lincolnshire in 1997. Since then she has worked in both commissioning and senior managerial roles in Lincolnshire including Chief Nurse, Director of Operations and Deputy Chief Executive for Lincolnshire Community Health Services. Sue has retained her clinical qualification throughout her extensive career and continues to practice locally whilst also working for the Nursing and Midwifery Council as a Registrant panellist.



Neil Gammon

Non-executive director

Neil had a 37-year long career in the engineering branch of the Royal Air Force. He served in a dozen UK locations, as well as Germany and Saudi Arabia. His final post saw him commanding Royal Air Force Cosford and the Defence College of Aeronautical Engineering, where he was responsible for training aeronautical engineers for the three Service up until 2009. Neil has an Honorary Doctorate of Business Administration from the University of Lincoln.

Linda Jackson

Non-executive director

Linda is from Cleethorpes and studied hotel, catering and institutional management at Grimsby College before graduating with a Diploma in Management from the University of Reading. Her career in facilities management began in London where she secured a position of trainee manager for ISS Facility Services who provide facilities services across the NHS. Linda quickly worked her way up the ranks to hold positions including regional director providing facilities services across NHS organisations in the capital and became board director at the age of 38. In her last 10 years in the private sector she undertook a transformational change role responsible for implementing the company's new business and initiatives nationally within the NHS.

Stan Shreeve

Non-executive director

Stan is a semi-retired businessman and qualified accountant with experience at board level as CEO, CFO and NED in both the public and private sectors Stan is used to working in change environments, with experience of evaluating, funding, integrating and reorganising businesses. He has worked extensively with venture capitalists and financial institutions. With VC backed Anker Stan gained experience of pan-European management and reorganisation within a culturally diverse business. He integrated acquisitions and reorganised businesses in most EU member states and has sector experience in FMCG, Food – including the management and development of brands, manufacturing environments including light engineering, service based IT and software businesses. Stan has worked in large multinational, SME and start up environments.

Anthony Bramley

Non-executive director

Anthony is an independent housing and regeneration consultant having retired in 2017 from a 38 year career in various public and private housing organisations around the country – with his last role as founding Chief Executive of 8,000 home social landlord Shoreline Housing Partnership based in North East Lincolnshire. A Fellow of the Chartered Institute of Housing, Tony is also chair of the Grimsby Institute of Further and Higher Education as well as being a governor at Grange Primary School in Grimsby. Married with grown-up children he lives in the Louth area.

Sandra Hills

Non-executive director

Sandra has a history of working in the NHS having joined as a student orthopaedic nurse in Newcastle-upon-Tyne in 1973. Did her general training in York and worked as a staff nurse in Bradford, Leeds and Durham where she then went on to do her midwifery and health visitor training. She went onto to work as a health visitor in the 1980s and became the first primary care facilitator in coronary heart disease for York in 1990. She transferred into management roles in the early 90's and has held a range of director level posts since 1999 including Chief Executive of a PCG, Assistant Chief Executive and Company Secretary for West Surrey Health Authority, Director of Clinical Services and Chief Nurse and then Director of Commissioning for Surrey Heath and Woking PCT. Over the past 10 years she has worked independently in a variety of interim Director level roles.

Executive Directors

Dr Peter Reading

Chief Executive

Dr Peter Reading joined us in August 2017. Peter has 33 years' experience as a manager and management consultant in UK healthcare, including 18 years as Chief Executive of five NHS trusts (teaching hospitals, DGHs and mental health). These include Leicester, UCLH, Doncaster and Peterborough. He has an outstanding record of leading people and organisations to high levels of achievement and of delivering successful organisational, clinical and financial transformation programmes. For the past three years Peter has been associate director with PwC's healthcare advisory practice, advising on leadership and on quality and financial transformation in more than a dozen NHS trusts across the country, including a number in Special Measures.

Richard Sunley

Deputy Chief Executive and Director of Operations

Richard Sunley was appointed Interim Chief Executive in March 2017 and then went on to become Deputy Chief Executive and Chief Operating Officer on October 2017. He has a longstanding career in the NHS having worked his way up from clerical worker to manager and director. He has held several senior positions including eight years as director of operations at Cambridge University Hospitals NHS Foundation Trust, three years as CEO at Scarborough and North East Yorkshire Healthcare NHS Trust and more recently a year's tenure as acting CEO at East Sussex Healthcare NHS Trust.

Tara Filby

Chief Nurse

Tara has worked at the Trust since 1987 when she joined the Scunthorpe and Goole school of nursing. She qualified in 1990 and landed temporary nursing roles at the former Glanford and Brumby hospitals before being appointed to a nurse role on ward 3 at Goole hospital. Tara went onto become a ward sister and then in 2003 she was asked to open and run a new surgical treatment centre at Goole, which she did as well as later opening the ophthalmic suite, and managing the surgical wards at the hospital. Tara left Goole in 2011 when she took on the role of assistant director of nursing at Grimsby hospital before being quickly promoted to the deputy chief nurse position. In 2015 she was appointed chief nurse.

Marcus Hassall

Director of Finance

Marcus was previously deputy director of finance at the Trust for three years, and has been at the Trust in a variety of finance roles since joining the previous Grimsby Health NHS Trust back in 1995. Marcus has spent his working career in NHS finance, having started as a finance trainee in Bradford.

Wendy Booth

Director of Performance Assurance and Trust Secretary

Wendy specialises in governance and risk management and is the lead for our complaints, legal, risk and quality assurance teams as well as our Foundation Trust office. She was appointed to her role in August 2012, having previously held the posts of head of governance and Trust Secretary, Assistant Director of Risk Management and Trust Risk Manager.

Jayne Adamson

Director of People and Organisational Effectiveness

Jayne prior to her appointment provided support as a specialist HR advisor and worked on Healthy Lives, Healthy Futures as the organisational development lead. Jayne has been an executive director in the NHS for seven years and prior to that has worked in the private sector with Smith & Nephew and Nestle.

Pam Clipson

Director of Strategy and Planning

Pam has been with the Trust since starting out as an apprentice straight from school in 1995. Pam has held a number of roles in the finance directorate since then, most recently as assistant director of finance and performance, leading the Trust's planning, contracting and information functions.

Jug Johal

Director of Estates and Facilities

Jug joined the NHS in 2006 after working his way up from transport administrator to group operation manager in a private logistics firm. He has worked in a number of roles at the Trust including transport manager and general manager for hotel services before being appointed to director of estates and facilities in August 2014. Jug oversees our estate, facilities and commercial services which include catering, cleaning, transport, security, parking, reprographics, property services and portering. He is also chair a Board Member of the National Skills Academy for Health and has won several national awards including including HefmA Project Manager of the Year.

Mr Lawrence Roberts

Medical Director

Mr Roberts has a wealth of experience having graduated from Charring Cross Medical School before being commissioned into the Royal Navy as a medical student on a short service commission. He worked as a ship's medical officer and on an air-sea rescue squadron and was also attached to the Royal Marines. He trained as a GP during his time in the Royal Navy before transferring to the Army where he trained in obstetrics and gynaecology. He also worked as a perinatal training fellow at the University College of London and became a consultant in 1994. He went on to take up the post of Command Consultant in Obstetrics and Gynaecology (British Army of the Rhine) and was promoted to lieutenant-colonel before being made redundant in 1996. He then joined Scunthorpe hospital as a consultant, and has held various posts.

Claire Phillips

Interim Chief Operating Officer

Claire grew up in the area and joined the Trust in 1999 as a clinical audit officer before moving to managerial positions in the operations directorate. She led the women and children, and surgery and critical care divisions, as well as worked across the directorates. Claire was appointed Deputy Chief Operating Officer in 2017.

Dr Kate Wood

Acting Medical Director

Dr Wood studied medicine at Glasgow University, graduating in 1994. She started work in anaesthetics in 1999 training in Hull, during which time she worked as a Senior House Officer and Registrar at Grimsby Hospital. She loved her time in Grimsby so much she returned in 2006 when she was appointed as a Consultant Anaesthetist. Since then she has held a number of managerial roles including Lead for Obstetric Anaesthesia in Grimsby, Clinical Director, Associate Medical Director and Deputy Medical Director and Acting Medical Director.

Dr Karen Dunderdale

Deputy Chief Executive and Director of Operations

Karen's last day as a Director in the Trust was on July 13 2017.

Robert Toole

Acting Director of Finance

He resigned from the Trust 7 July 2017.

Balance of the Board

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

The Board of Directors considers the balance and breadth of skills and experience of its members to be appropriate with the needs of the Trust. The skill mix of the Board was considered by the Chair, Chief Executive, Trust Secretary and Director of People and Organisational Development following the Well-Led Review and in response to a Non-Executive Director vacancy, and the impending retirement of another Non-Executive Director.

All non-executive directors are considered to be independent, meeting the criteria for impendence as laid out in NHS Improvement's Code of Governance.

Non-executive directors are appointed and removed by the Council of Governors, while executive directors are appointed and removed by the Chief Executive.

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

Operation of the Board

NLaG is run by a Board of Directors, comprising of a non-executive director who is the chair, and five other non-Executive Directors and five Executive Directors. The Executive Directors include: the Chief Executive, Deputy Chief Executive/Director of Operations, Chief Nurse, Medical Director and Director of Finance. The Director of Performance Assurance/ Trust Secretary and Director of People and Organisational Development attend meetings but cannot vote.

The Director of Strategy and Planning and Director of Estates and Facilities are no longer Board Directors.

The Chief Executive leads the executive team and is accountable to the Board for the operational delivery of the Trust.

The Chair of the Board is also the Chair of the Council of Governors.

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

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

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

It does this through the approval of key policies and procedures, the annual plan and budget for the year, and scheme for investment or disinvestment above the level of delegation.

The Board meets monthly and its role is to determine the overall corporate and strategic direction of the Trust and to ensure the delivery of the Trust's goals and targets.

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

The Board of Directors has reserved powers to itself covering:

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

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

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

The Board is also responsible for ensuring proper standards of corporate governance are maintained. It accounts for the

performance of the Trust and consults on its future strategy with its members through the Council of Governors (CoG).

The Board works closely with the Trust's CoG. The Trust Chair is also Chair of the CoG and works closely with the Lead Governor to review all relevant matters. The Chair, Chief Executive, Trust Secretary and Membership Manager meet before each meeting of the CoG to set the agenda and review key issues. The Non-Executive and Executive Directors of the Board attend the CoG meetings as observers and take part in open discussions for part of each meeting.

Executive Directors or their deputies, and Non-executive Directors, are assigned to and are integral members of each of the CoG sub-groups. Participation in each quarterly sub-group ensures an understanding of the views of the governors and subsequently members of the public. During 2017/18, work was undertaken to align the CoG sub-groups and the Board assurance sub-committees and governor chairs of sub-groups attend Board assurance sub-committees as observers.

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

Should this meeting not resolve the issue then the Chair shall have the authority to make a decision on behalf of the Trust. This decision, and the reasons supporting it, will be communicated in writing to all members of both the Board of Directors and the Council of Governors. This has not been required during the period April 1 2016 to March 31 2017.

The Board ensures that adequate systems and processes are maintained to measure and monitor the Trust's effectiveness, efficiency and economy as well as the quality of local healthcare delivery.

The Trust Devolution Policy including Reservation of Powers to the Board and Scheme of Delegation details which types of decisions are to be taken by the Board, and which decisions are to be delegated to the management by the Board of Directors.

The Board of Directors also has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The Board of Directors keeps the performance of its committees under regular review and requires that each committee considers its performance and effectiveness during the year.

The Trust has arranged appropriate insurance to cover the risk of legal action against its directors and is insured through the NHS Litigation Authority.

Deputy Chair

Good practice suggests that the Trust should have a Deputy Chair to stand in during any periods of absence of the Chair.

NHS Improvement's guidance states that this should be a Council of Governors appointment although it would be expected that the Chair would make a recommendation to governors. Linda Jackson, non-executive director, is the Deputy Chair. The Trust Constitution makes provision for this.

Senior Independent Director

The Senior Independent Director is a Non-Executive Director appointed by the Board as a whole in consultation with the Council of Governors.

The Senior Independent Director has a key role in supporting the Chair in leading the Board and acting as a sounding board and course of advice for the Chair. They also lead the performance evaluation of the Chair. Stan Shreeve, Non-Executive Director, is the Senior Independent Director.

Board meetings

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

Attendance at public Board meetings April 1 2016 to March 31 2018

Name	30.5.17	25.7.17	26.9.17	28.11.17	19.12.17	30.1.18	27.2.18	27.3.18
Anne Shaw	P	P	P	P	P	P	P	P
Dr Peter Reading	-	-	P	P	P	P	P	P
Richard Sunley	P	P	A	A	A	P	P	P
Dr Karen Dunderdale	P	-	-	-	-	-	-	-
Marcus Hassall	P	P	P	P	P	P	P	P
Tara Filby	P	P	P	P	P	P	P	A
Mr Lawrence Roberts	P	P	P	A	A	A	A	A
Dr Kate Wood	-	-	-	P	P	P	P	P
Jayne Adamson	P	P	P	P	P	P	P	P
Robert Toole	P	-	-	-	-	-	-	-
Neil Gammon	P	P	-	-	-	-	-	-
Stan Shreeve	P	P	P	P	P	P	P	P
Linda Jackson	P	P	A	P	P	P	P	P
Sue Cousland	P	A	A	P	P	A	P	P
Sandra Hills	P	P	P	A	P	P	A	P
Anthony Bramley	P	P	P	A	P	P	P	P
Jug Johal	P	P	-	-	-	-	-	-
Wendy Booth	P	P	P	A	P	P	P	P
Pam Clipson	P	P	-	-	-	-	-	-
Claire Phillips	-	-	-	-	-	-	-	-
Karen Jackson	-	-	-	-	-	-	-	-
Karen Griffiths	-	-	-	-	-	-	-	-

P – present A – absent – not applicable

Non-executive Directors

Non-executive Directors (NEDs) are appointed for a period of three years and can be appointed for a further period of three years. Any term beyond six years is subject to rigorous review.

Arrangements for the appointment and termination of Non-executive Directors are set out in the Trust Constitution.

The Constitution states that the Council of Governors has the power to appoint and remove the Chairman of the Trust and other Non-executive Directors. Removal can only happen if three quarters of the Council of Governors members approve the motion.

The Board determines whether each NED is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could affect, the person's judgement. All of our Non-executive directors are considered to be independent by the Board of Directors as per the Code of Governance for NHS Foundation Trusts.

The Chair is responsible for the leadership of both the Board of Directors and the Council of Governors.

As Chair of the Board of Directors she is responsible for ensuring the Board's effectiveness and setting its agenda.

As Chair of the Council of Governors she provides a pivotal link between Governors and Directors, especially the NEDs. Listening to the governors is one of the ways the Chair can hear the views of the local community. She regularly provides feedback to the Board of Directors on the views of the governors and the local community.

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

The Chair, other Non-executive Directors, and the Chief Executive are responsible for deciding the appointment of executive directors.

Evaluation of the Board/its committees/ directors and Chair

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

Risks in respect of compliance with other statutory requirements are escalated to the Trust Board via established governance and performance management frameworks including receipt by the Trust Board of quarterly Trust Assurance Framework and Risk Register reports.

More urgent risk issues are escalated directly to the Executive Team and the Trust Board via the relevant Executive Director.

The Scheme of Delegation,

which defines accountabilities for the delivery of performance, is monitored via the performance management framework led by the Chief Executive.

The Board ensures that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance.

The Trust Board receives assurance through a suite of financial and non-financial performance reports including:

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

The Trust undertakes an annual evaluation of the Board and its sub-committees. During 2017/18 the Trust commissioned a Well Led Review. An improvement plan is in place in response to the findings and recommendations.

Development of the Board is essential in ensuring that it is functional, relationships are constructive, healthy and challenging, in making sure it has control of the business of the organisation and that it has robust plans in place for the future. A Board Development Programme is in place with external support.

Changes to the make-up of the Board provide an ideal opportunity to consider the professional requirements of the team, and to understand the new dynamics, behaviour and leadership style.

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

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

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

None of our directors or governors hold similar positions in any other NHS foundation trust. No Executive Directors were appointed as a Non-executive Director in other organisations during the year, and no Board director is a Governor or director of another foundation trust.

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

How the Directors are assisted in their roles

Our Trust Board and Council of Governors are provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make. They receive assurance through a suite of financial and non-financial performance metrics including such things as the monthly quality report, mortality report and monthly finance report.

The Board of Directors ensures that directors, especially non-executive directors, have access to independent professional advice, at the Trust's expense, where they judge it necessary to discharge their responsibilities as directors or to provide additional assurance on areas of challenge. The corporate Trust Secretary facilitates such events.

New Directors receive a full, formal and tailored induction on joining the Board of Directors.

They also have access, at the Trust's expense, to training courses and/or materials that are consistent with their individual and collective development. The availability of independent external sources of advice is made clear at the time of appointment.

Directors, governors and members are all supported by the Trust Secretary and the Trust Membership Officer.

Where Directors have concerns that cannot be resolved about the running of the Trust or a proposed action, any concerns are recorded within the Trust Board minutes. Minutes of the Trust Board are comprehensive and are

published in the public domain.

Our Trust Board, and in particular our Non-executive Directors, may reasonably wish to challenge assurances received from the executive management team.

The executive directors ensure, wherever possible, that the Non-executive Directors receive sufficient information and understanding to enable challenge and to take decisions on an informed basis. The Board minutes reflect any challenges of the executive management. There is also in place a schedule of Non-executive Director challenge roles whereby individual non-executives provide challenge in respect of specific areas of risk eg risk management, mortality, sustainability and quality.

Code of conduct for the Trust Board

All members of NHS Boards and clinical commissioning group governing bodies should undertake and commit to the practice of good governance and to the legal and regulatory frameworks in which they operate.

As individuals they must understand both the extent and limitations of their personal responsibilities. To this end, in November 2012, the Professional Standards Authority (PSA) published new standards for members of NHS boards and CCG governing bodies in England. The standards cover three domains: personal behaviour, technical competence and business practices, and puts compassion and respect at the heart of NHS leadership. The standards also aim to capture existing standards, codes and principles (the Nolan Principles) by which NHS Board members are currently bound and are also intended to underpin existing systems for recruitment, training and development and appraisal.

In May 2013 the Trust Board formally signed up to these standards.

All Board directors meet the 'fit and proper persons' test as described in the provider license as confirmed annually by each individual Director and collectively within the annual chairman's declaration to the Trust Board.

The Trust Board has maintained its support of the Nolan Principles of public life and has continued to make the majority of its decisions at Board meetings held in public.

To support this there is the Directors Code of Conduct, which applies to all directors and has been adopted by all Board members. This Code of Conduct builds on the NHS Code of Conduct and includes the Nolan principles of public life.

Board committees

The Board has established a number of formal sub-committees that support the discharging of the Board's responsibilities.

In addition to meeting the statutory requirements of having an Audit Committee and Remuneration Committee, we also have a Finance and Performance Committee, Quality and Safety Committee, and a Charitable Funds Committee (known as the Health Tree Foundation Trustees Committee).

Minutes of the sub-committees are presented to the Trust Board as is a monthly highlight report which provides escalation of issues and concerns for the attention of the Trust Board.

Each sub-committee comes under the remit of an executive director and is chaired by a non-executive director. Appropriate resource is allocated to ensure these sub-committees can undertake their duties.

Arising from the Well led Review commissioned by the Trust during 2017/18, changes have been made to the Trust's meeting structures (including the Board assurance sub-committees) in order to provide clear reporting lines and separation of management decision making from assurance.

As at March 31 2018, the current sub-committee structure is as follows:

Audit, Risk and Governance

The Audit, Risk and Governance Committee is a standing committee formally established by the Trust Board.

Formerly known as the Audit Committee, it consolidated responsibilities transferred to it from the defunct Trust Governance and Assurance Committee becoming the Audit, Risk and Governance Committee.

Terms of reference were duly updated and approved by the Trust Board.

The committee's remit is to ensure that effective internal controls and systems are in place, and compliance with law, guidance and codes of conduct.

It also oversees the establishment and maintenance of an effective system of internal control that supports the achievement of the organisation's objectives and monitors the integrity of the financial statements of the Trust.

The committee, which meets seven times per annum, is appointed by the Board from among the Non-Executive Directors of the Trust and consists of three core Non-Executive Director members.

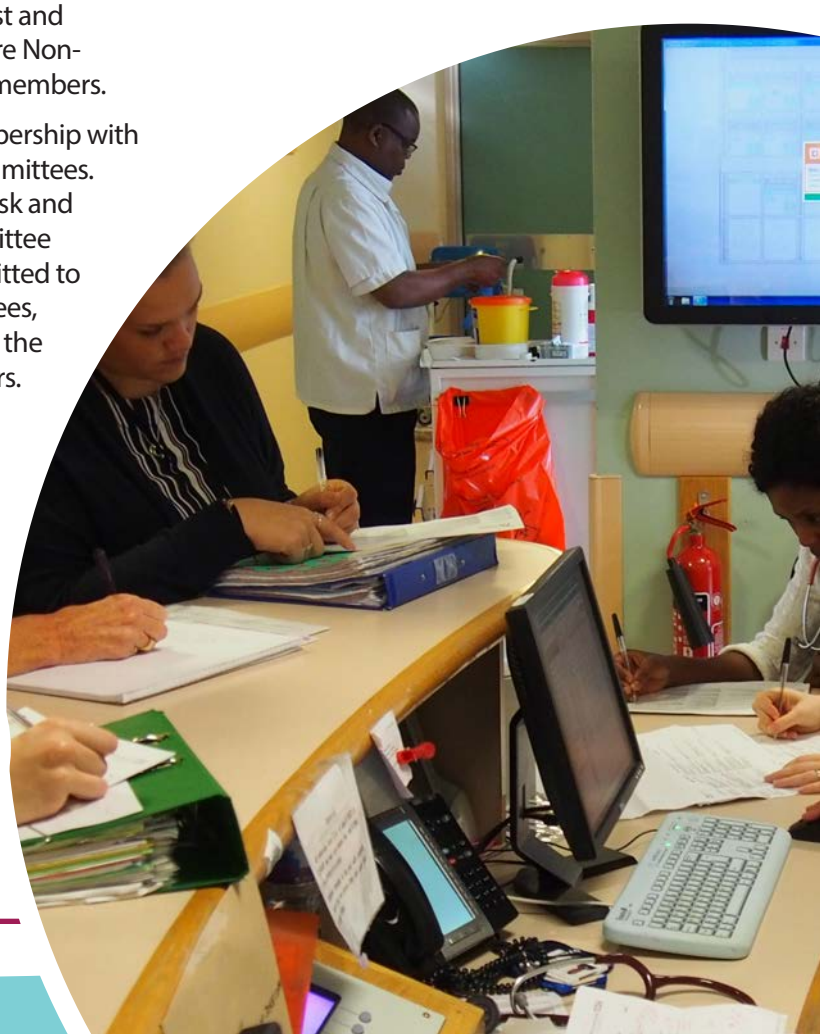
There is cross membership with other standing committees. Minutes of Audit, Risk and Governance Committee meetings are submitted to other sub-committees, the Trust Board and the Council of Governors.

Internal Auditor services are provided by KPMG, appointed for three years on 1 June 2014 and awarded a one year extension for 2017/18 as allowed. Procurement rules require that a tendering exercise be undertaken for future provision thereafter.

Internal Audit's role is to provide an independent and objective opinion to the Chief Executive, the Audit, Risk and Governance Committee and the Board on the degree to which risk management, control and governance arrangements support the effective operation of the Trust.

The Head of Internal Audit produces an annual audit opinion on the effectiveness of the system of internal control.

The Head of Internal Audit and/or the Internal Audit Manager for the Trust will normally attend Audit, Risk and Governance Committee meetings and has a right of access to all Audit, Risk and Governance Committee members, the Chairman and



Chief Executive of the Trust. The Head of Internal Audit is accountable to the Director of Finance.

During 2017/18 the Audit, Risk and Governance Committee received regular written progress reports from its internal auditors outlining the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate.

The annual Head of Internal Audit Opinion, which forms part of the Annual Governance Statement in this report, contains details of high risk recommendations made during the year.

The internal auditors also provided regular useful technical update reports which highlighted to the committee the main technical issues impacting on the health sector at the time of each report.

The Audit, Risk and Governance Committee also monitors the implementation of all internal audit recommendations made, and has duly received progress reports at each meeting to enable monitoring of these actions.

The Trust's External Auditors are PwC who have been the Trust's External Auditor since 2012 and were re-appointed for a further three years in 2016 with the option for a one year extension following a tendering exercise.

Representatives of the Audit, Risk and Governance Committee acted as advisors to the Council of Governors in relation to this tendering exercise.

The Council of Governors convened a sub-committee to oversee the process and make a recommendation to the full Council of Governors.

The value of external audit services is disclosed in the Trust's financial statements (note 5.2 page 164) and is circa £74k per annum.

An annual review of effectiveness will be performed. PwC may also provide non-audit services to the Trust and the Trust has a formal policy for the engagement of the External Auditor for non-audit work to ensure that their objectivity and independence are safeguarded, and this policy is also subject to annual review by the Audit, Risk and Governance Committee.

The value of any non-audit services is routinely disclosed in the Trust's financial statements at note 5.2, but there was no such work performed by PwC during 2017/18.

The committee received and reviewed the draft financial statements and the audited accounts, as well as the Annual Governance Statement.

Due to the challenging financial deficit position of the Trust at the end of 2017/18, as with the previous three years, and coupled with being placed into Financial Special Measures in March 2017 one of the significant issues given full consideration by the Audit, Risk and Governance Committee as part of the accounts preparation process was the Trust's ability to continue as a going concern.

The Audit, Risk and Governance Committee considered this in detail and note 1.1.2 of the financial statements refer to the accounts being prepared on a going concern basis. The Audit, Risk and Governance Committee endorsed this as appropriate.

As part of the committee's regular review of its own governance arrangements it conducted a self-assessment workshop in January 2018, in line with the latest NHS Audit Committee Handbook (HFMA, 2014).

A review of its formal terms of reference was also undertaken to ensure that they remain up to date and fit for purpose.

As a result of this review only minor changes were considered necessary.

The Trust Board approved the

committee's terms of reference for a further year.

In line with the Foundation Trust Code of Governance, the Audit, Risk and Governance Committee also has a role in reviewing the organisation's arrangements for staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.

In order to discharge this function the Audit, Risk and Governance Committee received an initial introduction to the role of the Trust's Freedom to Speak Up Guardian at its June 2017 meeting, with a further update on progress and activity at the October 2017 meeting.

Schedule of Attendance at Audit, Risk and Governance Committee meetings 2017/18

Member / Attendee	Apr-17	May-17	Jun-17	Aug-17	Oct-17	Dec-17	Feb-18	Overall Attendance
Members:								
Stan Shreeve – Chair	Y	Y	Y	Y	Y	Y	Y	100%
Neil Gammon – NED	Y	Y	Y1	-	-	-	-	100%
Linda Jackson – NED	Y	N	Y	N	Y	Y	Y	71%
Anthony Bramley - NED	-	-	Y2	Y	Y	N	Y	86%
Regular Attendees:								
Marcus Hassall – Director of Finance	N3	N3	N3	Y	Y	Y	Y	100%
Wendy Booth – Director of Governance & Assurance	Y	Y	Y	Y	Y	Y	Y	100%
Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	Y	Y	Y	100%
LCFS	Y	N/A4	Y	Y	Y	Y	Y	100%
Head of Procurement	Y	N/A4	N	Y	Y5	Y5	Y	100%
Internal Audit	Y	Y	Y	Y	Y	Y	Y	100%
External Audit	Y	Y	Y	N	Y	Y	Y	86%
Head of Quality Assurance	-	-	-	Y6	Y	Y	Y	100%
Head of H&S and Fire	-	-	-	Y6	N	Y	N	50%
Ad-hoc Attendees:								
Asst. DoF – Process & Control (NP)	Y	Y	-	-	-	-	Y	-
Deputy Director of Finance (PC)	Y	Y	-	-	-	-	-	-
Chief Executive (RS)	-	Y	-	-	-	-	-	-
Director of People & Organisational Effectiveness (JA)	-	-	Y	-	Y	-	-	-
Associate Freedom to Speak Up Guardian (DB)	-	-	Y	-	Y	-	-	-
Emergency Planning & LSMS (MO)	-	-	-	Y	-	-	-	-
Listening into Action Lead (KF)	-	-	-	Y	-	-	Y	-
Deputy Director of Improvement (KH)	-	-	-	-	-	Y	-	-
IT Network & Telecommunications Manager (JLH)	-	-	-	-	-	Y	-	-
Associate Chief Operating Officer – Patient Access (JF)	-	-	-	-	-	-	-	Y

Notes:

1 Neil Gammon, NED, last meeting before leaving the Trust
2 Anthony Bramley, NED, first meeting as new member of the committee
3 Interim DoF in attendance in absence of substantive DoF
4 Not required to attend, Final Accounts meeting only
5 Interim Head of Procurement in attendance
6 First attendance at newly named Audit, Risk and Governance Committee (having extended remit from August 2017 for responsibilities transferred from the former Trust Governance and Assurance Committee).

Health Tree Foundation Trustees Committee

This committee was established as a formal sub-committee of the Trust Board, under the Trust Constitution Part IV Section 6.8 d. Its membership is appointed by the Trust Board among the Non-Executive and Executive members, and the local community, and consists of the following voting members: an independent Chair, three Non-Executive Directors, Chief Executive, Medical Director, Chief Nurse, Director of Finance and two independent trustees.

It is tasked with overseeing and managing the affairs of the Trust's charitable funds. The working name of the charity is The Health Tree Foundation.

It ensures that the charity acts within the terms of its declaration of trust, and all appropriate legislation on behalf of the Trust Board as corporate trustee.

Its minutes are shared with the Trust Board. Further information about the charity is available on page 126.

Quality and Safety Committee

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

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

Finance and Performance Committee

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

It submits copies of its minutes for inclusion on the Trust Board agenda, and significant issues are escalated to the Trust Board via a monthly 'highlight' report.

Its core membership includes three Non-Executive Directors, Deputy Chief Executive/Chief Operating Officer, Director of Finance and Turnaround Director.

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

Remuneration Committee

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

It reviews and approves leadership needs and succession planning to ensure the Trust can fulfil its own strategic and statutory requirements for the two levels below executive level.

It also reviews and approves the overall structure of the Executive team in terms of structure, size, skills, knowledge, experience and diversity.

It also reviews and agrees on the remuneration of senior directors and commissions recruitment exercises to fill any vacancies amongst the Executive team.

It reports to the Trust Board through updates provided to the non-executive directors by the Trust Chair and the Council of Governors and members of the public through a committee and remuneration report included as part of the Trust's statutory annual report and accounts. Its membership is made up of three Non-Executive Directors who are appointed by the Board.

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

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

Cost allocation and charging

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

Donations

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

Payments Practice Code

	2017/18		2016/17	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	88,145	183,178	86,825	178,637
Total non-NHS trade invoices paid within target	27,316	39,017	25,925	42,997
Percentage of non-NHS trade invoices paid within target	31%	21%	30%	24%
Total NHS trade invoices paid in the year	3,560	24,256	3,400	20,173
Total NHS trade invoices paid with target	1,706	15,496	826	12,672
Percentage of NHS trade invoices paid within target	48%	64%	24%	63%

Income disclosures to auditors

The directors confirm that, as required by the Health and Social Care Act 2012, the income that the Trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

The Trust has processes in place to ensure that this statutory requirement will be met in future years.

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

Statement as to disclosures to auditors

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

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

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

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

Trust Board approach to clinical governance

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

The effectiveness of the Trust governance arrangements continued to be tested during 2017/18 via internal and external testing including internally via the annual internal audit programme and externally as part of a Trust commissioned Well Led Review.

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

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

Monitoring occurs via the monthly Improving Together progress report to the Trust Board.

More detailed updates are provided quarterly to the Trust Board.

Changes have been agreed during 2017/18 to the configuration of the Trust's (central) governance team and arrangements; not least to ensure increased focus on clinical governance. To this end, key

responsibilities will be re-aligned as follows:

- Patient experience: to transfer to Chief Nurse from 1 May 2018
- Patient safety and clinical effectiveness to transfer to the Medical Director from 1 August 2018.

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

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

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

We ensure there is regular reporting to and dialogue with NHS Improvement.

This includes monthly accountability meetings (MAM) in respect of the Trust's position on performance and quality and financial special measures.

Stakeholder relations

Collaborative working is key to the local health community.

Our approach is, and always has been, based on openness, honesty and a genuine desire to listen and act on feedback to improve our services and our patients' experience.

We work with our partners in the local 'health and care community' to continually progress our services which includes GPs, community healthcare providers, social care providers, charities, the ambulance service, mental health providers, local health scrutiny panels and the clinical

commissioning groups across our population footprint.

We are a member of the Humber Coast and Vale Sustainability and Transformation Plan (STP) with linkages into neighbouring STPs given our patient flows.

As part of this work the planning principles we have adopted focus on the priority to deliver the care needed by our patients as close to them as is safe and is financially viable to do so.

Further details about the STP are available in our Operational Plan which is available on the Trust website.

The governance structure associated with the Humber, Coast and Vale STP includes a Humber Acute Services Review Programme.

This structure enables the acute providers of Hull and East Yorkshire and Northern Lincolnshire and Goole hospitals to come together to strengthen and further develop clinical networks.

The development of clinical networks will build upon the emerging clinic strategy.

For NLaG the emerging strategy includes maintaining an urgent and emergency care front door in each of the Grimsby and Scunthorpe hospitals with access to maternity and critical care.

The Trust has good stakeholder relations and regularly attends meetings of the overview and scrutiny committees and topical issues. The also has a Joint Working Protocol in place with the three local Health Watch organisations and there are twice yearly meetings with Health Watch and Trust governors.

The Trust also has monthly engagement meetings with the CQC and meets monthly with stakeholders through the System Improvement Board, put in place to provide support and challenge to the Trust following it being placed in special measures.

There are also quarterly engagement and listening events for Trust members and the public to meet with governors and either the Trust Chair, or a Non-Executive Director and the Membership Manager. The Trust has now moved to holding joint engagement events with North and North East Lincolnshire Clinical Commissioning Group and hope to establish something similar for the Goole and Howdenshire area.

The Trust also has in place a policy outlining those third parties with whom it has a duty to co-operate which is regularly reviewed and agreed by the Trust Board.

Complaints

We constantly strive to provide the best quality care to our patients but recognise that there will be occasions when they, their relatives or carers do not feel happy with their visit or the services they have received.

We welcome feedback from patients, their relatives or carers, as it provides us with the opportunity to investigate and learn from the occasions when things have gone wrong or the patient has had a poor experience. We also welcome any comments, concerns in addition to any compliments about the services we provide.

There are a number of ways an individual can provide the Trust with feedback relating to their experiences including through our comment cards provided throughout the Trust, our patient advice and liaison service (PALS), and formal complaints process.

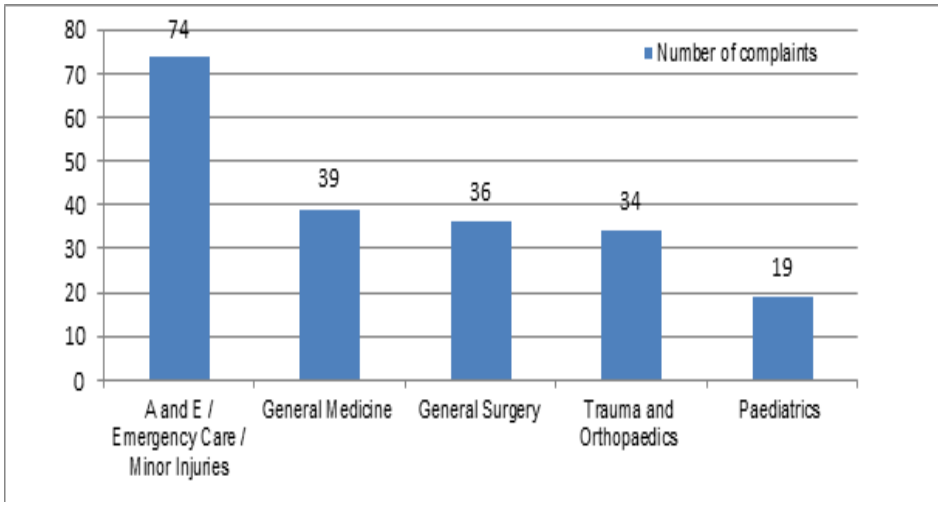
In 2017/18, the PALS team received:

- 2,105 concerns; 273 of which were resolved within one working day
- 62 per cent of the concerns were responded to in the expected three to five working days, which is a 10 per cent increase on the previous year. It is however recognised that this figure needs to improve further and we will endeavour to concentrate efforts on this over the next year.

The Trust received 476 formal complaints throughout the year with 100 per cent of new complaints being acknowledged in three working days. In line with the Trust's Policy and Procedure for the Management of Complaints, Concerns, Comments and Compliments, each complainant is allocated an individual complaints facilitator, who will liaise with them from the outset, obtaining specific questions and desired outcomes, ensuring that they are kept up to date a throughout the investigation process.

The team ensure that an investigation is completed and an open and honest response is provided, either in written format or via a meeting.

Of the total number of formal complaints received, nine related to our community services; 245 related to Grimsby hospital; 20 related to Goole hospital; 200 related to Scunthorpe hospital and two spanned across a number of our sites. The top five areas of complaint were as follows:



Of the complaints closed during 2017/18, 54 per cent were responded to within 60 working days. We acknowledge that receiving a timely response is important to complainants and we will be seeking solutions to reduce response timescales over the next year.

As a Trust, we appreciate how important feedback is and just as we like to know when things go wrong, it is also helpful to know when we are doing things well. This not only helps boost staff morale and motivation, but also allows us to identify which areas are doing better than others so we can then try to replicate the good practice across other areas of the Trust.

In 2017/18, 253 compliments were received by the Trust and formally logged by the central governance directorate. All compliments

received are circulated to the relevant management teams and are shared with staff to acknowledge and celebrate their successes. Examples of the compliments received are:

"Patient says she was very anxious when he arrived at the hospital for an ophthalmology procedure but felt everyone showed care and understanding. She would particularly like to thank Dr Dar who carried out the procedure and says she is more than happy with the results."

"It has been of great help at this difficult time, to be dealt with by professional and courteous people, enabling informed decisions to be made. The NHS has served me well and I wish to offer my sincere thanks to all concerned." (Urology)

"I am a senior nurse myself, having trained at this hospital over 30 years ago, I am at present supporting my sister through her cancer pathway. Working currently in the NHS I am very aware of the impact the national position is having on our services. I attended an emergency oncology clinic yesterday to see a doctor, someone we have not seen before (as this was an emergency appointment) to find the clinic running at least 1.5 hours behind. The healthcare assistant apologised to us after some time and invited us to go for a coffee and return later. We did this and duly went in for our appointment at 6pm (scheduled for 4.45pm). The doctor was obviously running late and it had been a long day, however, he did not rush us, explained everything and spent considerable time explaining my sister's unexpected results to us, ensuring we fully understood her plan moving forward. A thoroughly lovely gentleman who was supported by a cheerful and friendly healthcare assistant, in obviously challenging circumstances.

This experience made me continue to have faith in a system which is quite obviously broken from a national perspective, but it also made me proud to still be a nurse and ever grateful for the extra mile the staff in your organisation took yesterday in order to ensure we were given the time required. Thanks to all."

Governors' report

Council of Governors

As a foundation trust, NLaG has a Council of Governors (CoG). The Board of the Trust is directly responsible for the performance and success of the Trust, and satisfying the CoG that the Board is achieving its aims and fulfilling its statutory obligations. Governors act as a link to the local community and report matters of concern raised with them, to the Board, via their quarterly CoG meetings. It receives and considers all appropriate information required to enable it to discharge its duties, and is provided with high-quality information appropriate to its function and relevant to the decisions it has to make.

Members of the Council of Governors during 2017/18

Name	Initial date elected	Date re-elected	Term of office	Term of office ends	Date of retirement	Political party
Public governors – East and West Lindsey						
Jeremy Baskett	19.4.16	-	3 years	19.4.19	-	
Christopher Bayne	19.4.16	21.10.16	3 years	21.10.19	-	
Public Governors - Goole and Howdenshire						
Janthea Capitani	19.4.16	-	3 years	19.4.19	-	
Rob Pickersgill	3.12.15	-	3 years	3.12.18	-	
Roy Taylor	21.1.11	3.12.15	3 years	3.12.18	31.5.17	
Barbara Jeffreys	28.7.17	-	17 mnths	3.12.18	-	
Public Governors – North East Lincolnshire						
Cheryl George	19.4.16	-	3 years	19.4.19	7.4.17	
Ann Maggs	13.12.16	-	3 years	13.12.19	-	
Brian Page	3.12.15	-	3 years	13.12.18	-	
Jeff Shaw	23.11.08	21.10.16	3 years	21.10.19	-	
Liz Stones	23.11.11	22.11.14	3 years	3.12.17		
David Walker	28.7.17	22.11.14	21 mnths	19.4.19	26.3.18	
Public Governors – North Lincolnshire						
Harpreet Atwal	21.10.16	-	3 years	21.10.19	5.5.17	
Maureen Dobson	28.11.07	21.10.16	3 years	21.10.19	-	
Paul Grinell	4.11.09	3.12.15	3 years	3.12.18	-	
Carol Anscombe	17.11.17	-	3 years	17.11.20	-	UKIP
John Anscombe	17.11.17	-	3 years	17.11.20	-	UKIP
Staff Governors						
Mr Sid Goel	28.7.14	-	3 years	28.7.17	28.7.17	
Mr Makani Hemadri	28.7.14	28.7.17	3 years	28.7.20	-	
Tim Mawson	21.1014	28.7.17	3 years	28.7.20	-	
Tony Whyte	28.7.14	28.7.17	3 years	28.7.20	-	
Vacancy						
Stakeholder governors						
Vacancy – North Lincolnshire						
Melanie Dickerson – North East Lincolnshire	20.7.15	-	3 years	20.7.18	-	Conservative
John Barrett – Goole and Howdenshire Council	20.7.16	-	3 years	20.7.18	-	Conservative
Richard Young – North Lincolnshire	1.9.16	-	3 years	1.9.19	-	
Eddie McCabe – North East Lincolnshire	19.4.16	-	3 years	19.4.19		
Vacancy – Hull York						

Role of Governors

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

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

The council takes the lead in agreeing with the Audit Committee the criteria for appointing, re-appointing and removing external auditors. When the council ends an external auditor's appointment in disputed circumstances, the Chair will write to NHS Improvement informing it of the reasons behind the decision.

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

Composition of the CoG and CoG meetings

The CoG comprises of the following constituencies:

Elected Public Governors

The CoG has 16 Governors elected from its membership that represent the four main catchment areas of the Trust. Public Governors are elected from within local authority areas. The number of Governors for each constituency is in proportion to the population within the area using NLaG services.

Area	Number
North Lincolnshire	5
North East Lincolnshire	5
Goole and Howdenshire	3
East and West Lindsey	2

Elected Staff Governors

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

Appointed Stakeholder Governors

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

Governor elections were held three times during the year, as several had come to the end of their term of office. The results of each election are detailed below:

- **Elections ending July 18 2017**

For Goole and Howdenshire a public governor was elected for a term of 17 months (being the remainder of the term of office of the proceeding Governor who had retired). A new public governor was elected for North East Lincolnshire for a term of 21 months (being the remainder of the term of office of the proceeding governor who had retired), and three staff governors were elected for a term of three years.

- **Annual elections ending on November 17 2017**

Three new governors were elected for North Lincolnshire (all for a three year term of office).

The Council of Governors meets sufficiently regularly to discharge its duties. During the year April 1 2017 to March 31 2018 attendance at the Council of Governor meetings was as follows:

Governors	Council of Governor meetings						
		AR		AMM			
Constituencies	11.4.17	13.6.17	11.7.17	21.9.17	17.10.17	16.1.18	Total
East and West Lindsey							
Jeremy Baskett	P	P	P	A	P	P	5 out of 6
Christopher Bayne	P	P	A	P	P	A	4 out of 6
Goole and Howdenshire							
Janthea Capitani	P	A	A	A	P	P	3 out of 6
Rob Pickersgill	P	P	P	P	P	P	6 out of 6
Barbara Jeffreys	n/a	n/a	n/a	n/a	P	A	1 out of 2
North East Lincolnshire							
Ann Maggs	A	A	P	A	A	A	1 out of 6
Brian Page	P	P	P	P	P	P	6 out of 6
Jeff Shaw	P	P	P	P	P	P	6 out of 6
Liz Stones	A	A	P	A	A	A	1 out of 6
David Walker	n/a	n/a	n/a	P	A	P	2 out of 3
North Lincolnshire							
Carol Anscombe	n/a	n/a	n/a	n/a	n/a	A	0 out of 1
John Anscombe	n/a	n/a	n/a	n/a	n/a	A	0 out of 1
Judith Bett	n/a	n/a	n/a	n/a	n/a	A	0 out of 1
Maureen Dobson	A	P	P	P	P	P	5 out of 6
Paul Grinell	A	P	P	P	P	P	5 out of 6
Robin Perry	A	A	A	A	n/a	n/a	0 of 4
Staff Governors							
Makani Hemadri	A	A	A	P	A	A	1 out of 6
Sid Goel	A	A	n/a	n/a	n/a	n/a	0 out of 2
Tim Mawson	P	P	P	P	P	P	6 out of 6
Anthony Whyte	A	P	P	P	A	P	4 out of 6
Stakeholder Governor							
John Barrett	P	P	A	P	P	A	4 out of 6
Eddie McCabe	P	A	P	P	P	P	5 out of 6
Melanie Dickerson	P	P	P	A	P	P	5 out of 6
Richard Young	A	A	A	A	A	A	0 out of 6

P Present

A Absent

n/a Not applicable

During the year April 1 2017 to March 31 2018 attendance by Non-Executive Directors (NED) and Directors at the Council of Governor meetings was as follows:

Name	11.4.17	13.6.17	11.7.17	21.9.17	17.10.17	16.1.18	Total
Anne Shaw - Trust Chair	P	P	P	A	P	P	5 out of 6
Jayne Adamson - Director of People and Organisational Effectiveness	A	A	A	A	A	A	0 out of 6
Wendy Booth - Director of Performance Assurance & Trust Secretary	A	P	A	A	A	A	1 out of 6
Pam Clipson - Director of Strategy and Planning	P	P	P	A	A	P	4 out of 6
Dr Karen Dunderdale - Deputy Chief Executive/Director of Operations	P	A	A	n/a	n/a	n/a	1 out of 3
Tara Filby - Chief Nurse	A	P	P	P	A	P	4 out of 6
Marcus Hassall - Director of Finance	A	A	A	P	P	P	3 out of 6
Jug Johal - Director of Estates and Facilities	P	P	P	A	A	P	4 out of 6
Claire Phillips - Deputy Director of Operations	n/a	n/a	P	A	A	P	2 out of 4
Dr Peter Reading - Chief Executive	n/a	n/a	n/a	A	P	P	2 out of 3
Mr Lawrence Roberts - Medical Director	A	P	A	A	A	A	1 out of 6
Richard Sunley - Interim Chief Executive/Deputy Chief Executive	A	A	P	A	A	A	1 out of 6
Robert Toole - Interim Director of Finance	A	P	A	A	n/a	n/a	1 out of 4
Tony Bramley - Non-executive Director	A	P	A	P	P	P	4 out of 6
Sue Cousland - Non-executive Director	P	A	P	A	A	P	3 out of 6
Neil Gammon - Non-executive Director	P	P	n/a	n/a	n/a	n/a	2 out of 2
Sandra Hills - Non-executive Director	A	P	A	P	A	P	3 out of 6
Linda Jackson - Non-executive Director	P	P	A	A	P	P	4 out of 6
Stan Shreeve - Non-executive Director	P	P	P	P	A	A	4 out of 6

P Present A Absent n/a Not applicable

Lead Governor

NHS Improvement (NHSI) requires that a CoG elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to NHSI if circumstances required direct communication between the CoG and the regulator.The Lead Governor is Paul Grinell, a public Governor for North Lincolnshire. He was elected as Lead Governor on July 2 2013, and re-elected on January 14 2016 by the CoG.

Governor engagement

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

Our Governors also hold Governor and Non-Executive Director briefings without the Executive Directors in attendance to receive updates and discuss matters among themselves. They held eight such meetings during 2017/2018.

A review of the collective performance of the CoG is held annually in June and members of the Board of Directors are invited to attend and support this process. The review is led by the Trust Chair, supported by the Trust Secretary and Membership Manager, and utilises a framework document that incorporates NHS Improvement's Code of Governance. This meeting was held on June 13 2017.

The CoG has a number of active and vibrant sub-committees including Steering Group, Membership Working Group, Staff Governor Working Group, Quality Review Group and the Steering Group and Healthwatch. In addition to this Governors also have an Appointments and Remuneration board sub-committee.

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

Governors are supported and involved in many aspects of the Trust including undertaking Patient Led Assessments of the Care Environment (PLACE) visits, ward reviews and they also assist in the preparation for the Care Quality Commission Inspection by undertaking 'mock inspections' with members of staff.

The Chair invites Governors to take up one-to-ones with her where they are encouraged to attend Trust Board meetings. During the course of the year there have also been two bi-annual half day Governor and Non-Executive Director briefing and training sessions, and a further five sessions on topical health matters which have included:

- Sustainability Transformation Plan
- Operational plan
- Finance training including the forward plan and a simplified NHS finance and Trust update
- Winter pressures update
- Outpatient waiting lists
- Care Quality Commission updates
- Quality Account and various updates
- Staff engagement.

Governors held a series of quarterly Governor and Members' Forums and drop-in sessions throughout 2017/18 which then evolved into the Listening and Engagement events. Governors also utilise the Trust staff and member magazine, Trust website, membership portal website, news releases and emails to communicate with members. During the year Governors also attended a number of community engagement events and held various members recruitment events.

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

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

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

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

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

no time during 2017/18 has the CoG exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust.

Non-Executive Directors attend all CoG meetings and rotate attendance at CoG sub-groups and Governors can hold them to account at any of the sessions as required and appropriate.

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

Appraisal and appointment

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

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

The committee, also on an annual basis, reviews the remuneration of Non-Executive Directors in the context to changes to the cost of living.

It also reviews the remuneration taking in reference to remuneration levels in comparable organisations. It also considers and makes recommendations for the Council of Governors for the reappointment of the Lead Governor.

The council will only exercise its power to remove the Chair or any Non-Executive Director after exhausting all means of engagement with the Board.

The Chair and other NED appraisals for 2017 have been undertaken and reported to the full Council.

Key items discussed in 2017/18

Some of the key items discussed by the CoG during the year were:

- Trust Board minutes
- Strategy and planning
- Sustainability and Transformation Plan and Healthy Lives, Healthy Futures
- Care Quality Commission
- Finance

- Internal sustainability plan
- Overview and ratification of the external auditor contract
- Monthly staffing report, staff morale and staff engagement
- Appointment of the Trust Chair and NEDs (and ratification)
- Performance compliance
- Trust Assurance Framework
- Quality development plan and performance indicators
- Feedback from CoG sub-groups

Reports from Board committees:

- Finance and Performance Committee (FPC)
- Audit, Risk and Governance Committee (ARGC)
- Quality and Safety Committee (QSC)
- Quality and Safety Patient Experience
- Mortality Assurance and Clinical Improvement
- Workforce and Organisational Development Committee (now subsumed within QSC)
- Infection and Prevention Control
- Audit

Membership

Membership Strategy

The Trust has a Membership Strategy for the period 2016 to 2019, which is updated with the help of the Governor's Membership Committee.

This strategy acknowledges that it is the responsibility of a foundation trust to recruit, communicate and engage with members and the broader public as a way of ensuring service provision meets the needs of service users.

The Trust's strategy aims to recruit a representative membership base that is actively engaged in working for the good of the Trust.

The key priorities of the strategy are:

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

Governors perform a key role in recruiting new members. They hold recruitment events within the hospitals, as well as community venues. Governors spend time at these events describing the role of a Trust member and gathering feedback on services across the Trust and its future plans.

All Governors can be contacted via the Trust Membership Office by emailing: nlg-tr.foundationoffice@nhs.net, or by ringing (03303) 302852 or writing to: The Membership Office, Scunthorpe General Hospital, Cliff Gardens, Scunthorpe, North Lincolnshire, DN15 7BH.

An individual who wants to become a member must live within one of the four constituencies and aged 16 and above.

Currently the Trust has 6,122 public members. All staff are automatically enrolled as members on starting employment with the Trust and can choose to opt out if they wish.

The Trust's membership for 2017/18 and the planned membership for 2018/19 are shown below:

	2017/18 planned	2017/18 actual	2018/19 planned
Public constituency: At year start (April 1)	6,300	6,122	6,300
New members	550	720	550
Leaving members	200	175	200
Minimum required under Constitution	1400		1,400
Staff constituency: At year start (April 1)	7,200	7,211	7,200
New members	850	660	850
Members leaving	800	797	800

As at March 31 2018, the Trust had a membership of 13,363 (including 30 members with no date of birth). The number of new members for the period of 2017/18, including staff members was 1,380. The number of members leaving was 972, again, including staff. This is an overall increase of 201members. The tables below provide a detailed breakdown:

Figures as at March 31 2018

Total membership overview	
Public members	6,122
Staff members	7,211
(no DOB)	30
Total members	13,363

Age group – public members	Number	Percentage	Population*
0 to 16	26	0.42%	19%
17 to 21	508	8.30%	6%
22 +	5,557	90.77%	75%
(Not stated)	30	0.49%	n/a
Total	6,122	100%	100%

* Persons under the age of 16 have been excluded from the calculation of population percentages as they are not eligible for Trust membership

Breakdown by constituency

Constituency	Male	Female	Not stated	Total
Goole and Howdenshire	253	374	2	627
North East Lincolnshire	815	1,746	0	2,561
North Lincolnshire	1,029	1,758	2	2,787
East and West Lindsey	259	444	0	703
Staff	1,301	5,910	0	7,211
Total	3,404	10,232	4	13,893

Breakdown by ethnicity

Ethnicity	Number	Percentage	Population	Percentage
White	6,268	93.78%	372,737	97.63%
Mixed	31	0.46%	1,854	0.49%
Asian or Asian British	120	1.80%	5,529	1.45%
Black or Black British	32	0.48%	882	0.23%
Other	0	0%	786	0.21%
Not stated	233	3.49%	0	0%

The current Trust membership generally reflects the demographic of the population served, and is representative for the majority of categories.

Membership recruitment events will continue to be undertaken in 2018/19, some of which will target various groups to further ensure representative membership (eg 16-year-olds through schools and colleges etc).

Keeping in touch with members

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

We issue a 'welcome' pack to all new members which provides an outline of the Trust and what we do. Our membership office strives to maintain contact with members using a variety of methods including:

- Trust website with a designated section for members
- Members' portal – an external website specially designed for member engagement
- Email – newsletters, invites to meetings and volunteer opportunities
- Face-to-face through informal governor drop-in sessions, membership recruitment and engagement events, and attendance at Governor and Member Forums
- Posters around the Trust sites and publicised with our partner organisations
- Twitter and Facebook

The Trust newsletter which is aimed at staff, members and the public is sent out bi-monthly and includes news from across our three hospitals and community services that we think we will be of interest to people, as well as event dates.

Our forum sessions provide members with an opportunity to listen to presentations and debate the hot topics of the day, and our drop-in sessions give people the chance to speak to Governors in private about issues they may be concerned about.

It is also an opportunity for people to pass on their praise for the services they have received. Feedback from the drop-in sessions is shared with the Membership Office who forward on queries or seek responses on behalf of Governors as appropriate and feedback to the Governors.

Disclosures and declarations of interests

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

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

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

Resolution of disputes

The Trust Constitution sets out the process for dealing with any dispute between the Council of Governors and the Trust Board. The Council and Trust Board have a positive working relationship, and the process has not been used during the 2017/18 year.

Remuneration report 2017/18

Introduction

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

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

The details of this are set out in this chapter of the Annual Report.

The NHS Foundation Trust Annual Reporting Manual indicates this means those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or services.

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

The remuneration report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2017/18) as required by NHSI's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager of the Trust during the periods 2017/18 and 2016/17.

The information in this section is not subject to audit by our external auditors, but they will read the narrative to ensure it is consistent with their own knowledge of the Trust. The auditable section is on page 77.

Annual statement on remuneration

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

The key decisions made on senior managers' remuneration in 2017/18 were as follows:

- The Remuneration Committee made its decisions concerning the chief executive and executive directors and there were no substantial changes to the policy or approach
- There was only two uplifts during 2017/18 and in both cases for taking extra responsibility.

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

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

Appointment and Remuneration Committee – Non-Executive Directors' remuneration

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

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

Senior managers' remuneration policy

All directors' performance is subject to an annual appraisal, the outcome of which is reported to the Remuneration Committee by the Chief Executive. This is prior to any decision being made on executive remuneration. The Trust had a number of Chief Executive and Executive movements during 2017/18 which resulted in this being postponed during 2017/18

For the Chief Executive, their appraisal is undertaken by the Chair of Trust with a report then submitted to the

committee this will be completed when the Chief Executive has been in post for a year in 2018.

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

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

In considering senior managers pay the committee has benchmarked against 22 comparator Trusts on an annual basis and the NHS Providers benchmark. This is then reviewed by an external advisor to the committee using the Hay methodology where recommendations are presented. The committee also now follows NHSI pay table recommendations following the guidance being published. Final decisions are taken by the committee. It also took note of the requirement to consider any pay above a threshold of £142,500. This is a requirement from the Secretary of State in respect of salaries higher than that of the national salary of the Prime Minister. All salaries above this threshold have been sanctioned by his office.

Future policy tables

This section describes the policy narrative relating to the components of the remuneration packages for senior managers (Executive and Non-Executive Directors). Each of the components detailed in those tables supports the Trust in terms of its long term strategic objectives.

Setting and reviewing pay is not a simple matter. It is vital to recruit and retain talent and to operate the pay system fairly; but it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money.

In the case of executive jobs, we use the Hay Group Method of job evaluation to identify the scale and challenge in each role. This enables us to make real, like for like comparisons with jobs elsewhere in the economy if this is relevant; it also casts light on internal relativities and on the size of Northern Lincolnshire and Goole jobs compared to those in other trusts and elsewhere in the economy. This helps with the interpretation of remuneration data from the NHS, which tends to be rooted in titles rather than a true assessment of job sizes. This is particularly relevant in relation to pay gap analysis.

These findings then feed into broader discussion of policy and practice, to ensure that the future arrangements match the setting and the roles and are appropriate to the individuals.

The Hay Guide method of determining the relative importance of individual jobs:

The objective of any job evaluation method is to assist those involved in making consistent judgements. These judgements must be explicable and take into account the value standards of the organisation in which they exist. Hay provides a framework for making such judgements, and for checking and assessing their overall consistency.

There are three broad facets which determine the size and importance of any job. These are:

ACCOUNTABILITY: The extent to which the position is held responsible for achieving results, and the degree to which it can directly or indirectly influence the business.

PROBLEM SOLVING: The degree to which the job is required to analyse events, draw conclusions, offer advice, make judgements or be innovative and creative.

KNOW-HOW: The amount of knowledge, skill and experience both general and specific that is needed to meet the Accountability and Problem Solving requirements.

Hay Charts yields numbers (units of job content) which quantify the judgements made. The total of these job units is a reflection of the "size" of the job and forms, when compared with those of other jobs, the pattern of internal relativities upon which the salary structure is based. Certain relationships exist between these common elements. Different types of job will need different combinations of the three. The shape and composition of jobs will differ but their relative value to the organisation can still be explained and expressed through describing the jobs in terms of Know-How, Problem Solving and Accountability.

The Hay Group scheme has found widespread acceptance as it is based on the step difference principle, which is applicable to any job from the shop floor to the Chairman, can relate different cultures

and styles of organisation, and has been shown to be effective in both private and public sectors. Consequently it is now used by more organisations on a worldwide basis than any other single type of evaluation scheme.

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

No new elements were added within the remuneration packages during 2017/18 and no changes to the current elements were made.

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

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

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

The maximum value of each pay element is determined on a case-by-case basis.

The NHSI guidance is also used for positioning of salaries using the tables and guidance produced.

Remuneration policy for Non-Executive Directors

Remuneration of the Chair and Non-Executive Directors for 2017/18 is as follows:

Name	Salary 2017/18	Salary 2016/17
Anne Shaw (Chair)	£50,000	£50,000
Linda Jackson	£12,500 £2,426 for Vice Chair	£12,500
Neil Gammon	£12,500 left July 17	£12,500
Stan Shreeve	£12,500 £2,426 for chair of the Audit Committee	£12,500 £2,426 for chair of the Audit Committee
Sue Cousland	£12,500 left March 18	£12,500
Anthony Bramley	£12,500	£12,500
Sandra Hills	£12,500	£12,500

Future Policy Table for Non-Executive Directors:

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

Performance and appraisal of the Executive Directors

The system of appraisal is the same as all staff, in that the Trust's appraisal process, which is linked to our vision and values, is used to appraise executives.

Service contract obligations

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

All contracts are permanent with no fixed end date. However, one executive position is interim with an end date of May 2018.

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

Policy on payments for loss of office

There is currently no provision within the Remuneration Policy for payment for loss of office on senior managers' contracts and no payments have been made during 2017/18. There is a clause which enables the Trust to reclaim relocation monies if the individual leaves within an agreed period of their appointment. None have been claimed during 2017/18.

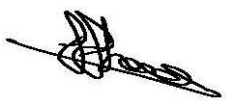
Statement of consideration of employment conditions elsewhere in the Trust

There has been no formal consultation regarding senior managers' Remuneration Policy.

Policy on notice periods

Executive Directors have to provide a period of three months' notice.

Signed: Stan Shreeve: Chair of the Remuneration Committee



Annual report on remuneration

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

- The Remuneration Committee
- The Appointments and Remuneration Committee.

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

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

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

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

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

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

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

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

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

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2017/18 the committee has taken advice internally from the Director of People and Organisational Effectiveness (POE).

Between April 1 2017 and March 31 2018, the Remuneration Committee met five times. The table below illustrates the attendees and their attendance.

Name	Title	Date of attendance
Stan Shreeve	Non-Executive Director/Remuneration Committee Chair January 2017 to May 2017	27.5.17 16.11.17
Tony Bramley	Non-Executive Director/Remuneration Committee Chair from June 2017 to February 2018	27.05.17 16.11.17 15.2.18
Anne Shaw	Trust Chair/ Remuneration Committee Chair from March 2018	15.2.18
Neil Gammon	Non-Executive Director	27.5.2017
Linda Jackson	Non-Executive Director	27.5.17 16.11.17 15.2.18
Jayne Adamson	Director of People and Organisational Effectiveness	27.5.17 16.11.17 15.2.18
Wendy Booth	Director of Performance Assurance and Trust Secretary	15.2.18
Sue Miller	External Advisor	27.5.17
Wendy Stokes	Minute taker	27.05.17 16.11.17 15.2.18

Advice to the committee

External advice to the Remuneration Committee is provided by The Hay Group and People Pool – DAC Beechcroft.

They provide job evaluation and remuneration benchmarking from their NHS executive pay database and interpret that advice with recommendations for the committee.

They also support the job evaluation and pay review process for all Executive Directors.

This provided clarity of job size and relativities which facilitated decision-making on remuneration and enabled the Remuneration Committee to minimise risks of equal pay for equal value claims.

It also provided transparency of the methods of awarding pay and the pay decisions themselves, which mirrors the Agenda for Change process for other staff.

The Remuneration Committee appointed The Hay Group and DAC Beechcroft to provide advice during 2017/18 which was objective and independent in helping it make its decisions around executive remuneration. It paid DAC Beechcroft £4,719.84.

The decision was taken in May 17 to delay the reviews for that year until the appointment of a substantive Chief Executive.

Directors' contracts

Details of the contract start date for the Chief Executive and other members of the Executive Team who served during 2016/17 are set out in the table on the next page.

Name	Title	Date of contract	Notice period from the Trust	Notice period to the Trust
Richard Sunley	Interim Chief Executive Interim Deputy Chief Executive/Director of Operations	March 1 2017 to August 13 2017 August 14 to May 31 2018	Three months	Three months
Karen Jackson	Chief Executive	September 2010	On secondment from January 3 2017 to January 3 2018	
Dr Karen Dunderdale	Deputy Chief Executive/ Director of Operations	June 29 2015	On secondment from July 24 2017 to July 23 2018 - date due to leave	
Dr Peter Reading	Chief Executive	August 18 2017		
Jayne Adamson	Director of People and Organisational Effectiveness	August 1 2016	Three months	Three months
Tara Filby	Chief Nurse	October 9 2015	Three months	Three months
Mr Lawrence Roberts	Medical Director	July 7 2015	Three months	Three months
Kate Wood	Acting Medical Director	October 1 2017 to June 30 2018	Three months	Three months
Wendy Booth	Director of Performance and Assurance	August 2012	Three months	Three months
Marcus Hassall	Director of Finance	August 2014	Three months	Three months
Pam Clipson	Director of Strategy and Planning	June 2014	Three months	Three months
Jug Johal	Director of Estates and Facilities	August 2014	Three months	Three months
Robert Toole	Interim Director of Finance	March 20 2017 to June 30 2017	n/a	n/a

There are no defined end dates to the contracts for substantive staff.

Details of the non-executive directors who have served during the course of 2017/18 are shown in the table below, along with details of their current terms of appointments. The tenure (length) of employment for Non-executive Directors is set out in the Trust's Constitution and is for three years, and then subject to reappointment. Any terms beyond six years is subject to rigorous review by the Council of Governors (CoG) and Non-executive Directors serving beyond this are subject to an annual reappointment.

Name	Appointment date	Start of current term	End of current term
Anne Shaw	15.09.2016	15.09.2016	15.09.2019
Linda Jackson	30.09.2014	30.09.2017	30.09.2019
Neil Gammon	01.08.2010	31.07.2013	31.07.2017
Stan Shreeve	07.06.2012	07.06.2015	07.06.2018
Sue Cousland	10.08.2016	10.08.2016	31.03.2018
Sandra Hills	03.01.2017	03.01.2017	03.01.2019
Anthony Bramley	03.01.2017	03.01.2017	03.01.2019

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

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

The table below shows the number of Appointments and Remuneration Committee meetings in 2017/18 that were attended by each member of the committee.

Meeting dates					
Public Governors	**5.4.17**	**6.9.17**	**6.12.17**	**6.3.18**	**Total**
Jeremy Baskett	A	P	P	P	3 out of 4
Paul Grinell (ARC chair)	P	P	P	P	4 out of 4
Brian Page	P	A	P	P	3 out of 4
Rob Pickersgill	P	P	P	P	4 out of 4
Barbara Jeffreys			P	P	2 out of 2
Tim Mawson	n/a	n/a	P	P	2 out of 2
Liz Stones	A	A	A	A	0 out of 4
Anne Shaw (Trust Chair)	P	A	P	A	2 out of 4
Kathryn Helley (Deputy Director of Performance Assurance and Assistant Trust Secretary)	A	A			
Jayne Adamson Director of People and Organisational Effectiveness)	P	A	P	A	2 out of 4
Wendy Booth (Director of Performance assurance and Trust Secretary)	P	P	P	P	4 out of 4
Angie Davies		P			
David Sprawka			P		
Mano Jamieson				P	

Appointment of Executive and Non-Executive Directors in 2017/18

There was the appointment of a Chief Executive in August 2017 and the appointment of an interim Deputy Chief Executive /Director of Operations in August 17.This appointment is until May 18.

Off-payroll arrangements

For all off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for longer than six months	2017/18 Number of engagements
Number of existing engagements as of 31 March 2018	4
Of which:	
Number that have existed for less than one year at the time of reporting	4
Number that have existed for between one and two years at the time of reporting	0
Number that have existed for between two and three years at the time of reporting	0
Number that have existed for between three and four years at the time of reporting	0
Number that have existed for four or more years at the time of reporting	0

For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last for longer than six months	2017/18 Number of engagements
Number of new engagements, or those that reached six months in duration between 1 April 2017 and 31 March 2018	1
Of which:	
Number assessed as within the scope of IR35	1
Number for assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

For any off-payroll engagements of board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018	2017/18 Number of engagements
Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	1
Number of individuals that have been deemed "board members and/or senior officials with significant financial responsibility". This figure should include both off-payroll and on-payroll engagements.	20

In any cases where individuals are included within the first row of this table, please set out:	
Details of the exceptional circumstances that led to each of these engagements.	Current director on special leave
Details of the length of time each of these exceptional engagements lasted.	The contract ceased on 7 July 2017.

Directors' and governors' expenses

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

Directors and Governors expenses 2017/18

2017/18	Total in office	Total receiving expenses	Total expenses £00's
Directors	20	18	£382
Governors	22	9	£35

Directors and Governors expenses 2016/17

2016/17	Total in office	Total receiving expenses	Total expenses £00's
Directors	21	12	£125
Governors	22	11	£47

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

Remuneration of all other staff

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

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

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

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

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

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

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

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

Salaries are inclusive and there is no additional cost of living award. Strategically, this strategy is designed to enable the Trust to recruit and retain the level of skills and expertise we cannot effectively function without.

The remuneration policy for senior managers is determined independently to that for employees of the Trust.

Audited directors' remuneration 2017/18

Name and Title			2017/18 Salary (bands of £5,000) £000's	2017/18 Benefits on kind (£s, to the nearest £100) £'s	2017/18 Pension related benefit (bands of £2,000) £000's	2017/18 Total (bands of £5,000)	2016/17 Salary (bands of £5,000) £000's	2016/17 Benefits in kind (£s, to the nearest £100) £'s	2016/17 Pension Related benefit (bands of £2,500) £000's	2016/17 Total (bands of £5,000)
Dr J Whittingham		Chairman (resigned 14.9.16)	-	-	-	-	£15-£20	-	-	£15-£20
Mrs A Shaw		Chair (appointed 15.9.18)	£50 - £55	-	-	£50 - £55	£30 - £35	-	-	£30 - £35
Dr P Reading		Chief Executive (appointed 14.8.17)	£125 - £130	3,800	-	£130 - £135				
Mrs K Jackson	1.2	Chief Executive (seconded to NHSI 3.1.17)	-	-	-	-	£145-£150	5,000	£62.5-£65.0	£215-£220
Mr R Sunley	3	Deputy Chief Executive (from 31.8.17)	£145-£150	-	-	£145 - £150	£10 - £15	-	-	£10 - £15
Dr K Dunderdale	1,4	Deputy Chief Executive (acting CEO 3.1.17 to 28.2.17)	£35 - £40	12,000	£20-£22.5	£65-£70	£140 - £145	16,100	-	£160 - £165
Mrs J Adamson	7	Director of People and Organisational Effectiveness (appointed 1.8.16)	£125 - £130	-	-	£125 - £130	£80 - £85	-	£142.5 - £145.0	£225 - £230
Mrs T Filby	1,7	Chief Nurse	£115 - £120	10,200	-	£130 - £135	£115 - £120	5,600	£282.5 - £285.0	£410 - £415
Karen Griffiths	1	Chief Operating Officer (resigned 3.7.17)	-	-	-	-	£30 - £35	1,800	£2.5 - £5.0	£35 - £40
Mr Lawrence Roberts	1	Medical Director	£190 - £195	-	£52.5 - £55.0	£240 - £245	£190 - £195	3,200	£7.5 - £10	£200 - £205
Dr Kate Wood		Acting Medical Director (from 1.10.17)	£75 - £80	-	£75.0 - £77.5	£160 - £165	-	-	-	-
Wendy Booth	1	Director of Performance Assurance & Trust Secretary	£120 - £125	7,500	£65.0 - £67.5	£190 - £195	£120 -£125	4,700	£37.5 - £40.0	£160 - £165
Marcus Hassall	1	Director of Finance	£120 - £125	5,500	£37.5 - £40.0	£160 - £165	£110 - £115	4,600	£45.o - £47.5	£160 - £165
Robert Toole		Acting Director of Finance (resigned 7.7.17)	£70 - £75	-	-	£70 - £75	£10 - £15	-	-	£10 - £15
Pam Clipson		Director of Strategy and Planning	£110 - £115	-	£20.0 - £22.5	£130 - £135	£110 - £115	-	£105.0 - £107.5	£215 - £220
Jug Johal	1	Director of Estates and Facilities	£110 - £115	10,100	£17.5 - £20.0	£140 - £145	£110 - £115	9,200	£80.0 - £82.5	£205 - £210
Claire Phillips	1	Interim Chief Operating Officer (17.7.17 to 30.7.17)	£0 - £5	2,000	£17.5 - £20.0	£20 -£25	-	-	-	-
Alan Bell		Non-Executive Director (resigned 31.12.16)	-	-	-	-	£5 - £10	-	-	£5 - £10
Anthony Bramley		Non-Executive Director	£10 - £15	-	-	£10 - £15	£0 - £5	-	-	£0 - £5
Sue Cousland		Non-Executive Director	£10 - £15	-	-	£10 - £15	£5 - £10	-	-	£5 - £10
Neil Gammon		Non-Executive Director (resigned 31.7.17)	£0 - £5	-	-	£0 - £5	£10 - £15	-	-	£10 - £15
Sandra Hills		Non-Executive Director	£10 - £15	-	-	£10 - £15	£0 - £5	-	-	£0 - £5
Linda Jackson		Non-Executive Director	£10 - £15	-	-	£10 - £15	£10 - £15	-	-	£10 - £15
Stan Shreeve		Non-Executive Director	£15 - £20	-	-	£15 - £20	£10 - £15	-	-	£10 - £15

		2017/18 £000	2017/18 £'s		2016/17 £000	2016/17 £'s	
Gross remuneration including national insurance and pension contributions		1,788	51,100		1,607	50,200	
Band of Highest Paid Director's Total Remuneration (£000)		£190-£195			£190 - £195		
Median Remuneration (£000)		23		5	£22		5
Ratio		8.6		6	8.6		6

1 - Benefit in kind relates to lease cars

2 - Mrs K Jackson seconded to NHS Improvement from 3.1.17 to 31.1.18

3 - Mr R Sunley - Chief Executive from 1.4.17 until to 13.8.17 and Deputy Chief Executive from 31.8.17

4 - Dr K Dunderdale seconded to NHS Improvement from 14.7.17

5 - The median remuneration is the middle item salary when the annualised salaries of all members of staff including agency and seconded staff, (excluding bank staff and he highest paid director) are arranged in descending order.

6 - The ratio is obtained by dividing the highest paid directors salary by the median salary.

7 - The increase in pension related benefit reflects the full year effect of the Director post.

8 - Where the calculation of the pension related benefit results in a negative value, this has been shown as zero.

Audited Pension Benefits 2017/18

Name and Title		Real increase/(Decrease) in pension at age 60 (bands of £2,500) £'000	Real Increase in lump sum at aged 60 related to real increase in pension (bands of £2,500) £'000	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000) £'000	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000) £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Cash Equivalent Transfer Value at 31 March 2018 £'000	Real Increase/(Decrease) in Cash Equivalent Transfer Value £'000
Dr Peter Reading	Chief Executive	-	-	-	-	-	-	0
Richard Sunley	Deputy Chief Executive	-	-	-	-	-	-	0
Jayne Adamson	Director of People and Organisational Effectiveness	(0 - 2.5)	-	20 - 25	-	287	299	(12)
Wendy Booth	Director of Performance Assusrance & Trust Secretary	2.5 - 5.0	2.5 - 5.0	45 - 50	125 - 130	876	776	100
Pam Clipson	Director of Strategy and Planning	0 - 2.5	(0 - 2.5)	30 - 35	75 - 80	385	344	41
Dr Karen Dunderdale	Chief Nurse and Deputy Chief Executive (part year)	0 - 2.5	0 - 2.5	50 - 55	145 - 150	865	759	106
Tara Filby	Chief Nurse	(0 - 2.5)	(12.5 - 15.0)	40 - 45	120 - 125	725	729	(4)
Marcus Hassall	Director of Finance	2.5 - 5.0	0 - 2.5	35 - 40	95 - 100	624	557	67
Jug Johal	Director of Estates and Facilities	0 - 2.5	(0 - 2.5)	15 - 20	30 - 35	210	185	25
Claire Phillips	Acting Director of Operations (part year)	0 - 2.5	0 - 2.5	20 - 25	50 - 55	306	-	306
Mr Lawrence Roberts	Medical Director	2.5 - 5.0	10.0 - 12.5	45 - 50	140 - 145	1,096	986	110
Dr Kate Wood	Acting Medical Director (part year)	2.5 - 5.0	7.5 - 10.0	35 - 40	95 - 100	594	462	132

The Chairman and and Non-Executive Directors do not received pensionable remuneration, therefore there are no entries of pensions for the Chairman and Non-Executive Directors.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme.

The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

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

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another scheme or arrangement) and uses common market valuation factors for the start and end of the period. No inflation factors have been applied this financial year as per the guidance from NHS Pensions Agency.

Name: Dr Peter Reading
Chief executive

Date: 24 May 2018

Staff report

Our staff

We can only realise the Trust's vision and values – Together we care, respect and deliver – if we have an enthusiastic, innovative, hardworking and engaged workforce.

How they feel about working here and their commitment to their patients and the Trust are all essential if they are to provide outstanding care to our patients.

It is absolutely crucial that we recruit and retain the right people, and it is crucial that the organisation supports their health and wellbeing, enable them to maintain the highest knowledge and skills, and support them in doing their jobs.

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

The morale across our staff has been low as demonstrated through the national staff survey and the medical engagement scale.

Since these were undertaken in the autumn of 2017, the Trust has launched its Pride and Respect Programme (anti-bullying campaign). There has been a fantastic response from staff across all disciplines wanting to be involved.

Our quality improvement programme – Improving Together - has a focus on delivering safe staffing. We face critical workforce shortfalls across our workforce, medical and nursing staffing in particular. We are in the process of refreshing our approach to workforce development which has a focus on designing alternative roles. The following provides an insight into progress to date:

Across our medical workforce

- We have commenced a rolling programme of recruitment for Advanced Clinical Practitioners across all divisions; these will be a combination of trainees and also, recruitment of qualified staff. These roles once qualified, will support the gaps within the medical rotas, as well as provide an improved experience for our Junior Doctors
- The Foundation Graduate post (FY3) is being considered; this would be a two year fixed term non-training post to support Junior Doctors in training. This role will also support to fill the medical rotas
- Physician Associates will be a new introduction to NLaG, although Trainees Physician Associates already receive work experience at this Trust. This post will be introduced as part of the workforce planning process, but with a clear remit where they are able to offer the most impact and support medical teams by taking on certain tasks that free up medical time
- To complement the medical workforce, there will also be the introduction of the Doctors Assistant post; this will be a Band 3 post that supports the Doctors in a pro-active follow up capacity to maximise efficiency for medical practitioners by chasing and undertaking administrative tasks. These will be introduced in specific high pressure areas, particularly in where time restrictive activity applies, such as the four hour target in A&E.

Across our nursing workforce

There will be the introduction of Nursing Associates (band 4), that will support the qualified nursing establishment.

This role is in response to the shortage of available band 5 Nurses. The first cohort will be employed within the medicine division.

Nursing and Midwifery are currently working through the feasibility of introducing pre-registered Nursing Apprenticeships to 'grow our own' as there is likely to be limited movement geographically for staff Bands 1-4, and these posts can be filled easily from within our local population.

We currently have a small number of Care Navigators within certain areas of the Trust, namely our acute medical unit and A&E. To release clinical time through reassigning non clinical tasks improves the

inpatient journey, reduces length of stay, reduces deconditioning and improves discharge planning.

The role of Care Navigators across the wards will be considered as part of the workforce planning process with divisions.

Across our workforce

Investment in upskilling current staff as part of the workforce development and retention agenda, such as with the Assistant Practitioners in Therapies, and the Pharmacy Support Technicians, 40 Health Care Assistants will be recruited onto the apprenticeship programme.

Development of roles which will free up the time of our critically short clinical teams enabling our most scarce resource to focus solely on providing care to our patients.

Other considerations will also be given over the next few years as to other innovative roles that could be introduced through the development of clear career progression routes, maximised use of the apprenticeship levy in line with Talent Management and effective appraisals to support staff retention.

By helping to offer ways into health care posts via the Traineeship scheme and the Apprenticeship route can offer an interim and transitional approach by increasing the support within the Trust to release clinical time through reassigning non clinical tasks.

Nurse recruitment

Nurse recruitment activities have been successful, seeing a closing vacancy percentage of 9.3 per cent which equates to approximately 150 whole time equivalents.

This is a reduction from 10.88 per cent which peaked in August 2017. During the year a number of methodologies were used to attract and recruit nurses:

- Newly qualified nurse campaigns, working closely with local and national universities
- Campaigns designed to attract the experienced nurse from the UK and a small number from overseas interviewed using Skype facilities.

We have run a series of successful targeted recruitment schemes to improve registered nurse staffing for areas with high vacancies such as the emergency care centre and maternity services.

We utilised social media and video campaigns which has resulted in increased interest in job applications.

We welcomed 67 newly qualified nurses into the Trust in September and October and are providing preceptorship supported by our continuing practice development team and using our well evaluated 'care camp' approach.

We have also within the nursing directorate been looking at not only recruitment but also retention.

Wide staff engagement resulted in the development of a Trust retention strategy and detailed plan that has been endorsed by NHS Improvement.

Keeping staff informed and engaged

Ensuring that we listen to our staff and take on board their views is pivotal in delivering better outcomes for patients and their care.

It is also recognised that where individuals feel valued and respected, this supports the retention of skilled staff and increases our attractiveness to potential recruits.

During 2017/18 we have undertaken Listening into Action. Its aim was to help us to connect better with everyone who works at the Trust to deliver the best outcomes for our patients and our staff.

Designed to empower people from the grass roots, it set out to empower people to make the 'patient first' changes they have always wanted to happen.

The Trust Board has also set aside dedicated time as part of their monthly meetings to visit different areas of the organisation. Splitting up into four teams, the Executive and Non-Executive Directors visit wards and departments to talk to staff, patients and visitors.

We also:

- Publish a weekly team brief which is emailed out to all staff
- Bulletins are posted on the Trust's intranet
- All staff emails issued with news and updates
- A bi-monthly staff and member magazine is printed and distributed to wards and departments, and emailed out to all staff
- The Chief Executive holds a monthly senior leadership community briefing.

Apprenticeships

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

As a Trust we are faced with skills shortages and an ageing workforce and we know that 'growing our own' is a key strategy for

the development and retention of our managers and staff.

During the past 12 months, senior leadership teams have reviewed how the apprenticeship levy can support the Trust's key learning and development as well as recruitment and retention needs. The organisation took the decision to maximise use of the levy and to aim to achieve the government target of achieving 2.3 per cent of the workforce as apprentices.

The Trust's target for 2017/18 apprenticeships was 148 apprentices, and with the structured and sound approach adopted, we have already achieved 169 apprenticeship starts.

While the levy has been a contributing factor in driving change to the way that training is delivered and provided, leading up to its introduction work had already begun looking at how the management of apprenticeships could become more beneficial and focused on the needs of the Trust, as well as linked to the recruitment and retention strategy.

The Executive Team and Board have approved high quality apprenticeship provision as a fundamental component of the organisation's long-term workforce development strategy.

They receive regular reports as to the success of this provision in addressing specific hard-to fill vacancies, skill shortages and in improving patient care through a more flexibly highly skilled workforce.

Managers across the Trust have been engaged to provide information to existing staff about what is available, dispelling myths and explaining how apprenticeships can help with workforce planning but ensuring managers understand the commitment apprenticeships need in terms of support and their team's commitment to an apprentice's development.

A current example, the Trust is looking to develop a nursing apprenticeship programme of sufficient quality to challenge conventional routes into nursing and attract young people direct into the organisation at grass roots level.

The Trust has adopted a set of quality principles to underpin the quality of apprenticeships, to demonstrate commitment and to ensure consistency across the Trust.

A centrally managed system was established to ensure that apprenticeship recruitment is always considered when a suitable vacancy arises.

In practice, this does not apply to every vacancy and offers are only made where it is believed that the Trust can deliver a quality learning experience.

As a result, apprenticeships are becoming embedded in a wide range of departments, and they are offered in a range of disciplines.

The recruitment and workforce team, together with our providers, have developed an innovative and robust entry-level apprenticeship scheme for specific job roles.

The Trust has also introduced a new recruitment process to create a talent pool of individuals who are considered 'apprenticeship ready' and this has vastly reduced the time it takes to recruit, using traineeships as one of the recruitment tools. All our apprenticeships have a guaranteed job at the end of the training.

In terms of staff development, apprenticeships have been identified as a substantive opportunity to provide sound deep learning opportunities to provide staff development to support progression.

Employment contracts have been reviewed in agreement with the unions, and a structure implemented utilising apprenticeships as a key requirement in terms of development, competency and progression across Trust roles.

As a Trust we have broadened our delivery from two apprenticeships to 23 apprenticeships within the last year.

Provision includes level 3 engineering, level 5 healthcare, level 3, 5 and 6 leadership and management, level 5 facilities management and level 6 healthcare science. There are currently 84 individuals on higher apprenticeships.

Roles that traditionally would have been recruited to using fully qualified applicants are now available to new external applicants through an apprenticeship route, including engineering, allowing individuals to train and acquire competency.

This is about encouraging individuals to consider an apprenticeship instead of university and to support our local community. We have already been able to offer level 3 upwards opportunities to new recruits and there is potential for further opportunities including nursing.

The Trust's delivery became

subject to tender with the implementation of the Levy and we now have a small number of trusted and reliable providers delivering the majority of our apprenticeships.

The relationships are built on a shared ethos of 'quality provision to enhance patient journey' and training providers work in partnership together and with the Trust.

This is an innovative development as providers are obviously in competition with each other, but with tenders awarded it has been key to the Trust to have a consistent and joined-up approach to delivery and management of apprenticeships.

Providers have embedded their managers and assessors within NLaG. Managers and apprenticeship leads and assessors regularly meet with managers and teams focused on development, delivery, quality and joint working.

Specific providers have recruited assessors who are based within the Trust who report to the Trust's Head of People Development on a daily basis, as well as the provider's line manager.

This supports efficient and effective working practices including team working, communications and problem solving.

The embedded assessors attend internal training and communications, which allow them to fully instil the Trust's requirements into the apprenticeships; including attendance at Trust senior management meetings.

This ensures that Trust developments and operational

topics are embedded within delivery.

As part of the provider-employer relationship the Trust is also benefiting from other partnership opportunities including existing staff being able to engage in learning by attending apprenticeship sessions on an in-fill basis for modules; staff being offered training provider continual professional development (CPD) opportunities including assessor and mentoring training; and joint conferences for apprentices offered to other Trust staff and provider learners.

Apprenticeship programmes are designed to support the organisation's workforce development objectives to deliver better patient outcomes, while at the same time providing the learner with the skills, qualifications and ambition to succeed in their role and progress to the next level.

Apprenticeships have allowed us to offer development opportunities to existing staff that we were not previously able to offer including level 3 qualifications to band two roles.

Apprenticeship delivery across the organisation follows consistent, clearly stated policies and procedures, and a clear and well understood apprenticeship 'identity' is used to help support positive perceptions of quality and relevance among learners and staff.

Learners are able to benefit from access to wider development opportunities and additional resources that are effectively integrated into their apprenticeship programme.

The Trust works with providers to ensure that the apprenticeship delivers what the Trust needs to make a real impact in the workplace.

Examples are property maintenance apprentices accessing computer aided design and specialist ventilation training; and engineering apprentices completing 17th edition training.

These courses are also being opened up to provide CPD for the provider's staff and to Trust staff not on the apprenticeship.

Although it is early days, managers and staff at the Trust are recognising a positive impact on staff retention, innovation and employee engagement.

Staff costs

In line with the HM Treasury requirements, some previous accounts disclosures relating to staff costs are now required to be included in the staff report section of the annual report instead. The following tables link to data contained in the TAC and are included here for ease of formatting for the annual report. They should not be included in the annual accounts and these tables are not a complete list of numerical disclosures for the staff report.

Staff costs				
Number of material transactions with other revenue and capital payments from a number of revenue and capital payments from a number of:	Group			
			2017/18	2016/17
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	188,987	9	188,996	187,830
Social security costs	19,435	–	19,435	17,184
Apprentices levy	999	–	999	
Employer's contributions to NHS pensions	21,458	–	21,458	21,436
Pension cost - other	–	–	–	–
Other post employment benefits	–	–	–	–
Other employment benefits	–	–	–	–
Termination benefits	–	–	–	–
Temporary staff		26,247	26,247	22,428
NHS charitable funds staff	–	–	–	–
Total gross staff costs	**230,879**	**26,256**	**257,135**	**248,878**
Total staff costs	230,879	26,256	257,135	248,878
Of which				
Costs capitalised as part of assets	–	–	–	–

Breakdown of male and female employees

At the end of the financial year, the breakdown of male and female staff was as follows (headcount):

	Director	Other senior managers	Employees	Total
Male	6	72	1,124	1,201
Female	4	136	5,002	5142
Total	10	208	6,126	6,344

*Senior managers have been classified as staff band 8 or above.

Workforce statistics

Average number of employees (WTE basis)	Group			
			2017/18	2016/17
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	489	109	598	624
Ambulance staff	–	–	–	–
Administration and estates	1,257	26	1,283	1,285
Healthcare assistants and other support staff	1,085	33	1,118	1,125
Nursing, midwifery and health visiting staff	1,507	240	1,747	1,746
Nursing, midwifery and health visiting learners	–	–	–	–
Scientific, therapeutic and technical staff	1,033	24	1,057	1,051
Healthcare science staff	–	–	–	–
Social care staff	–	–	–	–
Other	–	–	–	–
Total average numbers	5,371	432	5,803	5,831
Of which:				
Number of employees (WTE) engages on capital projects	–	–	–	–

Workforce sickness absence figures

Figures converted by DH to Best Estimates of Required Data Return		Statistics published by NHS Digital from ESR Data Warehouse	
	Expected sign	2017/18 Number	2016/17 Number
Total days lost	+	55,202	58,155
Total staff years	+	5,401	5,430
Average working days lost (per WTE)	+	**10**	**11**

Staff policies and actions

Policies applied during the year for giving full and fair consideration to applications for employment made by disabled persons	The Trust has a recruitment and selection policy, which sets out how the Trust ensures fair recruitment practices throughout the attraction, selection and recruitment of candidates, including compliance with the JobCentre Plus "Disability Confident" standards. This is reviewed through the Trust's electronic tracking 'TRAC' recruitment system.
Policies applied for continuing the employment of, and for arranging appropriate training for, employees who become disabled during the period	The Trust adheres to the Equality Act 2010, and has in last financial year introduced an Equality Impact Assessment Policy and Procedure that supports, line managers to make reasonable adjustments and use referrals to the occupational health team to ensure the continued employment of employees who become disabled persons. In addition, the HR team provides direct support to staff affected and their managers.

Policies applied during the year for the training, career development and promotion of disabled employees	There is equality access to training for all staff. Policies applied during the year for the training, career development and promotion of disabled employees are: • Personal Development Review Policy • Recruitment Policy • Attendance Management Policy • Managing Employee Performance • Special Leave Policy • Safeguarding Policy All our policies have an equality impact assessment.
Actions taken in the year to provide employees systematically with information on matters of concern to them as employees	The Trust uses a variety of internal communications channels to inform staff including: all staff emails; a weekly team brief which is emailed to all staff; bulletins posted on the Intranet; chief executive monthly senior leadership community briefing; face-to-face channels and our staff/members magazine.
Actions taken to consult staff on a regular basis so that the views of staff can be taken into consideration in making decisions which are likely to affect their interests	The Trust has regular meetings with its Joint Negotiating Consultative Committee for formal discussions relating to staffing issues. Collective consultations would be enacted where there are more specific issues affecting employees ie restructures. In addition an initiative called Pride & Respect was launched which will involve employees in developing a cultural change programme designed to improve engagement with all staff.
Actions taken to encourage the involvement of staff in the trust's performance	2017 saw the launch of Listening into Action a nationally recognised grass roots initiative that empowers frontline staff to bring their improvement ideas to life.

Fraud, bribery and corruption statement

Fraud costs the NHS millions of pounds a year that could have been spent on patient care, so everyone has a duty to help prevent it.

NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS.

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

The NHS Counter Fraud Authority (NHSCFA) provides the national framework through which NHS trusts seek to minimise losses through fraud.

The Director of Finance is nominated to lead counter fraud work and is supported by the Trust's Local Counter Fraud Specialist (LCFS).

The Trust follows the guidance contained in the NHS Provider Standards and ensures our contractual obligations with our local clinical commissioning groups are adhered to.

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

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

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

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

An annual work plan, approved by the Director of Finance with oversight from the Trust's Audit, Risk and Governance Committee, has been in place over the last year.

The key aims are to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and ensure that allegations of

fraud are appropriately and professionally investigated to a criminal standard.

Progress reports on all aspects of counter fraud work and details of investigations are received at each meeting of the Trust's Audit, Risk and Governance Committee.

The Trust has a well-publicised system in place for staff to raise concerns if they identify or suspect fraud.

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

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

Information on health and safety performance

Health and safety compliance is managed by the health, safety and fire team.

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

During the period the health, safety and fire team transferred to the directorate of Estates and Facilities and now has closer links with Estates and Facilities.

Governance and Health and Safety Groups have been established as well as those existing with other groups such as ARG, Security Group and Joint Negotiating Consultative Committee (a Senior Management Team from Estates and Facilities attends JNCC).

Highlight reports are submitted where appropriate to the relevant groups and board briefings on health and safety are undertaken at appropriate times.

Working with the Estates and Facilities directorate has strengthened the input of fire, health and safety advice into projects at an early stage to ensure projects are delivered on time and meet requirements when returned to operational use.

The Health, Safety and Fire Sub Group continues to review reports, policies and accident data on issues relating to the following areas of health and safety: fire, manual handling, security, training, estates and facilities, occupational health, staff incidents, stress, radiation protection and non-clinical risk management.

Health and safety incidents are logged on the Trust's Datix incident reporting system, while risk assessments are carried out and logged on the Safety, Health and Environment (SHE Assure) software package.

Health and safety training is mandatory for all staff on induction and additional health and safety training is delivered to staff where required.

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

Information on occupational health

Our occupational health team works to try and keep our workforce as healthy as possible.

They provide a range of services to both NLaG and external companies including pre-employment health clearances, ill health assessments and support to stay in or return to work.

Members of staff can refer themselves to the service or can be referred by their managers.

The team continues to develop its IT systems to gain efficiencies and continuously reviews its processes to ensure they are lean and maximise their resources.

Their achievements during 2017/18 include:

- The Silver Healthy Workplace Award
- A flu vaccination uptake of 72.6 per cent of frontline workers which met the CQUIN target but more importantly kept staff, colleagues and patients safe
- Continuing positive feedback from the members of staff accessing the service.

Staff survey report

The Trust conducted an all-staff national census staff survey between September and December 2017. From the 6,156 eligible staff, 2,066 completed surveys were returned. The findings report was provided to the Trust, under embargo, in February 2018 and published on March 6 2018.

Response rate				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (trust type) average	
Response rate	41.4%	33.6%	45.5%	Decrease in 7.8%

The staff survey was just one of several mechanisms the Trust used to engage with staff during 2017/18, some of the other methods were:

- Listening into Action Pulse Check Survey and Crowdfixing events – here staff were encouraged to discuss their frustrations at work and from this, together with leadership teams, seek out and implement solutions
- Equality and Diversity in-house survey where staff were asked to comment on their sense of inclusion and equality of opportunity at work
- Barrett Organisational Culture Values Assessment which helped the Trust to review with its staff the current vision and values and the associated 'standards of expected behaviour' framework.

In addition to the above, a monthly Chief Executive-led leadership community briefing was launched providing a new foundation for Board to ward information cascade.

This platform complements the existing bimonthly NLG@News newsletter, the local divisional newsletters and the weekly news and update which is emailed out to all staff.

Reviewing the staff survey results across the NHS as a whole reveals the impact of the overall pressures. This is reflected in the reduced number of staff nationally recommending the NHS as a place to work.

This trend was reflected locally in the Trust's own staff survey findings report. Although disappointing, it was not surprising given the Trust's organisational context of quality and financial special measures. Reviewing the Trusts staff survey 2018 key findings reveals:

- 0 have statistically significantly improved during 2017
- 13 remain unchanged from the 2016 staff survey report
- 19 have statistically significantly deteriorated in the last 12 months.

The staff survey results are as follows on page 89.

Top 5 ranking scores				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (trust type) average	
KF16 % of staff working extra hours	70%	71%	72%	Improvement
KF20 % of staff experiencing discrimination at work	11%	12%	12%	Deterioration
KF27 % of staff reporting most recent experience of harassment, bullying or abuse	47%	45%	45%	Improvement
KF29 % of staff reporting errors, near misses or incidents witnessed in the last month	92%	90%	90%	Improvement
KF11 % staff appraised in the last 12months	88%	86%	86%	Improvement

Bottom 5 ranking scores				
	2016/17	2017/18		Trust improvement/ deterioration
	Trust	Trust	Benchmarking group (trust type) average	
KF13 Quality of non-mandatory training, learning or development	4.02	3.90	4.05	Deterioration
KF7 % staff able to contribute towards improvements at work	65%	59%	70%	Deterioration
KF15 % staff satisfied with the opportunities for flexible working	44%	40%	51%	Deterioration
KF5 recognition and value of staff by managers and the organisation	3.30	3.21	3.45	Deterioration
KF32 Effective us of patient /service user feedback	3.51	3.41	3.71	Deterioration

Future priorities and targets

The Trust recognises that its greatest asset is its staff. As such the Trust's Improving Together plan contains numerous staff focused workstreams, including (but not limited to):

- Continuing the highly successful LiA Crowdfixing events
- Improving medical engagement, including the review of divisional structures and ensuring that effective clinical leadership is evidenced in the Trust and its decision making processes
- Further development of its nationally recognised apprenticeship programme
- Continued review of workshop establishments to enable the introduction of new roles such as Advanced Clinical Practitioners to support services and the medical rotas
- An extensive and targeted recruitment programme supported by a tailored Staff Retention Strategy and a wide range of retention deliverables.

The above workstreams performance and outputs are monitored through the Trust's Improving Together Oversight Committees and Improving Together Board. These workstreams will positively contribute to overcoming staffs concerns within the 2017 staff survey.

Importantly though the Trust recognised that as well as these initiatives, transformational change is required if it is to see improvements in, among other things, staff survey results and staffs' perception of working at NLaG.

Consequently the Trust, rather than embarking on a multi-stranded transactional action plan to address all the concerns within the findings report, is instead investing in a two workstream, staff engagement orientated, transformation approach to address staffs concerns:

- **Staff Survey Workstream 1:** Significant and sustained corporate investment in staff engagement, including investing heavily in increasing staff voice to improve clinical/non-clinical services
- **Staff Survey Workstream 2:** Invest in divisional Staff Survey Action Teams. Each divisional leadership team, working in partnership with their own staff, to jointly agree between themselves a maximum of three areas from within the survey that they want to improve within their area of work.

The above two workstreams will be monitored through the 'Culture and Organisational Development' Improving Together workstream. Additionally progress reports will be presented at the Trust Management Board and Trust Board itself. The staff survey transformational workstreams started in April 2018. The measure of success will be taken from quarterly pulse check surveys aligned to staff survey key finding KPIs and ultimately by the findings within the 2018 staff survey report.

Expenditure on consultancy

The Trust during 2017/18 has spent £3,230k on consultancy fees compared to £551k in the previous financial year.

Staff exit packages

Foundation trusts are required to disclose summary information of their use of their use of exit packages agreed in the year. This disclosure reports the number and value of exit packages agreed during the year 2017/18.

Reporting of compensation schemes - exit packages 2017/18			
	Number of compulsory redundancies	Number of other departures	Total number of exit packages
	Number	Number	Number
Exit package cost brand (including any special payment element)			
<£10,000	–	–	–
<£10,001 - £25,000	–	–	–
£25,001 - £50,000	–	–	–
£50,001 - £100,000	–	–	–
£100,001 - £150,000	–	–	–
£150,001 - £200,00	–	–	–
>£200,000	–	–	–
Total number of exit packages by type	–	–	–
Total resource cost (£)	£0	£0	£0

Reporting of compensation schemes - exit packages 2016/17			
	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	–	–	–
<£10,001 - £25,000	1	–	1
£25,001 - £50,000	–	–	–
£50,001 - £100,000	–	–	–
£100,001 - £150,000	–	–	–
£150,001 - £200,00	–	–	–
>£200,000	–	–	–
Total number of exit packages by type	1	–	1
Total resource cost (£)	£20,000	£0	£20,000

	2017/18		2016/17	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	–	–	–	–
Mutually agreed resignations (MARS) contractual costs	–	–	–	–
Early retirements in the efficiency of the service contractual costs	–	–	–	–
Contractual payments in lieu of notice	–	–	–	–
Exit payments following Employment Tribunals or court orders	–	–	–	–
Non- contractual payments requiring HMT approval	–	–	–	–
Total	–	–	–	–
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	–	–	–	–

NHS Foundation Trust Code of Conduct

The NHS Foundation Trust Code of Governance (the Code of Governance) was first published in 2006 and was most recently updated in July 2014.

The purpose of the Code of Governance is to assist NHS foundation trust boards in improving their governance practices by bringing together the best practice of public and private sector corporate governance.

The code is issued as best practice advice, but imposes some disclosure requirements.

Northern Lincolnshire and Goole NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis.

The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

For the year ending March 31 2018, the Board considers that it was fully compliant with the provisions of the NHS Foundation Trust Code of Governance.

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

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

- Supporting governors to appoint non-executive directors and external auditors with appropriate skills and experience
- Ensuring a tailored and in-depth induction programme for new non-executive directors and governors
- Facilitating an external review of the Trust's governance arrangements
- Working with governors to ensure they can engage with and hold the Board to account
- Ongoing review of compliance with the Code of Governance by the Council of Governors and Board of Directors when making decisions which impact on governance arrangements.

Full details on the disclosure required by the Code of Governance are below:

Part of schedule A	Relating to	Code of Governance reference	Summary of requirement	Where located in the annual report and further explanation
2: Disclose	Board and Council	A.1.1	Clear statement detailing roles and responsibilities of the council of governors. Should also describe how any disagreements between the CoG and the board of directors will be resolved. Statement on how the board of directors and the CoG operate, including a summary of the types of decisions taken by each of the boards and which are delegated to the executive management of the board of directors.	Governor report – role of the governors Governor report – resolution of disputes Directors' report –operation of the Board

2: Disclose	Board, Audit and REMCOM	A.1.2	Identify the chairperson, the deputy chair, the CEO, the senior independent director and the chair of the audit and REMCOM. Also set out the number of meetings of the board and those committees and individual attendance by directors.	Directors' report Directors' report
2: Disclose	Council of Governors	A.5.3	Identify the members of the council, including a description of the constituency or organisation they represent, whether they were elected or appointed, and the duration of the appointments. Should identify the lead governor.	Governor report – members of the Council of Governors
Additional requirement of FT ARM	Council of Governors	n/a	Statement about the number of meetings of the CoG and individual attendance by governors and directors.	Governor report – governor attendance at Council of Governors
2: Disclose	Board	B.1.1	Identify each non-executive director it considers to be independent, with reasons where necessary.	Directors' report
2: Disclose	Board	B.1.4	A description of director's skills, expertise and experience. Alongside this a clear statement about the board's balance, completeness and appropriateness to the requirements of the FT.	Directors' report – brief details of serving executives and non-executives Directors' report – balance of the board
Additional requirement of FT ARM	n/a	n/a	Brief description of the length of appointment of the non-execs, and how they may be terminated.	Directors' report
2: Disclose	ARC	B.2.10	Describe the work of the Appointments and Remuneration Committee (ARC), including the process it has used in relation to board appointments.	Governor report
Additional	ARC	n/a	An explanation if neither an external search consultancy nor open advertising has been used in the appointment of a chair or non-exec director	No Non-Executive Directors appointed in 2017/18
2: Disclose	Chair/CoG	B.3.1	Chair's other significant commitments should be disclosed. Changes to such commitments should be reported to the CoG as they arise, and included in the next annual report.	Directors' report
2: Disclose	Council of Governors	B.5.6	Governors should canvass the opinion of the trust's members and the public, and for appointed governors the body they represent, on the NHS foundation trust's forward plan, including its objectives, priorities and strategy, and their views should be communicated to the board of directors.	Governor report – governor engagement

			The annual report should contain a statement as to how this requirement has been undertaken and satisfied.	
Additional requirement of FT ARM	Council of Governors	N/A	If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. *Power to require one or more of the directors to attend a governors meeting for the purpose of obtaining information about the foundation trust's performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors performance). ** As inserted by section 151(6) of the Health and Social Care Act 2912).	Governor report – holding the Non-Executive Directors to account for the performance of the Trust Board
Disclose	Board	B.6.1	The board of directors should state in the annual report how performance evaluation of the board, its committees, and its directors, including the chair, has been conducted.	Directors' report – operation of the Board
Disclose	Board	B.6.2	Where there has been external evaluation of the board and/ or governance of the trust, the external facilitator should be identified in the annual report and a statement made as to whether they have any other connection to the trust.	Directors' report – Evaluation of the Board/its committees/ directors and Chair
Disclose	Board	C.1.1	The directors should explain their responsibility for preparing the annual report and accounts, and state that they consider the annual report and accounts, taken as a whole, are fair, balanced and understandable and provide the information necessary for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.	

			Directors should also explain their approach to quality governance in the Annual Governance Statement (within the annual report).	Directors' report - Statement as to disclosures to auditors
Disclose	Board	C.2.1	The annual report should contain a statement that the board has conducted a review of the effectiveness of its system of internal controls.	Directors' report - Trust Audit, Risk and Governance Committee
Disclose	Audit committee /control environment	C.2.2	A trust should disclose in the annual report: a)If it has an internal audit function, how the function is structured and what role it performs; or (b)If it does not have an internal audit function, that fact and the processes it employs for evaluating and continually improving the effectiveness of its risk management and internal control processes	Director's report – Trust Audit, Risk and Governance Committee
Disclose	Audit Committee/ Council of Governors	C.3.5	If the Council of Governors does not accept the Audit Committee's recommendation on the appointment, reappointment or removal of an external auditor, the board of directors should include a statement in the annual report from the Audit Committee explaining the recommendation and should set out reasons why the Council of Governors has taken a different position.	Not applicable
Disclose	Audit Committee	C.3.9	A separate section of the annual report should describe the work of the audit committee in discharging its responsibilities. The report should include: (a)The significant issues that the committees considered in relation to financial statements, operations and compliance, and how these issues were addressed (b)An explanation of how it has addressed the effectiveness of the external audit process and the approach taken to the appointment or re-appointment of the external auditor, the value of external audit services and information on the length of tenures of the current audit firm and when a tender was last conducted (c) If the external auditor provides non-audit services, the value of the non-audit services provided and an explanation of how auditor objectivity and independence	Director's report – Trust Audit, Risk and Governance Committee

Disclose	Board/ Remuneration Committee	D.1.3	Where an NHS FT releases an executive director, for example to serve as a Non-Executive Director elsewhere, the remuneration disclosures of the annual report should include a statement of whether or not the director will retain such earnings.	Not applicable
Disclose	Board/ Membership	E.1.6	The board of directors should monitor how representative the NHS foundation trust's membership is and the level and effectiveness of member engagement and report on this in the annual report.	Membership report
Disclose	Membership	E.1.4	Contact procedures for members who wish to communicate with governors and/or directors should be made clearly available to members on the NHS foundation trust's website and in the annual report.	Membership report
Additional requirement of FT ARM	Membership	N/A	The annual report should include: (a)A brief description of the eligibility requirements for joining different membership (b)Information on the number of members and the number of members in each constituency (c)A summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership including progress towards any recruitment targets for members	Membership report - membership strategy
Additional requirement of FT ARM	Board/ Council of Governors	N/A	The annual report should disclose details of company directorships or other material interests in companies held by governors and/or directors where those companies or related parties are likely to do business, or are possible seeking to do business, with the NHS foundation trust. As each NHS foundation trust must have registers of governors' and directors; interests which are available to the public, and alternative disclosure is for the annual report to simply state how members of the public can gain access to the registers instead of listing all the interests in the annual report.	Membership report – disclosures and declarations of interests Directors' report – Registers of interest

Comply or explain	Board	A.1.4	The board should ensure that adequate systems and processes are maintained to measure and monitor the NHS FT's effectiveness, efficiency and economy as well as the quality of its healthcare delivery	Directors' report – Operation of the Board
6: Comply or explain	Board	A.1.5	The board should ensure that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance	Directors' report - Evaluation of the Board/its committees/ directors and Chair
6: Comply or explain	Board	A.1.6	The board should report on its approach to clinical governance.	Directors' report – Trust Board approach to clinical governance
6: Comply or explain	Board	A.1.7	The chief executive as the accounting officer should follow the procedure set out by NHS Improvement for advising the board and the council and for recording and submitting objections to decisions.	Comply
2: Disclose	Board	E.1.5	The board of directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS FT, for example through attendance at meetings of the CoG, direct face-to-face contact, surveys of members' opinions and consultations.	Directors' report – Operation of the Board
Additional requirements of FT ARM	Membership	n/a	The annual report should include: • a brief description of the eligibility requirements for joining different membership constituencies, including the boundaries for public membership • information on the number of members and the number of members in each constituency; and • a summary of the membership strategy, an assessment of the membership and a description of any steps taken during the year to ensure a representative membership [see also E.1.6 above], including progress towards any recruitment targets for members	Membership report
6: Comply or explain	Board	A.1.8	The board should establish the constitution and standards of conduct for the NHS foundation trust and its staff in accordance with NHS values and accepted standards of behaviour in public life.	Directors' report – Code of Conduct of the Trust Board

6: Comply or explain	Board	A.1.9	The board should operate a code of conduct that builds on the values of the NHS foundation trust and reflect high standards of probity and responsibility.	Directors' report – Code of Conduct of the Trust Board
6: Comply or explain	Board	A.1.10	The NHS foundation trust should arrange appropriate insurance to cover the risk of legal action against its directors.	Directors' report - Operation of the Board
6: Comply or explain	Chair	A.3.1	The chairperson should, on appointment by the council, meet the independence criteria set out in B.1.1. A chief executive should not go on to be the chairperson of the same NHS foundation trust.	Membership report – disclosures and declarations of interests
6: Comply or explain	Board	A.4.1	In consultation with the council, the board should appoint one of the independent non-executive directors to be the senior independent director.	Directors' report – Senior Independent Director
6: Comply or explain	Board	A.4.2	The chairperson should hold meetings with the non-executive directors without the executives present.	Governor report – Governor engagement
6: Comply or explain	Board	A.4.3	Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, they should ensure that their concerns are recorded in the board minutes.	Directors' report - How the Directors are assisted in their roles
6: Comply or explain	Council of Governors	A.5.1	The council of governors should meet sufficiently regularly to discharge its duties.	Governor report – composition of the Council of Governors
6: Comply or explain	Council of Governors	A.5.2	The council of governors should not be so large as to be unwieldy.	Governor report – composition of the Council of Governors
6: Comply or explain	Council of Governors	A.5.4	The roles and responsibilities of the council of governors should be set out in a written document.	Governor report – role of the governors
6: Comply or explain	Council of Governors	A.5.5	The chairperson is responsible for leadership of both the board and the council but the governors also have a responsibility to make the arrangements work and should take the lead in inviting the chief executive to their meetings and inviting attendance by other executives and non-executives, as appropriate.	Governor report – governor engagement
6: Comply or explain	Council of Governors	A.5.6	The council should establish a policy for engagement with the board of directors for those circumstances when they have concerns.	Governor report – holding the Non-Executive Directors to account

6: Comply or explain	Council of Governors	A.5.7	The council should ensure its interaction and relationship with the board of directors is appropriate and effective.	Governor report – holding the Non-Executive Directors to account
6: Comply or explain	Council of Governors	A.5.8	The council should only exercise its power to remove the chairperson or any non-executive directors after exhausting all means of engagement with the board.	Governor report – appraisal and appointment
6: Comply or explain	Council of Governors	A.5.9	The council should receive and consider other appropriate information required to enable it to discharge its duties.	Governor report – Council of Governors
6: Comply or explain	Board	B.1.2	At least half the board, excluding the chairperson, should comprise non-executive directors determined by the board to be independent.	Directors' report – Operation of the Board
6: Comply or explain	Board/ Council of Governors	B.1.3	No individual should hold, at the same time, positions of director and governor of any NHS foundation trust.	Comply
6: Comply or explain	ARC(s)	B.2.1	The nominations committee or committees, with external advice as appropriate, are responsible for the identification and nomination of executive and non-executive directors.	Comply: Directors' report
6: Comply or explain	Board/ Council of Governors	B.2.2	Directors on the board of directors and governors on the council should meet the "fit and proper" persons test described in the provider licence.	Directors' report – Code of Conduct for the Trust Board. Membership report - Disclosures and declarations of interests
6: Comply or explain	Remuneration Committee	B.2.3	The nominations committee(s) should regularly review the structure, size and composition of the board and make recommendations for changes where appropriate.	Comply
6: Comply or explain	ARC committee	B.2.4	The chairperson or an independent non-executive director should chair the nominations committee(s).	Comply
6: Comply or explain	Nomination Committee(s)/ Council of Governors	B.2.5	The governors should agree with the nominations committee a clear process for the nomination of a new chairperson and non-executive directors.	Governor report -Appraisal and Appointment
6: Comply or explain	Nomination Committee(s)	B.2.6	Where an NHS foundation trust has two nominations committees, the nominations committee responsible for the appointment of non-executive directors should consist of a majority of governors.	Comply
6: Comply or explain	Council of Governors	B.2.7	When considering the appointment of non-executive directors, the council should take into account the views of the board and the nominations committee on the qualifications, skills and experience required for each position.	Membership report – appraisal and appointment

6: Comply or explain	Council of Governors	B.2.8	The annual report should describe the process followed by the council in relation to appointments of the chairperson and non-executive directors.	Membership report – appraisal and appointment
6: Comply or explain	Remuneration Committee	B.2.9	An independent external adviser should not be a member of or have a vote on the nominations committee(s).	Remuneration report
6: Comply or explain	Board	B.3.3	The board should not agree to a full-time executive director taking on more than one non-executive directorship of an NHS foundation trust or another organisation of comparable size and complexity.	Directors' report
6: Comply or explain	Board/ Council of Governors	B.5.1	The board and the council governors should be provided with high-quality information appropriate to their respective functions and relevant to the decisions they have to make.	Directors' report – Operation of the Board Governor report – Council of Governors
6: Comply or explain	Board	B.5.2	The board, and in particular non-executive directors, may reasonably wish to challenge assurances received from the executive management. They need not seek to appoint a relevant adviser for each and every subject area that comes before the board, although they should, wherever possible, ensure that they have sufficient information and understanding to enable challenge and to take decisions on an informed basis.	Directors' report – Operation of the Board
6: Comply or explain	Board	B.5.3	The board should ensure that directors, especially non-executive directors, have access to the independent professional advice, at the NHS foundation trust's expense, where they judge it necessary to discharge their responsibilities as directors.	Directors' report - How the Directors are assisted in their roles
6: Comply or explain	Board/ Committees	B.5.4	Committees should be provided with sufficient resources to undertake their duties.	Directors' report – Board Committees
6: Comply or explain	Chair	B.6.3	The senior independent director should lead the performance evaluation of the chairperson.	Directors' report – Senior Independent Chair
6: Comply or explain	Chair	B.6.4	The chairperson, with assistance of the board secretary, if applicable, should use the performance evaluations as the basis for determining individual and collective professional development programmes for non-executive directors relevant to their duties as board members.	Comply

6: Comply or explain	Chair/Council of Governors	B.6.5	Led by the chairperson, the council should periodically assess their collective performance and they should regularly communicate to members and the public details on how they have discharged their responsibilities.	Governor report – governor engagement
6: Comply or explain	Council of Governors	B.6.6	There should be a clear policy and a fair process, agreed and adopted by the council, for the removal from the council of any governor who consistently and unjustifiably fails to attend the meetings of the council or has an actual or potential conflict of interest which prevents the proper exercise of their duties.	Governor report – role of governors
6: Comply or explain	Board/ Remuneration Committee	B.8.1	The remuneration committee should not agree to an executive member of the board leaving the employment of an NHS foundation trust, except in accordance with the terms of their contract of employment, including but not limited to service of their full notice period and/or material reductions in their time commitment to the role, without the board first having completed and approved a full risk assessment.	Comply
6: Comply or explain	Board	C.1.2	The directors should report that the NHS foundation trust is a going concern with supporting assumptions or qualifications as necessary. See also ARM paragraph 2.12.	Performance report - Going Concern
6: Comply or explain	Board	C.1.3	At least annually and in a timely manner, the board should set out clearly its financial, quality and operating objectives for the NHS foundation trust and disclose sufficient information, both quantitative and qualitative, of the NHS foundation trust's business and operation, including clinical outcome data, to allow members and governors to evaluate its performance.	Directors report – Non-Executive Directors

6: Comply or explain	Board	C.1.4	a) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public's interest to bring to the public attention, any major new developments in the NHS foundation trust's sphere of activity which are not public knowledge, which it is able to disclose and which may lead by virtue of their effect on its assets and liabilities, or financial position or on the general course of its business, to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust. b) The board of directors must notify NHS Improvement and the council of governors without delay and should consider whether it is in the public interest to bring to public attention all relevant information which is not public knowledge concerning a material change in: • the NHS foundation trust's financial condition • the performance of its business; and/or • the NHS foundation trust's expectations as to its performance which, if made public, would be likely to lead to a substantial change to the financial wellbeing, healthcare delivery performance or reputation and standing of the NHS foundation trust.	Comply - Council of Governor's Engagement Policy
6: Comply or explain	Board/Audit Committee	C.3.1	The board should establish an audit committee composed of at least three members who are all independent non-executive directors.	Directors' report – Trust Audit and Risk Governance Committee
6: Comply or explain	Council of Governors/ Audit Committee	C.3.3	The council should take the lead in agreeing with the audit committee the criteria for appointing, re-appointing and removing external auditors.	Governor report – role of governors

6: Comply or explain	Council of Governors/ Audit Committee	C.3.6	The NHS foundation trust should appoint an external auditor for a period of time which allows the auditor to develop a strong understanding of the finances, operations and forward plans of the NHS foundation trust.	Director's report – Trust Audit, Risk and Governance Committee
6: Comply or explain	Council of Governors	C.3.7	When the council ends an external auditor's appointment in disputed circumstances, the chairperson should write to NHS Improvement informing it of the reasons behind the decision.	Governor report – role of governors
6: Comply or explain	Audit Committee	C.3.8	The audit committee should review arrangements that allow staff of the NHS foundation trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters.	Director's report – Trust Audit, Risk and Governance Committee
6: Comply or explain	Remuneration Committee	D.1.1	Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels.	Remuneration report
6: Comply or explain	Remuneration Committee	D.1.2	Levels of remuneration for the chairperson and other non-executive directors should reflect the time commitment and responsibilities of their roles.	Remuneration report
6: Comply or explain	Remuneration Committee	D.1.4	The remuneration committee should carefully consider what compensation commitments (including pension contributions and all other elements) their directors' terms of appointments would give rise to in the event of early termination.	Remuneration report
6: Comply or explain	Remuneration Committee	D.2.2	The remuneration committee should have delegated responsibility for setting remuneration for all executive directors, including pension rights and any compensation payments.	Remuneration report
6: Comply or explain	Council of Governors/ Remuneration Committee	D.2.3	The council should consult external professional advisers to market-test the remuneration levels of the chairperson and other non-executives at least once every three years and when they intend to make a material change to the remuneration of a non-executive.	Governor report – appraisal and appointments

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

NHS Improvement's Single Oversight Framework

Single Oversight Framework

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

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

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy.

A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

The Single Oversight Framework applied from quarter 3 of 2016/17.

Segmentation

This segmentation information is the Trust's position as at 31 March 2018. NHS Improvement placed the Trust in segment 4 and the Trust is in special measures for both quality and finance.

Current segmentation information for NHS truss and foundation trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from '1' to '4', where '1' reflects the strongest performance. These scores are then weighted to give an overall score. Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the trust disclosed above might not be the same as the overall finance score here.

Area	Metric	2017/18 Q1 score	2017/18 Q2 score	2017/18 Q3 score	2017/18 Q4 score
Financial sustainability	Capital service capacity	4	4	4	4
	Liquidity	4	4	4	4
Financial efficiency	I&E margin	4	4	4	4
Financial controls	Distance from financial plan	4	4	4	4
	Agency spend	2	3	3	3
Overall scoring		4	4	4	4

Signed: Dr Peter Reading

Date: 24 May 2018

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

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust.

The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS Improvement.

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Directions which require [name] NHS foundation trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions.

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

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

- Observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual (and the Department of Health Group Accounting Manual) have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

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

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

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

Signed: Dr Peter Reading

Date: 24 May 2018

Annual Governance Statement 2017/18

1. SCOPE OF RESPONSIBILITY

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Northern Lincolnshire and Goole NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Northern Lincolnshire and Goole NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accountable Officer Memorandum.

2. THE PURPOSE OF THE SYSTEM OF INTERNAL CONTROL

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Northern Lincolnshire and Goole NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northern Lincolnshire and Goole NHS Foundation Trust for the year ended 31 March 2018 and up to the date of approval of the annual report and accounts.

3. CAPACITY TO HANDLE RISK

Leadership and accountability

During 2017/18, changes have been made to the organisation's management structure including the appointment of a new Chief Executive and some changes to executive director portfolios.

As part of the strengthening of the operational management structures, new Divisional Directors have been appointed to lead each of our five Divisions, with the Divisional General Manager (formerly Associate Chief Operating Officer) and the Divisional Head of Nursing (formerly Associate Chief Nurse) reporting to them.

This is the first step in a shift to give greater strength to our Divisions and put clinicians firmly in charge of how we plan and deliver clinical services. The Divisional Clinical Directors will have authority and responsibility for quality, the use of resources (including staffing and finance), performance and governance.

The Trust also commissioned a Well Led governance review and the findings and recommendations from that review are being implemented.

This has included a review of the Trust's meeting structures to ensure a clear separation between Board assurance sub-committees and day to day management meetings and the implementation of a comprehensive Board Development Programme.

Following the decision of the existing Director of Governance and Assurance to retire, a revised central clinical governance structure has also been agreed and realignment of executive director responsibilities has commenced. A review and strengthening of the governance structures within Divisions is also underway with external support.

As part of plans to strengthen staff engagement and communication, the new Chief Executive also launched during 2017/18 the Senior Leadership Community, which brings together on a monthly basis all of the organisation's senior clinical and managerial leaders who will be responsible for making and sustaining the required improvements needed within the Trust including listening to, engaging with and supporting staff. Invites have also now been extended to all Band 7's within the organisation.

The Trust has in place a Performance Management Framework, which outlines

the approach to holding Directorates and Divisions to account for delivery of objectives and improvements including those relating to governance and quality governance.

The above arrangements and changes made during 2017/18 reflect the Trust's ongoing commitment to effective governance and quality governance including risk management processes.

The Trust's Internal Audit Programme continues to be used to test key aspects of the Trust's governance arrangements annually.

Training

Through the provision of a comprehensive mandatory training programme which includes governance and risk management awareness – with training sessions being delivered both centrally and within individual Directorates/ Divisions and engaging internal and external trainers, and through individual personal development, staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

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

There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role. A review of the Training Needs Analysis was undertaken during 2017/18 to ensure that mandatory training remains targeted and appropriate as well as manageable for staff.

Despite significant operational pressures, the Trust has continued to demonstrate good levels of compliance with mandatory training requirements but this focus continues. Monitoring and escalation arrangements are in place to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

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

Control Mechanisms including 'Learning Lessons'

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

Lessons learned when things go wrong are shared throughout the organisation via a range of mechanisms including safety alerts, 'learning lessons' newsletters, safety huddles/handovers, Quality and Safety Days and governance forums. Further mechanisms for ensuring the sharing of transferable lessons – as well as good practice – continued to be explored during 2017/18 via the learning lessons project within the Improving Together Programme and included the introduction of a one page summary following every Serious Incident (SI) which is widely dissemination across the organisation.

These mechanisms remain under review and in response to feedback from staff as to their effectiveness. The effectiveness of the revised arrangements will be tested through internal audit and were also reviewed as part of the recent CQC inspection visit held 8 – 11 May 2018. To date, the formal findings from that inspection are awaited.

A significant and specific piece of work on learning lessons has been focussed within the Trust's maternity services in response to the themes and lessons learnt from recent serious incidents. This work has been supported by NHS Improvement and NHS England maternity colleagues.

The Trust Board routinely considers specific risk issues and receives minutes from Board Sub-Committees including the Audit, Risk and Governance Committee, Finance and Performance Committee, and the Quality and Safety Committee. The Quality and Safety Committee, on behalf of the Trust Board, routinely receives information on SIs including lessons identified and learned. The Trust is also a member of and provides assurance to commissioners on its arrangements for investigating and learning from SIs via a

community-wide SI Collaborative Group.

The Clinical Harm Review Group, chaired by the Medical Director from NHSE, and convened to have oversight of the data quality issues arising from the waiting list validation exercise undertaken and reported in last year's statement, continued to meet during 2017/18.

This group dovetails in to existing governance processes including the SI and Being Open (Duty of Candour) Policy and Procedure.

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

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

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

4. THE RISK AND CONTROL FRAMEWORK

The management of risk

The Trust has in place a Governance and Risk Management Strategy which is reviewed annually.

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

The Trust's Governance and Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

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

These are appropriately graded and ranked and included on the Trust's Risk Register and Board Assurance Framework (BAF). A Risk Register – 'Confirm or Challenge' Group is in place to review and monitor risks added to the Risk Register and quarterly reports from the Risk Register are submitted to the relevant Board assurance sub-committees and Trust Board.

The Audit, Risk and Governance Committee has the delegated authority on behalf of the Trust Board for ensuring these arrangements are in place.

The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register and within the BAF is an ongoing, dynamic process. The BAF and Risk Register have undergone significant review and amendment during 2017/18 to ensure the two are more closely aligned and to ensure that they inform the agenda of the Trust Board and Board assurance sub-committees.

As a result of that work, a 'significant assurance with minor improvement opportunities' rating was received following the 2017/18 Internal Audit review.

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

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

/Trust Management Board or Trust Board for a decision to be made.

Supporting this devolved structure are central non-clinical directorates.

These Directorates have a nucleus of experienced and appropriately qualified staff to support and advise staff at all levels across the organisation with the identification and management of risk.

Risk Management is embedded in the activity of the organisation by virtue of robust organisational and committee structures which were reviewed and strengthened during 2017/18 as outlined above.

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

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

Despite these arrangements, feedback from the previous CQC visit and following a recent case review by the National Guardian's office, it has been identified that the Trust's culture and arrangements do no always support staff to speak out.

The findings and recommendations from that review have informed the development of a comprehensive improvement plan which was ratified by the Trust Board at its February 2018 meeting.

As part of that improvement plan, the Trust launched in March 2018 its anti-bullying campaign: Pride and Respect Project; an employee driven and owned programme which aims to improve the standard in which Trust staff deliver care and interact with each other. Linked to Pride and Respect, an employee advice help line was launched.

The Trust agrees annual governance/risk management Key Performance Indicators (KPIs), which are shared through the business planning and performance management framework/integrated performance report.

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

The Framework incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Information Governance Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via quarterly BAF /risk register reports and is supported by a robust Internal Audit Programme.

As outlined above, the BAF was further refined during 2017/18 in response to both audit findings and the findings from the Well Led Review and includes strengthening the links with the Trust's Risk Register.

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

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

A system of 'highlight' reports to the Trust Board is in place to highlight any risks to compliance.

Board sub-committees are well attended by Executive and Non-executive Directors as well as by other key Trust staff.

A review and strengthening of the Board sub-committees was undertaken during 2017/18 to ensure a clear separation between Board assurance sub-committees and day to day management meetings.

This will ensure that the Trust's meeting structure is able to meet the challenges to be faced by the organisation during 2018/19 and beyond.

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

- The Trust has in place a Quality Strategy which has been endorsed by the Trust Board and shared with the Council of Governors. The Trust Board also agrees annual quality objectives
- The Trust has in place a Quality and Safety Committee (a sub-committee of the Board) which meets monthly and is chaired by a Non-executive Director. The Quality and Safety Committee is responsible for monitoring performance against the agreed annual quality objectives. The minutes of the Quality and Safety Committee are submitted to the Trust Board
- The Trust publishes an Annual Quality Account
- Performance against key quality indicators are reported the Integrated Performance Report
- Quality improvements – including the response to CQC findings and recommendations are progressed through the Trust's Improvement Programme – Improving Together. Improving Together was first introduced in January 2017 and provides a more holistic approach to improvement than has previously been the case. A refresh of the programme was undertaken in September 2017 including strengthening of the Improvement Team to provide hands on, delivery support
- The Trust has in place arrangements and monitoring processes to ensure ongoing compliance with other service accreditation standards e.g. bowel screening, colposcopy, cancer, CPA, MHRA (for blood products) and HTA licences for mortuary and post mortems etc
- The Trust Quality and Safety Committee monitors performance with NICE guidance implementation and minutes of that committee are submitted to the Trust Board. Compliance with NICE guidance is also monitored, internally via the performance review process and externally via the Commissioner Quality Contract Group
- The Medical Director has the lead for mortality supported by two site clinical leads. A new Mortality Improvement Group was introduced during 2017/18 and includes relevant external stakeholders. A mortality improvement plan – including how the Trust learns from deaths – is in place. The Trust Board receives a monthly Mortality progress report. The Quality and Safety Committee retains a challenge and assurance role in respect of mortality
- Ward Standards have been introduced and are monitored via a programme of unannounced Ward Reviews
- A programme of announced and unannounced (Executive and Non-Executive) Director Visits is also in place to all wards and departments – clinical and non-clinical – in order to ensure that there is 'Board to Ward' oversight and ownership of quality and safety issues. Trust Board walkabouts are held on Board days
- The Trust has identified Non-Executive Directors to lead the challenge in respect of specific aspects of governance and risks. These challenge roles are reviewed annually
- The Chief Nurse has responsibility for focusing on the quality of the patient experience and is the Board lead for quality and the patient experience
- A nursing dashboard is in place to monitor the nursing contribution to safety and quality. This is being reviewed and refreshed during 2018/19
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, eg National patient surveys
- The Trust acts upon patient feedback from complaints and concerns and from feedback from Patient and Public Involvement (PPI) representatives (eg Health Watch)
- Patient and Staff Stories are presented to the Quality and Safety Committee and the Trust Board monthly and actions and lessons learned are widely shared.

The effectiveness of the Trust's governance structures also continued to be tested during 2017/18 via internal and external testing including internally via the Annual Internal Audit Programme (see Appendix A) and externally via relevant external reviews and visits including during 2017/18 a Well Led Review.

CQC: Registration and Essential Standards of Quality and Safety

During November and December 2016, the Trust received announced and unannounced visits by the CQC.

Arising from the visits, significant concerns were raised in respect of A&E (lack of comfort rounds, lack of risk assessment and documentation, cleanliness and infection control, environment and data recording), Maternity (lack of fresh eyes, lack of escalation and issues in respect of interpretation of continuous cardiotocography (CTGs) and Waiting List (referral to treatment (RTT) and outpatient department (OPD) follow-up) Recovery.

The Trust subsequently received a Section 29A Warning Notice requiring immediate improvements.

The full visit report was published on 6 April 2017 and the Trust received an overall rating of 'Inadequate'. Arising from the outcome of the visit, the Trust was placed in quality 'special measures'.

A support package from NHSI was put in place including dedicated Improvement Director support to assist the Trust in the implementation of the 'Improving Together' programme and buddying support from East Lancashire NHS Trust.

Progress continues with the implementation, embedding and testing of agreed actions and the Trust Board receives a monthly 'Improving Together' progress report including compliance with Key Performance Indicators (KPIs) intended to demonstrate the effectiveness and embedding of the improvements being put in place.

NHSI also introduced a System Improvement Board, which brings together all relevant stakeholders to support the Trust in the delivery of its improvement plan.

An announced re-visit to the Trust to test the improvements made was held between 8 to 11 May 2018.

As the inspection and corroboration process is not complete and the outcome is as yet unknown, as at the date of finalising this report, the Trust is not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC).

Patient and Public Involvement (PPI)

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

The Council meets at least five times per year in public and receives a comprehensive report on performance (and risks of non-delivery) on each occasion. These reports are published along with the rest of the council papers on the Trust internet site.

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

Additionally, the Trust engages actively with three Overview and Scrutiny Committees and continues to collaborate closely with the three local HealthWatch organisations.

A Protocol for joint working with Health Watch is in place and is reviewed annually and opportunities for joint working are agreed.

The Trust's comprehensive internet website provides the public with ready access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with.

This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, Diversity and Human Rights

Control measures are in place to ensure that all the organisation's obligations under

equality, diversity and human rights legislation are complied with. During 2017/18, the Trust strengthened these arrangements through the commissioning of an external review and has a detailed action plan in place in response to the findings. The Trust also appointed a dedicated Equality and Diversity lead.

Carbon Reduction

The Trust has both a Trust Board approved Sustainable Development Management Plan (SDMP) and a Travel Plan, both of which are reviewed annually. These documents include risk assessments to ensure the Trust can attain its carbon reduction targets in accordance with emergency preparedness and civil contingency requirements. These are based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. The Trust has been nationally recognised by the Sustainable Development Unit (SDU) for the quality of the 2016/17 sustainability report contained within the Trust's annual report.

5. REVIEW OF ECONOMY, EFFICIENCY AND EFFECTIVENESS OF THE USE OF RESOURCES

The Trust's clinical activities are managed under a devolved management structure, governed by a Scheme of Delegation renewed and refreshed annually. The Trust has in place a clinical management structure to support effective leadership of clinical services and ensure effective care.

The Medical Director is supported by two part time Deputy Medical Directors (who will continue to be engaged in clinical front line work), and Clinical Directors, covering each clinical Division. Each Clinical Director has a team of clinical leads for individual service areas.

The Finance Directorate provides dedicated support to each clinical Division and to non Clinical Directorates through nominated Business Accountants. Business planning, and information technology is provided by the Directorate of Strategy and Planning. This Directorate works to closely link strategy development across the wider health economy and the Humber Coast and Vale STP with service planning in clinical service areas.

Plans are being developed to transform and streamline the way in which services are provided ensuring patient care is provided closer to home limiting unnecessary expensive hospital attendances.

The Trust continues to adopt a project based approach to savings delivery through an established PMO-style approach. Whilst the Trust has enhanced governance and oversight arrangements in respect of savings delivery coupled with comprehensively documented plans, emerging cost pressures have begun to outweigh the level of savings being delivered. Savings are subject to full Quality Impact Assessment sign off process. Delivery support has been augmented during 2017/18 through the Financial Special Measures process, with additional regulatory scrutiny, a Turnaround Director in post, and support provided by external partners, Ernst and Young (EY).

The Trust maintains focus on performance management. All Directorates and Divisions are explicitly made responsible for the delivery of financial and other performance targets through a system of performance agreements, documented as part of the annual business planning cycle and monitored through a series of regular performance review meetings. The Trust is aware that whilst the framework in place is robust the changes and gaps in operational leadership have made these difficult to manage in practice.

The Financial Plan and budget adopted annually by the Trust Board contains an overarching assessment of the strategic planning climate within which the framework has been constructed and sets out the mechanisms by which the key risks emanating from the strategic context are to be managed. This assessment reflects both the national planning context and the local context; and recognises the financial planning context for the public sector as a whole; especially the expectation for significant efficiencies on an ongoing basis.

The Trust conducts a comprehensive review of the in-year progress of the Business and Financial Framework in the form of a Mid-Year Review report – any issues or emerging risks not previously identified within the original Framework are identified and mitigating actions recommended and actioned during this process. In 2017/18 this process was replaced by the plan resetting element of the Financial Special Measures process.

The Trust Finance and Performance Committee provides assurance to the Trust Board as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Trust Board Committees and the Trust Executive Team and also has particular regard to the work of the Financial Planning Group, which sets the agenda and co-ordinates the process of business planning, specific business case development, and capital programme management.

Compliance is further assured through quarterly monitoring and annual planning processes with auditors. The Trust has developed an internal audit programme, based on key business governance themes with internal audit providers KPMG, designed to enhance focus on business governance process and support improved compliance.

The Trust, building upon the lessons learned following the 2013 Keogh review process, understands that robust front line clinical services are the real purpose of the organisation, delivering effective quality outcomes for patients.

The Trust is proactive and continuously reviews and realigns its structure where necessary, to allow it to adapt and respond to the rapidly changing business environment brought about by the changes in the economy, the NHS environment, competitive markets and patient pathway best practice.

The Trust has also enhanced its focus on workforce planning in order to secure a more consistent supply of appropriately skilled and qualified staff to carry out front line service delivery, specifically to review plans for future workforce numbers and to oversee implementation processes, working jointly with Commissioners and other local provider organisations. In support of this work the Trust has developed a People and Organisational Effectiveness Strategy and an Employment Framework sustainability workstream, covering both retention and recruitment, which have been endorsed by the Trust Board.

The Trust continues to be non-compliant with NHS Improvements Use of Resources performance measure under the Single Oversight Framework recognising that this is within the context of a wider sustainability gap across the local health economy, in which work is ongoing to address through the newly formed Accountability Frameworks and the STP. NHS Improvement have issued enforcement undertakings stating that the Trust had not demonstrated that it has established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively and the Trust has been placed in financial 'special measures".

Arising from this, the External Audit opinion will be adverse from a perspective of economy, efficiency and effectiveness. This is based on the CQC findings, the issues identified in respect of data quality, the Trust's financial performance, the imposition of special measures (finance and quality) and the resultant licence conditions and associated enforcement undertakings.

The processes and review work established by the Trust in response to Financial Special Measures have been designed to supply corrective actions for any failures in delivery of services in an economic, effective and efficient manner. This remains a work in progress, with further actions required to strengthen planning and management systems across the Trust.

The Financial Governance Review previously undertaken within the Trust established an outline assessment of structural cost premium facing the Trust because of its configuration and also laid the foundations for a corrective savings programme addressing those issues within the Trust's control.

This review is currently in the process of updating by EY, to provide a more up to date view of the Trust's structural service and financial issues.

6. INFORMATION GOVERNANCE (IG)

The Trust continues to strengthen its arrangements for Information Governance and has the following arrangements in place:

- An Information Governance Steering Group;
- An Information Governance Strategy and Policy along with a dedicated Information Security Policy;
- The achievement of compliance with the requirements of the IG Toolkit at Level 2 by the deadline of 31 March 2018.

In respect of data security the following arrangements are in place:

A security feature at login to the Trust network, giving guidance to users and requiring acceptance of 'rules of use'; this is to be further strengthened following the recent review and updating of the duty of confidence statement that all new starters complete as part of their induction process.

Key points of the duty of confidence declaration, specifically those sections relating to users responsibilities will be added to the log-in screen of the Trust's network.

The review and acceptance of the duty of confidence will also be an ongoing reminder, as well as at the commencement of an employee's work in the Trust.

- IT policies which take account of updated national requirements;
- A 'best practice' IT security awareness leaflet alongside a dedicated email security and best practice leaflet;
- The encryption of all removable / portable devices including laptops, USB pens and CDs, specifically:

- laptop encryption has been completed on all laptops/ clinical tablets;

- encrypted USB pens have been allocated to staff;

- support for the use of staff who own PDA devices has been removed, floppy drives have been blocked from use, no machines are purchased with floppy drives as standard and port blocking software has been implemented;

- CD/DVD writers are not issued as a standard piece of equipment. Where the use of these writers is required, the creation of data on these devices is covered by Trust policies;

- the creation of data on PACs CDs is governed by Trust policy and encryption ability is available. Tracking procedures are in place for CDs sent off site.

A review of the Trust's compliance with the new General Data Protection Requirement (GDPRs) has been undertaken and a series of Task and Finish Groups have been put in place to progress the required actions.

Approval has been received through the Trust Management Board to appointment a dedicated Data Protection Officer and this post is currently out to advert. This dedicated role will provide more focus, pace and co-ordination on this key area of work.

During 2017/18, the Trust reported two serious incidents relating to disclosure in error, where a number of records were shared inadvertently with a partner health organisation and an unauthorised disclosure incident, where a video recorded of a child and their nursing carers was shared without authorisation on social media.

In line with the Trust's Serious Incident (SI) policy, both were reported via the IG Toolkit and also to the Information Commissioner's Office (ICO).

Both were investigated and appropriate action taken, including strengthening of policies regarding use of mobile phones with video recording capabilities and the Trust's social media policy, alongside learning lessons messages being broadcast within the Trust.

The Information Commissioners Office (ICO) on both occasions was assured by the Trust's response and has taken no further action in response.

The Trust also experienced a cyber-attack in May 2017, although no data loss was identified arising from that incident and the Trust continues to take steps to strengthen its security arrangements in this area with reporting to the Trust Board.

7. ANNUAL QUALITY REPORT

The Directors of Northern Lincolnshire AND Goole NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. NHS Improvement (in exercise of the powers conferred on Monitor) has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The following arrangements are in place within Northern Lincolnshire & Goole Hospitals NHS Foundation Trust to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

Governance and leadership:

- The Trust has appointed a member of the Board, the Chief Nurse, to lead on quality. The Chief Nurse, supported by the Medical Director and Director of Governance and Assurance, advises the Trust Board on all matters relating to the preparation of the Trust's annual Quality Account.
- The Trust's Director of Strategy and Planning is responsible for providing the information and performance data which informs the Annual Quality Account. An Information Services Manager, to whom this responsibility is delegated, is also in post.
- The Trust's Director of Strategy and Planning is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate. A Head of Performance, to whom this responsibility is delegated, is also in post.

Policies and plans in ensuring quality of care provided:

- Policies and procedures are in place in relation to the capture and recording of patient data.
- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.

Systems and processes:

- Systems and processes are in place for the audit and validation of performance data both centrally and at operational level. In relation to waiting list data, a revised governance accountability structure is in place which has been underpinned by the development of a training programme to support operational delivery for staff and their teams. Areas of training include: PTL management, RTT, demand and capacity, all of which have been designed to support the delivery of efficient services and the development of a robust recovery trajectory for 2018/19. The NHSI IST continues to support the Trust with this area of work.

People and skills:

- All staff involved in collecting and reporting on quality metrics are suitably trained and experienced.
- All PAS users have to receive training before being issued a password, and individual user activity is auditable.
- Clinical Coding is regularly audited both internally and externally and audits also take place with individual clinicians.

Data use and reporting:

- A monthly Integrated Performance Report which outlines the Trust's performance against key quality and other objectives including benchmarking and comparative data, and are the subject of discussion and challenge at every monthly Trust Board meeting and also informs the annual Quality Account. Work was undertaken during 2017/18, supported by Ernst and Young, to strengthen the Integrated Performance Report and the quality of the data that underpins it and this work continues.
- The Trust also considers and acts upon information received via the Dr Foster alerts and relevant CQC alerts and reports and the information also informs the relevant Trust action

plans eg mortality.

In preparation for the requirement for a published audit opinion in the 2017/18 Quality Account, the purpose of which is to provide assurance on the arrangements in place to ensure Quality Accounts are fairly stated and in respect of the accuracy of the information and indicators within the report, audit review is being undertaken. This will involve sample testing in respect of a number of mandated quality indicators.

During 2016/17, the Trust identified data quality issues in connection with the information on the Trust's waiting list which is used to manage delivery of the Referral to Treatment (RTT) Waiting Times (maximum waiting time of 18 weeks) standard.

The Trust, in response to these findings, appointed an external validation company to work through specific elements of the waiting list data to identify errors and correct accordingly. Work continued during 2017/18 to address all inaccuracies within the Trust's waiting list management process.

A comprehensive training plan is being rolled out across the Trust and this will continue in 2018/19. Areas of training include RTT, Patient Tracker List (PTL) Management and Demand and Capacity. Alongside this work, an external Clinical Harm Review Group, chaired by the NHSE Regional Medical Director, was introduced to have oversight of the above issues and to identify any harm to any patient on the waiting list waiting longer than they should to be seen.

At the time of preparing this report, no incidents of harm have been identified from this process to date.

Further testing of data quality in relation to the Trust's waiting list was undertaken during 2017/18 as part of the Internal Audit Programme. That audit aimed to assess amongst other things:

- Waiting list accuracy of RTT rules;
- Data Quality;
- Patient pathway management and tracking;
- Adherence to the Trust's Access Policy

On the basis of the results of this review and whilst acknowledging the significant work in this area, particularly in relation to data quality enhancement, validation, training and PTL development, an assessment of 'partial assurance with improvements required' was awarded. The audit found that core systems, processes and working practices are not yet fully effective.

The review raised 18 recommendations; seven of which have been rated as high priority. The Trust's response to these draft recommendations is currently being compiled and will be incorporated within existing and ongoing improvement plans.

8. REVIEW OF EFFECTIVENESS OF RISK MANAGEMENT AND INTERNAL CONTROL

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control.

My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Northern Lincolnshire and Goole NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework.

I have drawn on the content of the Annual Quality Report attached to this Annual Report and other performance information available to me.

My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit, Risk and Governance Committee and the Quality and Safety Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work (Appendix A refers).

The BAF and the monthly Integrated Performance Report provide me with evidence that

the effectiveness of the controls in place to manage the risks to the organisation achieving its principal objectives have been reviewed.

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust's BAF and Risk Register including NED review / challenge.
- Regular risk management activity reports to the Trust Board assurance sub-committees and the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learned / changes in practice.
- Receipt by the Trust Board of minutes / reports from key forums including the Audit, Risk and Governance Committee, Finance and Performance Committee and the Quality and Safety Committee.
- The ongoing development of the BAF and Risk Register with external support and training.
- Annual independent external review by KPMG of the Trust's board assurance and self-certification processes. No significant control issues identified.
- Consideration of a monthly 'Improving Together' report, allowing the Trust Board to monitor improvements across the five workstreams within 'Improving Together': Improving Quality and Safety, Improving Access and Flow, Improving Service Strategy, Improving Finance and Improving OD and Culture.
- The provision and scrutiny of a monthly Integrated Performance to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions. The Trust's performance management arrangements were further strengthened during 2017/18 including through the introduction and embedding of an Integrated Performance Report and some changes to Director Portfolios. Quarter 1 of 2018/19 will see the conclusion of the detailed data definitions work which ensures robustness of measures, signed off by the lead executive alongside further work to strengthen the Integrated Performance Report to ensure it captures the most relevant and meaningful indicators is underway.

The validity of the Annual Governance Statement has been provided to me by the Audit, Risk and Governance Committee, which has considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of

9. CONCLUSION

In conclusion, the following significant internal control issues arose or continued during 2017/18:

Finance and sustainability

The Trust is currently formally in breach of its Licence, specifically conditions CoS3(1)(a) and (b), CoS3(2)(c), and FT4(5)(a),(d), and (f), this is due to continued financial pressures and the inability to maintain and improve financial sustainability, efficiency and compliance with sector controls and has been placed in financial 'special measures'. This has resulted in the Trust failing to comply with the 'use of resources' oversight metric triggering financial special measures late in March 2017. Since that point, the Trust has been working with NHS Improvement and EY, our external support partners, in developing appropriate response plans. Financial improvement planning sits within the wider framework of the Trust's Improving Together programme, linking quality, performance and financial improvements together.

Operational pressure has seen increased cancellations of elective activity resulting in reduced income, though the impact has been mitigated through block value agreements in place with the two Northern Lincolnshire CCGs. The Trust has also experienced a significant and continuing reliance on premium

agency staffing costs mainly due to high medical staffing and registered nursing vacancy rates, and the need to insource additional urgent care and diagnostic services capacity to meet demand and improve flow.

The Trust deficit was £37.98m excluding WebV Solutions Ltd and Charitable funds. This was £2.11m better than plan due to general distribution of STF income. The Trust has also utilised a range of technical accounting changes to support the I&E position. The Trust has still significant work to do to improve the I&E run rate through improved productivity and expenditure controls – increasingly through the transformational redesign of services, working with partners in the health economy.

The Trust has a total outstanding loans balance of £117.4m, and aside from a small proportion related to specific capital projects, these are emergency revenue support loans from the Department of Health. No plans are in place which can support ultimate repayment of these support loans through normal business operations.

CQC

As outlined in section 4 above, as at the time of preparing this report, the Trust is not fully compliant with the registration requirements of the Care Quality Commission (CQC). Arising from the CQC visits in November and December 2016, the Trust was placed in quality 'special measures' and Enforcement Undertakings were agreed with NHSI. The Trust's improvement plan in response to the CQC findings and recommendations are captured within the Improving Together Programme with monthly reporting to the Trust Board. Testing in respect of specific actions is the subject of challenge and 'deep dives' through the Patient Safety Group of the System Improvement Board. A series of clinical review visits to test embedding of actions on the group have been completed.

A re-visit by the CQC to test the improvements made took place between 8-11 May 2018. An unannounced visit is also expected as part of this process and so the outcome is awaited.

Performance:

A&E

A&E performance showed an improvement in 2017/18 with a greater number of patients seen within four hours and the Trust was able to meet the revised target of 90% in quarter three as agreed.

However, latterly due to significant operational pressures associated with winter, compounded by vacancies and sickness as well as increased attendances when compared with the same period during 2016/17, performance across the Trust began to decline presenting significant operational challenges for the teams. The Trust did not achieve the 90% target for quarter four. Despite not achieving the target, the Trust delivered a 4.1% improvement in performance when comparing quarter three and quarter four, 2017/18 to quarter three and quarter four of 2016/17 with the Trust being the 12th improved Trust in the country moving from 45th out of 137th in the country. Improvement actions are monitored through the system-wide A&E Delivery Board with stakeholder support being seen as a contributor to the improvements seen. Work is also underway to improve the quality of data recording.

Cancer Performance

The Trust failed to achieve the 62 day GP referral to treatment target in Quarters 1, 2 and 3 though performance improved in Quarter 4. Non delivery was anticipated during 2017/18 as focus was given to treating those patients who had waited in excess of 62 days. This number has now significantly reduced. The increased emphasis on achieving a diagnosis and treating patients, through greater focus on diagnostics and the theatre and bed capacity available following the reduction in elective treatment as a result of winter pressures has support this. Work continues to improve pathways for patients across the clinical specialties. The rules regarding breach allocation of patients across the whole patient journey come into being during 2018/19. This has a material adverse impact on the Trust, forecast of up to 7%.

Referral to Treatment (RTT) and Outpatient Department (OPD) follow-ups

The Trust's focus on urgent and emergency care during the latter part of 2017/18 and compounded by capacity issues, vacancies and sickness has resulted in deterioration in the Trust's RTT position and deterioration in the OPD overdue follow-up position.

Despite this, work has continued to strengthen the infrastructure in place in support of the management of the Trust's waiting lists.

Support has been provided by NHSI throughout the year to maintain focus on the key priorities identified in 2016/17.

- Leadership and accountability
- Access Policy and Standard operating Procedures
- Data Quality
- RTT Training
- Demand and capacity
- Development of a recovery trajectory.

The Trust PTLs have been updated to meet the user needs with training provided. Front line teams now have access to live RTT, Endoscopy and Radiology.

A revised accountability structure is in place which has been underpinned by the development of a training programme to support operational delivery for staff and their teams. Areas of training include PTL management, RTT, demand and capacity all of which have been designed to support the delivery of efficient services and the development of a robust recovery trajectory for 2018/19.

As outlined above, a review of the arrangements in place to support the management of the Trust's waiting list was undertaken during 2017/18 via the Internal Audit Programme. Whilst the significant work undertaken to date was acknowledged, the audit found that core systems, processes and working practices are not yet fully effective. The review raised 18 recommendations; seven of which have been rated as high priority. The Trust's response to these draft recommendations is currently being compiled and will be incorporated within existing and ongoing improvement plans. Progress with the completion of these actions and monitoring and the agreement and achievement of improvement trajectories will be monitored by the Trust Board.

Finally, where control issues have been identified during 2017/18, action has been taken or improvement plans are in place to address the gaps in control identified. Key to delivery of the required improvement includes the strengthening of the Divisional operational and governance structures. A key area of focus for 2018/19 will be improvements to planned care, aligned to the system principles agreed. The Trust Board is satisfied that plans are adequate to ensure delivery of these targets or improvements during 2018/19.

Where appropriate these action / improvement plans will be tested via relevant external scrutiny and review processes. External support is in place as required including through the buddying arrangement in place with East Lancashire Hospital Trust. The support package in place will remain under review with support from NHSI.

Peter Reading

Chief Executive

May 24 2018

APPENDIX A

HEAD OF INTERNAL AUDIT OPINION ON THE EFFECTIVENESS OF THE SYSTEM OF INTERNAL CONTROL AT NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST FOR THE YEAR ENDED 31 MARCH 2018

Basis of opinion for the period 1 April 2017 to 31 March 2018

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards.

As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000.

PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and

The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The Head of Internal Audit (HoIA) is required to provide an annual opinion in accordance with Public Sector Internal Audit Standards, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (ie the system of internal control).

This is achieved through a risk-based programme of work, agreed with Management and approved by the Audit, Risk and Governance Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control.

This Opinion will in turn assist the Board in the completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion
- Overall opinion; and
- Commentary.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes

- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the process by which the Trust has assurance over its registration requirements of its regulators.

Overall opinion

For the period 1 April 2017 to 31 March 2018 our opinion is that:

Partial assurance with improvements required can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and controls.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period 1 April 2017 to 31 March 2018 inclusive, and is based on 13 audits that we completed in this period.

Our audits consist of 'core' reviews and 'risk based' reviews. Core reviews are those that are required under PSIAS to be completed on an annual basis or where the organisation requires assurance on an annual basis.

Risk based reviews are those where we have worked with management to provide assurance on areas of perceived high risk and therefore we would anticipate lower assurance ratings.

We also undertake follow-up reviews to ensure management are taking appropriate actions where necessary.

The design and operation of the Assurance Framework and associated processes

Overall our review found that the Assurance Framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Board. The Assurance Framework does reflect the organisation's key objectives and risks and is reviewed on a quarterly basis by the Board.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year.

We issued eight 'partial assurance' opinions in respect of our 2017/18 assignments. These related to the 'core reviews' completed in respect of 'Quality Governance' and 'Governance Arrangements'. The 'risk based' audits of 'Strategic Planning and VFM (Part 2)', 'Retention', 'Maternity Clinical Review', 'Sustainability Agenda and Carter' and 'Referral to Treatment (RTT)'. As part of our audits we raised twelve high risk recommendations relating to:

- Key Trust officers taking ownership of and are held to account for the delivery of the Trust's Strategic Plan through the revised governance structure;
- The implementation of a formal communications plan for the communication of the new governance structure and ensuring Assistant Chief Operating Officers are charged with the responsibility of communicating the Strategy to all of the staff members within their Group using the tools provided by the Strategy and Planning Team;
- The coordination of the Carter implementation work through the existing governance structure, with a sub-committee in place to oversee the work. The results and performance of this sub-committee should be scrutinised and challenged at a Board level;
- Ensuring a designated lead is appointed to oversee the Carter Implementation Programme and ensure regular reports are produced and shared once a reporting template has been established and a governance structure has also been established;
- Producing a template report to ensure progress reporting against the Carter Implementation Programme is provided to the relevant sub-committees once a governance structure has been established and a designated lead is assigned;
- Ensuring the Trust undertake urgent analysis of RTT incomplete pathway submissions and the reporting/

submission collation process to identify the key factors resulting in patients 'appearing' and 'disappearing' between months;

- Undertaking a further deep-dive review into RTT/waiting list management and data quality to identify root causes for data inaccuracies, the scale of the issue and in particular the level of inaccuracy of the reported RTT waiting list position and to ascertain the actual number of 'real' patient pathways on all of the Trust's waiting lists;
- Developing a robust validation programme for RTT with an enhanced triangulated approach encompassing data quality, analytics, training and system development/ integration;
- Reviewing Trust processes and management of non-RTT patients and how the Trust plans to achieve compliance with national guidance as well as considering the potential impact this will have;
- Reviewing and developing the Trust's Data Quality Strategy further by addressing key data quality challenges with a clearly defined roadmap and a realistic vision of short, medium and long term aims;
- Expediting the works being undertaken to improve diagnostics reporting and informatics support to develop an adequate diagnostic Patient Treatment List (PTL) and supporting diagnostics waiting list and activity reports; and
- Expediting the current work being undertaken to understand and document the current build and logic being applied to in the creation of PTLs and ensuring the Trust undertakes a detailed review of this documentation once available in order to ensure exclusion rules are being applied appropriately.

In summary, whilst we would anticipate lower assurance ratings associated with 'risk based' reviews, and despite the 'significant assurance with minor improvement opportunities' opinions given to 'core' reviews such as 'Core Financial Controls and Management', ' Data Quality' and 'Reference Costs', the common fundamental weaknesses identified within our key 'core' and 'risk based' reviews relating to governance arrangements, people management and the development and delivery of key operational and strategic plans, supports our annual opinion of partial assurance with improvements required.

Equality and Diversity

We aim to be an organisation that people want to access for care and treatment.

We aim to be an organisation that people want to join and remain with as staff because it allows them to make their distinctive contributions and achieve their full potential.

We do not tolerate any form of intimidation, humiliation, harassment, bullying or abuse and will ensure that patients, staff, visitors and the public are treated fairly, with dignity and respect.

Our aim is to break down all barriers of discrimination, prejudice, fear or misunderstanding, which can damage service effectiveness for service users and carers.

We are committed to compliance with the Public Sector Equality Duty as set out in the Equality Act 2010 and will do this by eliminating discrimination, harassment and victimisation and have due regard to advancing equality for the relevant protected characteristics:

- Age
- Disability
- Gender re-assignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion and belief
- Sex/gender
- Sexual orientation.

We aim to ensure that ours services and employment opportunities are equally accessible to all minority or potentially disadvantaged groups that are often 'seldom heard'.

We are committed to building a workforce which is valued and whose diversity reflects the community it serves, enabling us to deliver the best possible healthcare service to those communities.

By addressing any inequalities in employment practices, we seek to deliver equitable services to all.

We believe that unlawful discrimination is unacceptable and aim to ensure that all patients, applicants, employees, contractors, agency staff and visitors will receive appropriate treatment and will not be disadvantaged by conditions or requirements which cannot be shown to be justified.

This is particularly so on the grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation and trade union activity.

To support this we have a dedicated Equality and Diversity Lead whose remit includes providing strategic and operational advice and guidance to the Trust's Management Team, its staff and other key stakeholders on all matters around equality and diversity linked to patient care and workforce.

In the last year the following has been achieved:

- A new Equality and Diversity Strategy has been agreed by the Trust Board. To develop this strategy a large consultation exercise took place which involved staff, our commissioners and the local Healthwatch
- As part of the strategy a number of organisational equality objectives were identified and have also been agreed at the Trust Board. These equality objectives will give direction and support to the organisation to move forward against the equality and diversity agenda
- An Equality Impact Assessment Policy and Procedure has been agreed which will give assurance that our policies, procedures and functions do not unlawfully discriminate against any particular groups
- We have published our Workforce Race Equality Standard data and developed an action plan to address some of the gaps identified
- We have also published our gender pay gap data in line with recent legislation
- We have renewed our membership and satisfactorily maintained our Disability Confident status as an employer who supports and attracts people with a disability or long term condition.
- Equality and Diversity training is mandatory for all staff using

blended learning. Face-to-face training is delivered as part of the corporate induction course and refreshers are completed using workbooks. A half day equality and diversity course has been running for the last year with one or two courses taking place each month.

Looking ahead the new Equality and Diversity Strategy and the equality objectives will provide the organisational direction to move this challenging agenda forward. The equality objectives will consider implementing an equalities framework (Equality Delivery System Two), improving the collection of patient equality data, continuing to deliver a high level of equality and diversity training to our staff, reporting against the Workforce Race Equality Standard and developing staff equality support networks.

The Health Tree Foundation

The Health Tree Foundation is the working name for Northern Lincolnshire and Goole NHS Foundation Trust charitable funds and the official charity for the Trust.

The new name was launched in November 2015 with support from Hull and East Yorkshire Smile Foundation (Smile).

The name 'The Health Tree Foundation' was inspired by an organisation with roots in the NHS that branch out into the community.

After reaching the goals set out in the first strategy early, the Health Tree Foundation (HTF) carried out an exercise to refresh its vision and mission and set out a three year plan.

The new plan for the charity was approved at the Health Tree Foundation Trustees Committee (formerly Charitable Funds Committee) in March 2018.

The vision for the charity is: 'To be recognised as a leading NHS charity in the UK.' The mission is: 'We inspire, engage and channel the charitable intent of your local community, helping to turn donations of time and money into making your NHS sparkle'.

The Health Tree Foundation introduced the 'circle of wishes'. This is a process in which any patient, member of staff, relative or public visitor to the Trust can make a wish for a change at one of the hospital sites or in the community.

The Health Tree team will then look into turning their wish into a reality.

After a successful introduction we now receive more than one wish per day, in the last year we received more than 450 wishes for funding.

As a result of Circle of Wishes and supporting capital investments, in the year 2017/18 the Health Tree Foundation contributed £963,000 to Northern Lincolnshire and Goole NHS Foundation Trust.

Sustainability report

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve.

Sustainability means spending public money well, and the smart and efficient use of natural resources and building healthy, resilient communities.

By making the most of the social, environmental and economic assets we can improve health both in the immediate and long term even in the context of rising cost of natural resources.

Demonstrating that we consider the social and environmental impacts ensures that the legal requirements in the Public Services (Social Value) Act (2012) are met.

In order to fulfil our responsibilities for the role we play, Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) has the following sustainability mission statement located in our Sustainable Development Management Plan (SDMP):

"The Trust is committed to long term sustainability, it also recognises its Corporate Social Responsibility (CSR) both as one of the largest employers in the local economy and as an emitter of carbon in to the local environment. It seeks to use this position to engage, inform, persuade and influence staff, visitors, patients and contractors to reduce the emissions of carbon."

As a part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline) equivalent to a 28 per cent reduction from a 2013 baseline by 2020. It is our aim to supersede this target by reducing our carbon emissions to 34 per cent by 2020/21 using 2007/08 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Business Cases	No
Procurement	
(environmental and social aspects)	No
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of an SDMP. The board approved our SDMP in the last 12 months, therefore our plans for a sustainable future are well known within the organisation and are clearly laid out.

One of the ways in which we measure our impact as an organisation on CSR is through the use of the Sustainable Development Assessment Tool (SDAT). The last time we used the SDAT was in March 2018, scoring 55%. As an organisation that acknowledges its responsibility towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

We have not assessed the social and environmental impacts of the trust nor issued a statement on Modern Slavery.

Adaptation

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health.

Examples in recent years include the effects of heat waves, extreme temperatures and prolonged periods of cold, floods, droughts etc.

Our Trust Board approved plans address the potential need to adapt the delivery the organisation's activities and infrastructure to climate change and adverse weather events.

Green space and biodiversity

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

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner.

Crucially for us as a healthcare provider, evidence of this commitment will need to be provided in part through contracting mechanisms.

Strategic partnerships are already established with the following organisations: British Gas.

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

Performance

Organisation

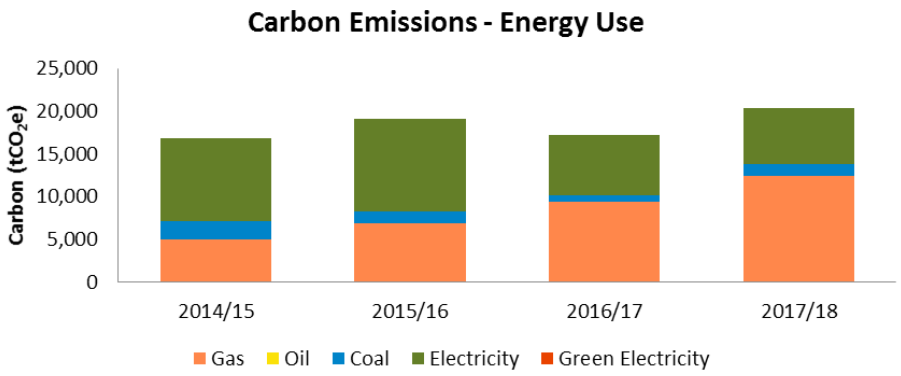
Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still on-going. Therefore in order to provide some organisational context, the following table may help explain how both the organisation and its performance on sustainability has changed over time.

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

In 2014 the Sustainable Development Strategy outlined an ambition to reduce the carbon footprint of the NHS as a system by 28% (from a 2013 baseline) by 2020. We have supported this ambition as follows:

Energy

NLaG has spent £3,416,821 on energy in 2017/18, which is a 3.5 per cent decrease on energy spending from 2016/15.



Resource		2014/15	2015/16	2016/17	2017/18
Gas	Use (kWh)	23,559,266	32,795,885	44,968,071	58,509,662
	tCO_2e	4,943	6,864	9,398	12,405
Oil	Use (kWh)	82,532	56,976	66,849	1,598
	tCO_2e	26	18	21	1
Coal	Use (kWh)	5,803,531	3,582,240	4,335,570	3,779,215
	tCO_2e	2,127	1,310	1,616	1,416
Electricity	Use (kWh)	15,717,738	18,949,354	13,661,699	14,499,282
	tCO_2e	9,734	10,894	7,060	6,463
Green Electricity	0	0	0	0	5,071,930
	0	0	0	0	0
Total Energy CO_2e		16,830	19,086	18,096	20,284
Total Energy Spend		£3,225,824	£3,574,947	£3,542,219	£3,416,821

Performance

The Trust's gas consumption has increased 30 per cent from the previous year, due to a number of factors within the organisation.

The major elements of this increase include the low calorific value of the coal at Goole District Hospital, as a result, the gas boiler was used for extended periods to meet site demand to sustain current site operational requirements.

Equally, there has been increased gas consumption for Scunthorpe General Hospital and Diana, Princess of Wales Hospital, therefore the Trust datasets suggest that the baseload demand for both estates has increased due to operational and weather-related factors.

The Combined Heat and Power unit (CHP) unit required a fossil energy input of 11,930,815 kWh (Gas) in order to produce 4,804,078 kWh of site utilised electricity at Grimsby Hospital with an overall efficiency of 81 per cent.

The low-efficiency percentage is largely due to a reduction in runtime due to unforeseen defects with the unit, hence the increase in Trust electricity consumption compared to 2016/17.

The oil consumption for Grimsby hospital has decreased due to a high sulphur content of the oil and the fact that is was contaminated with water, due to the nature of the oil it was not possible to run the three industrial steam boilers on oil as per maintenance schedule hence the significant reduction in Trust oil consumption.

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

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services.

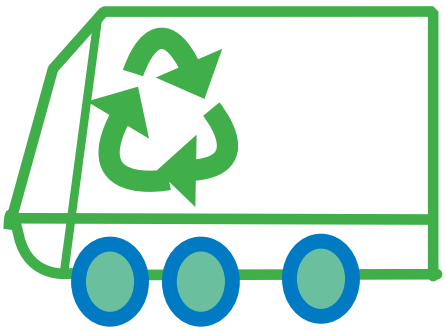
Every action counts and we are a lean organisation trying to realise efficiencies for cost and carbon (CO2e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

Air pollution, accidents and noise all cause health problems for our local population, patients, staff and visitors and are caused by cars, as well as other forms of transport.

Category	Mode	2014/15	2015/16	2016/17	2017/18
Patient and visitor own travel	miles	0	6,066,995	22,856,442	27,969,311
	tCO2e	0.00	2,194.04	8,260.56	9,966.16
Staff commute	miles	5,163,319	6,244,014	6,150,400	6,147,952
	tCO2e	1,897.15	2,258.06	2,222.82	2,190.67
Business travel and fleet	miles	0	0	0	4,519,564
	tCO2e	0.00	0.00	0.00	1,610.25
Active and public transport	miles	0	0	0	164,200
	tCO2e	0.00	0.00	0.00	14.80
Owned Electric and PHEV mileage	miles	0	0	19,717	22,033
	tCO2e	0.00	0.00	2.24	2.50
Total cost of business travel	£	0.00	0.00	0.00	1,575,389

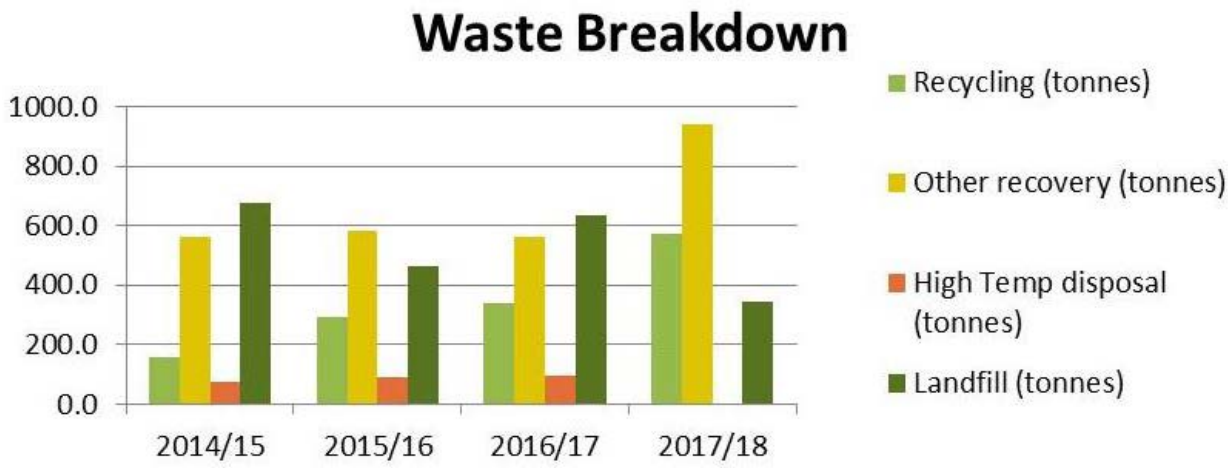
Performance

We are continually working towards a more carbon efficient fleet. We have introduced four electric vehicles and are planning to replace the main pool car fleet with further lower emission and hybrid vehicles. Staff are actively encouraged to consider alternatives to travelling by car with cycling promotion heavily on the agenda, with upgrades on Scunthorpe and Grimsby Hospital site cycle shelters. We also run a cross site shuttle service for staff to utilise for travelling between Grimsby and Scunthorpe hospitals which contributes to reducing our carbon footprint. Car Sharing is another initiative we are working on to encourage reduction if vehicular traffic on site.



Waste

Waste		2014/15	2015/16	2016/17	2017/18
Recycling	(tonnes)	160.00	293.00	341.00	573.00
	tCO2e	3.36	5.86	7.16	12.47
Other recovery	(tonnes)	561.00	583.00	564.00	938.00
	tCO2e	11.78	11.66	11.84	20.41
High Temp disposal	(tonnes)	72.00	92.00	93.00	0.00
	tCO2e	15.84	20.15	20.46	0.00
Landfill	(tonnes)	677.00	463.72	636.00	343.00
	tCO2e	165.47	113.34	197.16	118.16
Total Waste (tonnes)		1470.00	1431.72	1634.00	1854.00
% Recycled or re-used		11%	20%	21%	31%
Total Waste tCO_2e		196.45	151.01	236.63	151.04



Performance

We have seen a significant reduction in waste going to landfill through continued work with our waste contractors to redirect the waste to recycling and other recovery. We encourage staff to recycle across all sites. Clinical waste is using a high level of autoclave as the disposal method as oppose to incineration, Orange bagged infectious waste is shredded and autoclaved (made sterile) by our waste contractor and the residues are sent to landfill, however, the landfill sites used captures the gas produced which is used for running gas turbines to produce electricity, therefore this waste has been categorised as other recovery. This has resulted in a decrease in carbon emissions and an increase in tonnage diverting to recycling.

Finite resource use – Water

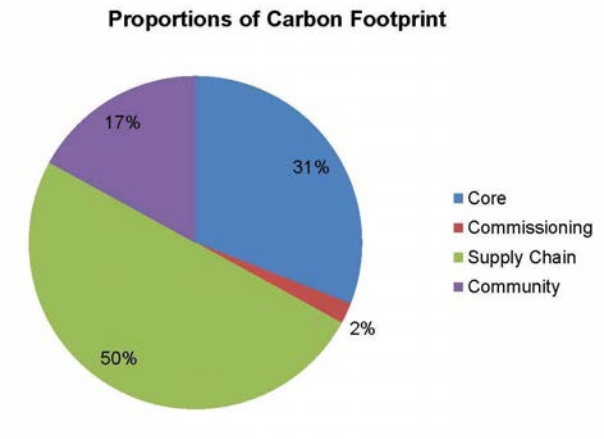
Water		2014/15	2015/16	2016/17	2017/18
Mains Water	m3	122,010	100,114	245,980	311,572
	tCO2e	111	91	224	284
Water & Sewage Spend		£343,284	£323,655	£ 470,137	£468,393

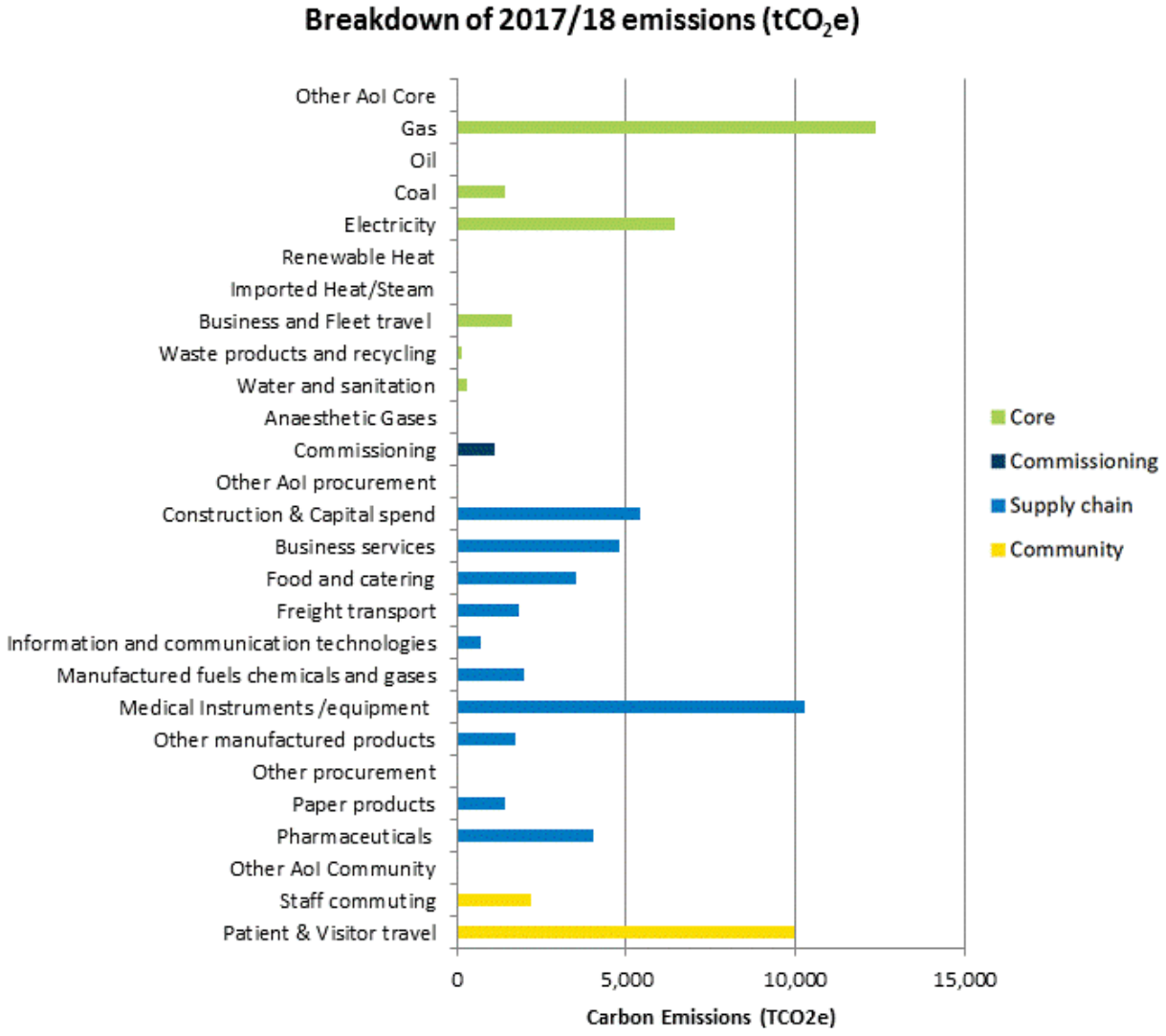
Performance

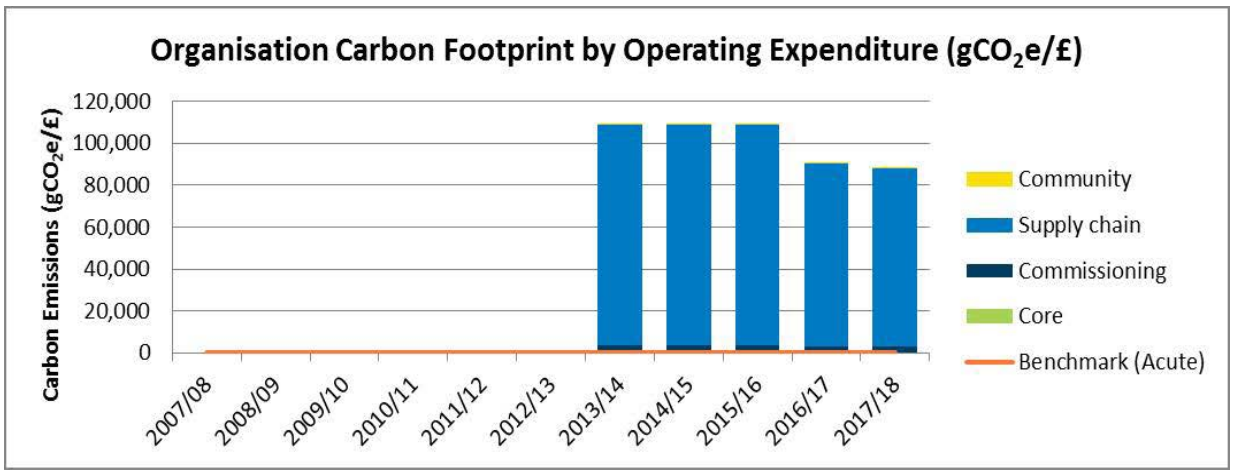
As a result of the stringent water flushing routine combined with infrastructure faults, repairs and leaks there has been a significant increase of 27 per cent in water consumption over the financial year 2017/18.

Modelled Carbon Footprint

The Trust is estimating total carbon footprint of 71,322 tonnes of carbon dioxide equivalent emissions (tCO_2e). Our carbon intensity per pound is 164 grams of carbon dioxide equivalent emissions per pound of operating expenditure ($gCO_2e/£$). Average emissions for acute services is 200 grams per pound.




Breakdown of 2017/18 emissions (tCO2e)
Other AoI Core
Gas
Oil
Coal
Electricity
Renewable Heat
Imported Heat/Steam
Business and Fleet travel
Waste products and recycling
Water and sanitation
Anaesthetic Gases
Commissioning
Other AoI procurement
Construction & Capital spend
Business services
Food and catering
Freight transport
Information and communication technologies
Manufactured fuels chemicals and gases
Medical Instruments /equipment
Other manufactured products
Other procurement
Paper products
Pharmaceuticals
Other AoI Community
Staff commuting
Patient & Visitor travel
0
5,000
10,000
15,000
Carbon Emissions (TCO2e)
Core
Commissioning
Supply chain
Community


Organisation Carbon Footprint by Operating Expenditure (gCO2e/£)
Carbon Emissions (gCO2e/£)
120,000
100,000
80,000
60,000
40,000
20,000
0
2007/08
2008/09
2009/10
2010/11
2011/12
2012/13
2013/14
2014/15
2015/16
2016/17
2017/18
Community
Supply chain
Commissioning
Core
Benchmark (Acute)

Independent auditors' report to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust

Report on the audit of the financial statements

Opinion

In our opinion, Northern Lincolnshire and Goole NHS Foundation Trust's Group and Trust financial statements:

- give a true and fair view of the state of the Group and Trust's affairs as at 31 March 2018 and of the Group's income and expenditure and cash flows for the year then ended;
- have been properly prepared in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18.

We have audited the financial statements, included within the Annual Report and Accounts (the "Annual Report"), which comprise: the Consolidated and Trust's Statement of Financial Position as at 31 March 2018; the Consolidated Statement of Comprehensive Income for the year then ended; the Consolidated Statement of Cashflows for the year then ended; the Consolidated Statement of Changes in Taxpayer's and Other Equity for the year then ended; and the notes to the financial statements, which include a description of the significant accounting policies.

Basis for opinion

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the "Code of Audit Practice"), International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities under ISAs (UK) are further described in the Auditors' responsibilities for the audit of the financial statements section of our report. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Independence

We remained independent of the Group in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, which includes the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements.

Material uncertainty relating to going concern

In forming our opinion on the Group and Trust financial statements, which is not modified, we have considered the adequacy of the disclosure made in note 1 (Accounting Policies) to the financial statements concerning the Group's and the Trust's ability to continue as a going concern.

In the year, the Trust delivered a deficit of £37.86m against its control total for 2017/18 of £13.29m deficit and was placed in financial special measures. It will require further financial support over the coming 12 months to enable it to pay its liabilities as they fall due. However, the extent and nature of any financial support from NHS Improvement is unknown.

These conditions, along with the other matters explained in note 1 to the financial statements, indicate the existence of a material uncertainty which may cast significant doubt about the Group's and the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Group or the Trust were unable to continue as a going concern.

Explanation of Material Uncertainty

In the year, the Trust delivered a deficit of £37.86m against its control total for 2017/18 of £13.29m. This has placed pressure on its cash reserves and, combined with the borrowings from the Department of Health and Social Care of £117.4m at 31 March 2018 and the financial plan for 2018/19, means that further financial support will be required over the coming 12 months to support the financial sustainability of the Trust. However, as described in note 1 to the financial statements, the extent and nature of any financial support from NHS Improvement (NHSI) is unknown and will be agreed between the Trust and NHSI on a monthly basis.

What audit work we performed

We obtained the 2018/19 financial plan and cash flow forecasts, and:

- assessed the reasonableness of the plan's assumptions;
- understood the Trust's Cost Improvement Plan target of £15.0m, and the impact on this of the deterioration in the financial position after the plan was agreed;
- calculated current ratio, gearing ratio and receivable days comparing the in-year performance against plan; and

- considered the reliance that the Trust has on external support to deliver its 2018/19 plan, which at the time of approval of the financial statements the nature and amount had not been agreed.

Our audit approach

Context

Our audit for the year ended 31 March 2018 was planned and executed having regard to the fact that the Group and Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview

- Overall materiality: £6,855,000 which represents 2% of total revenue.
- The scope of the audit covered the Northern Lincolnshire and Goole NHS Foundation Trust group. The Group includes the Trust's wholly owned subsidiary and wholly owned Charitable Funds.
- Risk of fraud in revenue and expenditure recognition; and
- Valuation of land and buildings.

The scope of our audit

As part of designing our audit, we determined materiality and assessed the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain.

As in all of our audits we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

Key audit matters

Key audit matters are those matters that, in the auditors' professional judgement, were of most significance in the audit of the financial statements of the current period and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by the auditors, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. These matters, and any comments we make on the results of our procedures thereon, were addressed in the context of our audit of the financial statements as a whole, and in forming our opinion thereon, and we do not provide a separate opinion on these matters. In addition to going concern, described in the Material Uncertainty relating to going concern section above, we determined the matters described below to be the key audit matters to be communicated in our report. This is not a complete list of all risks identified by our audit.

Key audit matter	*How our audit addressed the Key audit matter*
Risk of fraud in revenue and expenditure recognition and management override of control - Group and Trust *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to the recognition of revenue and expenditure and notes 3 to 5 for further information.* We focused on this area because there is a heightened risk due to: • The Trust being under increasing financial pressure: the	*Revenue* We evaluated and tested the accounting policy for income recognition and found it to be consistent with the requirements of the GAM 17/18. For income/receivable transactions close to the year-end we tested, on a sample basis that the transactions and the associated income had been posted to the correct financial year by tracing them to invoices or other documentary evidence. No differences were identified that required amendment within the financial statements.

Key audit matter	How our audit addressed the Key audit matter
deficit for the year is £37.86m, and whilst the Trust is actively looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate the timing of recognition of both revenue and expenditure. • In order to receive Sustainability and Transformation Funding ("STF") of £10.2m, the Trust needed to achieve its control total for 2017/18 of £13.3m deficit (£23.5m deficit excluding STF), providing further incentive to manipulate timing of both revenue and expenditure. • Given the continued financial support required by the Trust over that period, there remains an increased incentive to misreport the Trusts position. Given these incentives, we considered the key areas of focus to be: • Recognition of revenue and expenditure; • Manipulation through journal postings; and • Items of income or expenditure whose value is dependent upon estimates.	For revenue from Clinical Commissioning Groups, we reconciled revenue received to signed contracts and correspondence between the Trust and the CCG. We also tested a sample of reconciling items to confirm they related to contract variations. No differences were identified that required amendment within the financial statements. We tested a sample of income from activities and other income to invoice and remittance. *Expenditure* For invoices received/ balances paid for a period after the year-end we tested, on a sample basis that the transactions and the associated expense had been posted to the correct financial year by tracing them to other documentary evidence or invoices. Our testing did not identify any items incorrectly recorded. We tested a sample of operating expenses through to invoice to ensure that this had been correctly accounted for. No differences were identified that required amendment within the financial statements. *Intra- NHS balances* We obtained the Trust's mismatch reports received from NHS Improvement, which identified balances (debtor, creditor, income or expenditure balances) that were disputed by the counterparty. We then checked that management had investigated all disputed amounts over the investigation threshold set by NHS Improvement, namely £0.25m, and discussed with them the results of their investigation and the resolution. We also read correspondence with the counterparties, which validated these explanations. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact. *Manipulation through journal postings* We selected a sample of manual and automated journal transactions that had been recognised in both income and expenditure, focusing in particular on those with unusual characteristics. We traced these journal entries to supporting documentation (for example, invoices, good received notes and cash receipts and payments) to check that the transaction was valid and had been correctly accounted for within the financial statements. Our testing identified no issues that required further reporting. *Management estimates* We evaluated and tested management's accounting estimates, focussing on: • accruals; • provisions; • deferred income; and • Property, Plant and Equipment Valuation (see specific area of focus below). We evaluated and challenged the key accounting estimates on which management's estimates were based and the basis of their calculation on a sample basis by: • comparing the assumptions used by management in the calculation of their estimate with independent assumptions and investigating any differences.

Key audit matter	How our audit addressed the Key audit matter
Valuation of Property, Plant and Equipment –Group and Trust *See note 1 to the financial statements for the directors' disclosures of the related accounting policies, judgements and estimates relating to Property, Plant and Equipment and note 16 for further information.* We have focused on this area because Property, Plant and equipment ("PPE") represents the largest balance in the Trust's statement of financial position. PPE is valued at £159.3m. All property, plant and equipment assets are measured initially at cost with land and buildings being subsequently measured at fair value based on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date. A full valuation was undertaken during 2016/17 by the Trust's valuation experts which has been updated during the current year. This valuation has resulted in a net upwards valuation adjustment of £8.06m. The valuation of Land and Buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions therefore our work has focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.	We obtained and read the relevant sections of the full valuation performed by the Trust's Valuers. We have utilised our valuations experts to evaluate and challenged the assumptions and methodology applied in the valuation exercise. We found the assumptions and methodology applied to be consistent and in line with our expectations. We tested the underlying data upon which the valuation was based back to floor plans for a sample of properties. We found the valuation to have been based on appropriate and up to date floor space data. We tested a sample of new additions to land and buildings in the year to confirm they had been appropriately valued – this involved agreement back to supporting invoice. We physically verified a sample of assets to confirm existence and in doing so assessed whether there was any indication of physical obsolescence which would indicate potential impairment. We considered the disclosures in the financial statements and were satisfied that they appropriately reflected the valuation undertaken in the period We considered whether the change in valuation was appropriately disclosed in the financial statements and correctly reflected in management's corresponding accounting entries.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

In establishing our overall approach we assessed the risks of material misstatement, taking into account the nature, likelihood and potential magnitude of any misstatement. Following this assessment, we applied professional judgement to determine the extent of testing required over each balance in the financial statements. We performed most of our audit work at Diana Princess of Wales Hospital, which is where the finance function is based.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

	Group and Trust financial statements
Overall materiality	£6,855,000 (2017: £6,897,000)
How we determined it	2% of revenue (2017: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence of indicators that an alternative benchmark would be appropriate.

For each component in the scope of our group audit, we allocated a materiality that is less than our overall group materiality. Certain components were audited to a local statutory audit materiality that was less than our overall group materiality.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £300,000 (Group audit) (2017: £250,000) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Reporting on other information

The other information comprises all of the information in the Annual Report other than the financial statements and our auditors' report thereon. The directors are responsible for the other information. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except to the extent otherwise explicitly stated in this report, any form of assurance thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit, or otherwise appears to be materially misstated. If we identify an apparent material inconsistency or material misstatement, we are required to perform procedures to conclude whether there is a material misstatement of the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact. We have nothing to report based on these responsibilities.

With respect to the Performance Report and the Accountability Report, we also considered whether the disclosures required by the NHS Foundation Trust Annual Reporting Manual 2017/18 have been included.

Based on the responsibilities described above and our work undertaken in the course of the audit, ISAs (UK) and the Code of Audit Practice require us also to report certain opinions and matters as described below.

Responsibilities for the financial statements and the audit

Responsibilities of the directors for the financial statements

As explained more fully in the Accountability Report set out on page 34, the directors are responsible for the preparation of the financial statements in accordance with the Department of Health and Social Care Group Accounting Manual 2017/18, and for being satisfied that they give a true and fair view. The directors are also responsible for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the directors are responsible for assessing the Trust's ability to continue as a going concern, disclosing as applicable, matters related to going concern and using the going concern basis of accounting unless the directors either intend to liquidate the Trust or to cease operations, or have no realistic alternative but to do so.

The Trust is also responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditors' responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditors' report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the FRC's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditors' report.

We are required under Schedule 10(1) of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively. We have undertaken our work in accordance with the Code of Audit Practice, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice. Based our on risk assessment, we undertook such work as we considered necessary.

We will prepare an annual audit letter which will cover the Trust's key risks in securing economy, efficiency and effectiveness in its use of resources, how these have been discharged by the Trust, and our actions to review these. The Trust is responsible for publishing this annual audit letter, and ensuring that it is available to the public.

Use of this report

This report, including the opinions, has been prepared for and only for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust as a body in accordance with paragraph 24 of Schedule 7 of the National Health Service

Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Other required reporting

Opinions on other matters prescribed by the Code of Audit Practice

Performance Report and Accountability Report

In our opinion, based on the work undertaken in the course of the audit, the information given in the Performance Report and Accountability Report for the year ended 31 March 2018 is consistent with the financial statements and has been prepared in accordance with applicable legal requirements.

In light of the knowledge and understanding of the Trust and its environment obtained in the course of the audit, we did not identify any material misstatements in the Performance Report or Accountability Report.

In addition, the parts of the Remuneration and Staff reports to be audited have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2017/18.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report, by exception, if we conclude we are not satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis of adverse conclusion

License condition

The license condition issued by Monitor on 6 August 2013 to the Board of Directors and the Council of Governors, triggered by a deterioration in the Trust's financial position, still remains in place. In addition on 8 April 2015, Monitor (now NHS Improvement) issued enforcement undertakings, which remain in place, stating that the Trust had not demonstrated that it had established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively.

Financial Performance and financial special measures

In 2017/18 the Trust planned a budgeted deficit of £13.3m (ex STF of £10.2m). The Trust experienced financial pressure during the year that resulted in it failing to meet the control total for all four quarters. Recovery plans did not result in the anticipated financial improvement and the Trust delivered a £37.86m deficit.

On 24 March 2017, NHS Improvement placed the Trust in Financial Special Measures, noting the following:

- It had a control total, but had a significant negative variance against the control plan and is forecasting a significant deficit; and
- There are no factors NHS Improvement considers that mitigate the need for Financial Special Measures.

CQC Inspection and Quality special measures

In November 2016, the Trust had a follow up Care Quality Commission (CQC) inspection, the outcome of which was received on 6 April 2017, with an overall 'Inadequate' rating being determined. The CQC also recommended to NHS Improvement that the Trust be placed back in quality special measures. NHS Improvement placed the Trust in quality special measures on 6 April 2017, a status which remains in place.

The above issues are evidence of weaknesses in proper arrangements for:

- planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- for planning and developing workforce to deliver strategic priorities effectively.

Adverse conclusion

As a result of these matters, we have concluded that the Trust has not put in place proper arrangements for securing economy, efficiency and effectiveness in the use of its resources for the year ended 31 March 2018.

Other matters on which we report by exception

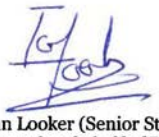
We are required to report to you if:

- the statement given by the directors on page 49, in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that they consider the Annual Report taken as a whole to be fair, balanced and understandable, and provides the information necessary for members to assess the Group and Trust's performance, business model and strategy is materially inconsistent with our knowledge of the Trust acquired in the course of performing our audit.
- the section of the Annual report on page 45, as required by provision C.3.9 of the NHS Foundation Trust Code of Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.
- the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 or is misleading or inconsistent with our knowledge acquired in the course of performing our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.
- we have referred a matter to Monitor under Schedule 10 (6) of the National Health Service Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful, or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.
- we have issued a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006.
- we have not received all the information and explanations we require for our audit.

We have no exceptions to report arising from this responsibility.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code of Audit Practice.



Ian Looker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Leeds
24 May 2018


Claire Verhees
Staff Nurse

Northern Lincolnshire and Goole NHS Foundation Trust

Annual accounts for the year ended 31 March 2018

Foreword to the Accounts

These accounts, for the year ended 31 March 2018, have been prepared by Northern Lincolnshire and Goole NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed: 

Name: Dr Peter Reading

Job title: Chief Executive

Date: 24 May 2018

Consolidated Statement of Comprehensive Income for the year ended 31 March 2018

	Note	2017/18 £000	2016/17 £000
Operating income from patient care activities	3	307,771	305,173
Other operating income	4	38,727	39,716
In addition, the NHS Foundation Trust has had a number of material transactions with other Government departments and other central and Local Government bodies	5.1	(380,119)	(375,586)
The NHS Foundation Trust has also received revenue and capital payments from a number of charitable funds. The trustees of the charitable funds are also members of the NHS Foundation Trust Board		**(33,621)**	**(30,697)**
Finance income	10	121	99
Finance expenses	11.1	(2,898)	(1,214)
PDC dividends payable		(571)	(1,744)
Net finance costs		**(3,348)**	**(2,859)**
Other gains / (losses)	4.2, 11.3, 20.1	(116)	2,563
Share of profit / (losses) of associates / joint arrangements		79	168
Gains / (losses) arising from transfers by absorption		-	-
Corporation tax expense	13	(30)	-
Deficit for the year from continuing operations		**(37,036)**	**(30,825)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	14	-	-
Deficit for the year		**(37,036)**	**(30,825)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	6,12	(763)	(779)
Revaluations	12	5,973	2,522
Total comprehensive expense for the period		**(31,826)**	**(29,082)**
Deficit for the period attributable to:			
Northern Lincolnshire and Goole NHS Foundation Trust		(37,984)	(31,668)
Total comprehensive expense for the period attributable to:			
Northern Lincolnshire and Goole NHS Foundation Trust		(31,826)	(29,925)
Breakdown of Deficit			
Trading deficit		(40,835)	(30,996)
Impairments or reversals or previous impairments		2,851	(672)
Deficit after impairments		(37,984)	(31,668)
Consolidation of WebV Solutions Limited		122	1
Consolidation of Charity net income		826	842
Accumulated Deficit		**(37,036)**	**(30,825)**

Statements of Financial Position as at 31 March 2018

		Group		Trust	
		31 March 2018	31 March 2017	31 March 2018	31 March 2017
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	15	849	865	849	865
Property, plant and equipment	16	159,279	145,975	159,279	145,975
Investments in associates (and joint ventures)	20.2	-	-	-	-
Other investments / financial assets	20.1	1,978	2,032	-	-
Trade and other receivables	24.1	-	224	-	224
Total non-current assets		**162,106**	**149,096**	**160,128**	**147,064**
Current assets					
Inventories	23	2,773	2,658	2,773	2,658
Trade and other receivables	24.1	22,649	20,571	22,501	20,464
Cash and cash equivalents	29.1	12,555	7,672	11,370	7,469
Total current assets		**37,977**	**30,901**	**36,644**	**30,591**
Current liabilities					
Trade and other payables	30.1	(48,867)	(40,666)	(48,665)	(40,561)
Borrowings	32	(2,146)	(1,960)	(2,146)	(1,960)
Provisions	35.1	(1,008)	(2,446)	(1,008)	(2,446)
Other liabilities	31	(177)	(133)	(177)	(133)
Total current liabilities		**(52,198)**	**(45,205)**	**(51,996)**	**(45,100)**
Total assets less current liabilities		**147,885**	**134,792**	**144,776**	**132,555**
Non-current liabilities					
Borrowings	32	(115,282)	(70,375)	(115,282)	(70,375)
Provisions	35.1	(4,696)	(5,584)	(4,696)	(5,584)
Total non-current liabilities		**(119,978)**	**(75,959)**	**(119,978)**	**(75,959)**
Total assets employed		**27,907**	**58,833**	**24,798**	**56,596**
Financed by					
Public dividend capital		126,939	126,039	126,939	126,039
Revaluation reserve		18,861	13,651	18,861	13,651
Income and expenditure reserve		(120,880)	(83,018)	(121,002)	(83,094)
Charitable fund reserves	21	2,987	2,161	-	-
Total taxpayers' equity		**27,907**	**58,833**	**24,798**	**56,596**

The notes on pages 8 to 51 form part of these accounts.

Name: Dr Peter Reading

Position: Chief Executive

Date: 24 May 2018

Consolidated Statement of Changes in Taxpayers' and other Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	WebV Limited Income and expenditure reserve	Charitable fund reserves	Total taxpayers' and others' equity
Group and Parent	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Taxpayers' and others' equity at 1 April 2017 - brought forward	**126,039**	**13,651**	**(83,019)**	**1**	**2,161**	**58,833**
Surplus/(deficit) for the year	-	-	(38,668)	122	1,510	(37,036)
Impairments	-	(763)	-		-	(763)
Revaluations	-	5,973	-		-	5,973
Public dividend capital received	900	-	-		-	900
Other reserve movements	-	-	684		(684)	-
Taxpayers' and others' equity at 31 March 2018	**126,939**	**18,861**	**(121,003)**	**123**	**2,987**	**27,907**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	WebV Limited Income and expenditure reserve	Charitable fund reserves	Total taxpayers' and others' equity
Group and Parent	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Taxpayers' and others' equity at 1 April 2016 - brought forward	**126,039**	**11,908**	**(51,920)**	**-**	**1,888**	**87,915**
Surplus/(deficit) for the year	-	-	(31,668)	1	842	(30,825)
Impairments	-	(779)	-		-	(779)
Revaluations	-	2,522	-		-	2,522
Other reserve movements	-	-	569		(569)	-
Taxpayers' and others' equity at 31 March 2017	**126,039**	**13,651**	**(83,019)**	**1**	**2,161**	**58,833**

Information on Reserves

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care (DHSC). A charge, reflecting the cost of capital utilised by the Trust, is payable to the HDSC as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reserve impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

NHS Charitable funds reserves

This balance represents the ring-fenced funds held by the NHS Charitable Fund consolidated within these financial statements.

These reserves are classified as restricted or unrestricted.

Consolidated Statement of Cash Flows for the year ended 31 March 2018

	Note	Group 2017/18 £000	2016/17 £000
Cash flows from operating activities			
Operating deficit		(33,621)	(30,697)
Non-cash income and expense:			
Depreciation and amortisation	5.1	7,077	7,449
Net impairments/(reversal of impairments)	6	(2,851)	672
Income recognised in respect of capital donations	4	(281)	(91)
(Increase)/decrease in receivables and other assets		(1,989)	(4,513)
(Increase)/decrease in inventories		(115)	(169)
Increase/(decrease) in payables and other liabilities		5,153	2,424
Increase/(decrease) in provisions		(2,331)	132
Movements in charitable fund working capital		97	(61)
Tax (paid)/received		-	-
Other movements in operating cash flows		-	(78)
Net cash generated used in operating activities		**(28,861)**	**(24,932)**
Cash flows from investing activities			
Interest received	10	46	32
Purchase of intangible assets		(379)	(116)
Purchase of PPE and investment property		(9,846)	(10,685)
Sales of PPE and investment property		183	2,973
Receipt of cash donations to purchase assets		281	91
Net cash flows from charitable fund investing activities		75	67
Cash from acquisitions/disposals of subsidiaries		128	-
Net cash used in investing activities		**(9,512)**	**(7,638)**
Cash flows from financing activities			
Public dividend capital received		900	-
Movement on loans from DHSC		45,194	37,841
Capital element of finance lease rental payments		(22)	(49)
Interest paid on finance lease liabilities	11.1	(7)	(14)
Other interest paid	11.1	(2,128)	(1,187)
PDC dividend paid		(681)	(1,697)
Net cash generated from financing activities		**43,256**	**34,894**
Increase in cash and cash equivalents		**4,883**	**2,324**
Cash and cash equivalents at 1 April		**7,672**	**5,348**
Cash and cash equivalents at 31 March	29.1	**12,555**	**7,672**

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

NHS Improvement (NHSI), in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the NHS Foundation Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2017/18 issued by the DHSC. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS Foundation Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to accounts.

Note 1.1.1 Accounting Convention

These accounts have been prepared on a going concern basis, under the historical cost convention modified to account for the revaluation of land and buildings. Plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities have been reviewed to represent fair value as at 31 March 2018.

Note 1.1.2 Going Concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust's Annual Reporting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

The Trust's performance in year showed a deficit of £37.86m inclusive of all non cash balance sheet review adjustments and impairment reversals.

The Trust did not receive any Sustainability and Transformational Funding (STF). The Trust had year end cash balances of £11.4m. During the year the Trust had to utilise revenue support funding of £46.75m.

In March 2017 NHSI formally placed the Trust in Financial Special Measures. Financial Special Measures presents no risk of the Trust having to cease trading within the next twelve months, or face regulator action to cease or modify its trading status in that period.

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

Delivery of this level of improvement will require material improvement in productivity (averaging around 4%), to support income projections, a savings programme of approximately 4% of expenditure, and also some degree of progress on strategic redesign of services, delivering verifiable improvement.

In addition to the savings programme the Trust has also identified planned risks to income driven by restrictions on CCG allocations.

The Trust remains dependent upon central loan support to maintain cashflow.

There obviously continues to be some uncertainty around the extent and nature of any financial support from NHSI, however, given there is no indication from regulators that the Trust will cease any part of its' trading activities the Trust will continue its' ability as a going concern.

The directors have determined that it remains appropriate to prepare these accounts on a going concern basis.

The accounts do not include any adjustments that would result if the NHS Foundation Trust was unable to continue as a going concern.

Note 1.2 Consolidation

1.2.1 Subsidiaries - Charitable Funds

The NHS Foundation Trust is the corporate trustee to Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds.

The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because it is exposed to variable returns from its involvement with the charitable fund to obtain benefits for itself, its patients or its staff.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- Eliminate intra-group transactions, balanced, gains and losses.

Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds Accounting Policies:

a) Funds Structure

Perpetuity funds are funds which are to be used in accordance with specific restriction imposed by the donor. Where the restriction requires the gift to be invested to produce income but the capital cannot be spent, it is classed as a perpetuity fund.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non-binding wishes or where the trustees, at their discretion, have created a fund for a specific purpose.

The charity does not have any perpetuity funds or expendable endowments:

b) Incoming Resources

All incoming resources are recognised once the charity has entitlement to the resources. Provided it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

c) Incoming Resources from Legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

A receipt is normally probable when;

- there has been grant of probate;

- the executors have established that there are sufficient assets in the estate, after settling any liabilities, to pay the legacy; and

- any conditions attached to the legacy are either within the control of the charity or have been met.

Legacies to which the charity is entitled and for which notification has been received but uncertainty over measurement remains, are disclosed, if material, as contingent income.

d) Gifts in Kind

Assets given for distribution by the funds are included in the Statement of Financial Activities only when distributed.

In all cases the amount at which the gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised.

e) VAT and Tax

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

The charity is a registered charity, and as such is entitled to certain tax exemptions on income and profits from investments, and surpluses on any trading activities carried on in furtherance of the charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

f) Allocation of Overhead and Support Costs

Overhead and support costs have been apportioned on an appropriate basis between all funds. The apportionment is in proportion to the quarterly aggregate balance on each of the funds and is distributed on a quarterly basis.

g) Non Current Investments

Investments are stated at market value as at the balance sheet date. The Statement of Comprehensive Income includes the net gains and losses arising on revaluation and disposals throughout the year.

The Common Investment Fund Units and Brewin Dolphin Ltd portfolio are included in the balance sheet at the closing dealing price at 31 March 2018

h) Realised Gains and Losses

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later). Gains or losses arising on revaluation are credited or charged in the 'Movement in the fair value of other investments' in the income and expenditure account.

Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.2.2 Subsidiaries - WebV Solutions Limited

The NHS Foundation Trust owns 100% of the share capital in WebV

Solutions Limited. The statutory accounts are prepared to 31 March in accordance with UK Financial Reporting Standards (FRS) 102. On consolidation, necessary adjustments are made to the companies' assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and

- Eliminate intra-group transactions, balances, gains and losses.

1.3 Joint Venture

The Foundation Trust entered into a cooperation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operated from Ward 4 at Goole District Hospital. The joint venture provided both NHS Care and care independent to the NHS but within an NHS location.

The joint venture ceased on 31 August 2017. The Trust includes within its financial statements its share of the activities, assets, liabilities and any transactions relating to the termination of this agreement.

1.4 Critical Accounting Judgements and Key Sources of Estimation and Accuracy

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

a) Going Concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. Please refer to Accounting Policy 1.1.

b) Property Valuations and Asset Lives

Valuations are undertaken by an independent external valuer. These values will therefore be subject to changes in market conditions and market values. The asset lives are also estimated by the independent external valuer and are subject to professional judgement.

c) Accruals

Accruals included within the accounts are based on the best available information. This is applied in conjunction with historical experience and based on individual circumstances.

d) Annual Leave Accruals

The NHS Foundation Trust has written to all members of staff requesting details of their outstanding annual leave at the end of March 2018. The value of the outstanding amount has been calculated based on the returns received back from staff and their average salary. The NHS Foundation Trust is carrying £0.217m.

e) Provisions

The estimates of outcome and financial effect of provisions are determined by the judgement of the management of the Trust, supplemented by experience of similar transactions and, in some cases, reports of independent experts.

Uncertainties surrounding the amount to be recognised as a provision are dealt with by various means according to the circumstance. Where the provision being measured involves more than one outcome, the obligation is estimated by weighing all possible outcomes by their associated probabilities; the expected value of the outcome.

Where there is a range of possible outcomes, and each point in the range is likely as the other, the mid-point of the range is used. Where a single outcome is being measured, the individual most likely outcome may be the best estimate of the liability. However, even in such a case, the Trust considers other possible outcomes.

During the year the NHS Foundation Trust released £1.088m (net) of restructuring provision to the Income and Expenditure account. The NHS Foundation Trust continues to carrying a restructuring provision of £0.168m to support payments in line with the NHS Foundation Trust pay protection policy.

1.5 Income

Income is accounted for applying the accruals convention. The income is shown gross except where administrative arrangements exists, whereby the associated income is netted off with the corresponding expenditure in accordance with the DHSC Accounting Manual (DH GAM). In recognising income in the current financial year, the NHS Foundation Trust has considered and followed IAS18.

Income in respect of services provided is recognised when, and to the extent that, performance occurs

and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Where income has not been received prior to the year end, but the provision of a healthcare service has commenced, i.e. partially completed patient spells, then the income relating to the patient activity is accrued. The closing accrued income is estimated based on the number of days of incomplete spells at an average daily tariff adjusted to reflect the case mix.

The Foundation Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts which is 2.16% above the national recommended rate of 22.84%. This rate is based on local trends and experiences of recovery.

1.6 Expenditure

1.6.1 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

1.6.3 Apprentice Levy

The Apprentice levy was introduced by the UK Government on 6 April 2017.

There are two aspects to the treatment of the levy in local accounts:

- Recognition of the initial payment in social security cost;

- Recognition of the receipt of the associated training grant.

1.6.4 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, Plant and Equipment

Recognition

"Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control."

Items form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of

components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Borrowing costs associated with the construction of new assets are not capitalised.

Measurement

"Valuation
All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Foundation Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed by professional valuers every five years and in the intervening years by the use of appropriate indices or by interim valuation as necessary to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Freehold Properties – Existing Use Value (EUV);
- Specialised buildings – Depreciated Replacement Cost (DRC) – Modern Equivalent Asset (MEA);
- Others – DRC – EUV;
- Land – Modern Equivalent Asset (MEA).

1.7 Property, Plant and Equipment

For any new acquisition of property, plant and equipment, the following table details the useful economic lives for the main classes of assets and where applicable, sub categories within each:

Main Assets	Sub Category	Life in Years
Buildings	Structural Engineering	Up to 100 years
Fixtures	Plant, machinery and equipment	5 to 15 years
	Furniture and fittings	5 to 10 years
	IT equipment	Up to 5 years
Vehicles/ transport equipment		Up to 7 years
Intangible		Up to 10 years

Valuations are carried out in accordance with the current Valuation Standards and UK Valuation Standards contained within the Royal Institute of Chartered Surveyors (RICS) Valuation Standards – The Red Book, which are consistent with the agreed requirements of the DHSC and HM Treasury.

Property assets have been valued primarily by using the Depreciated Replacement Cost (DRC) approach. In accordance with VS6.6, the DRC will be subject to the prospect and viability of the continued occupation and use by the Foundation Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The ultimate objective of the valuation is to place a value upon the asset. In this the value of the land in providing a modern equivalent facility was also considered. The modern equivalent may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at present, which has given rise to reduction in the land values.

The results of these valuations have been incorporated into these financial statements.

Equipment assets are valued using appropriate indices (for 2017/18 no change) and predominantly the Depreciated Replacement Cost is assumed to be the fair value. Annually, an equipment review is also conducted by the department/ directorate/equipment specialist and the life of the equipment assets is reviewed in conjunction with the experts in the field (medical electronics/suppliers/market intelligence). Assets in the course of construction are valued at current cost and they are revalued by professional valuers when they are brought into use or as part of the five or intervening years valuation whichever occurs first. These assets include any existing land or buildings under the control of a contractor.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Revaluation and Impairments

At each reporting period end, the Foundation Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the DHSC GAM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item under "Other Comprehensive Income".

De-Recognition

Assets intended for disposal, are reclassified as 'Held for Sale' once all of the following criteria are met:

· The asset is available for immediate sale in its present condition subject only to terms;
· Which are usual and customary for such sales; · The sale must be highly probable i.e.:

Management are committed to a plan to sell the asset;

An active programme has begun to find a buyer and complete the sale;

The asset is being actively marketed at a reasonable price;
The sale is expected to be completed within 12 months of the date of classification as "held for Sale"; and

The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significantly changed.
Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8 Donated Assets

Donated and grant funded property, plant and equipment assets are

capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor imposes a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Within these financial statements, the Foundation trust does not have any donations with conditions attached at this present moment in time.

1.9 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally Generated Intangible Assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- The Foundation Trust intends to complete the asset and sell or use it;
- The ability to sell or use the intangible asset;
- How the intangible asset will generate probable future economic benefits or service potential;
- The availability of adequate financial, technical and other resources to complete the intangible asset and sell or use it, and
- The ability to measure reliably the expenses attributable to the intangible asset during its development.

Software

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Economic lives of intangible assets:		
Intangible assets – internally generated	**Min. Life – Years**	**Max. Life – Years**
Information technology	5	5
Intangible assets – purchased		
Software	5	10
Licences & Trademarks	5	10

1.10 Government Grants

Government grants are grants from Government bodies other than income from Clinical Commissioning Groups (CCG's) or NHS Trusts for the provision of services. Where a Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.12 Private Finance Initiative (PFI) Transactions

At the 31 March 2018, the Foundation Trust did not have any PFI transactions.

1.13 Leases

The Trust as Lessee

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires."

Operating Leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease."

Leases of Land and Buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. "

The Foundation Trust as a Lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs, Disability Trust etc. renewable on an annual basis. These are operating leases and the rental from these leases is recognised on a straight line basis within these financial statements."

1.14 Cash and Cash Equivalent

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the NHS Foundation Trust is disclosed at note 35.2 but is not recognised in the NHS Foundation Trust's accounts. "

1.16 Non-Clinical Risk Pooling

The NHS Foundation Trust participates in the Property Expenses Scheme (PES) and the Liabilities to Third Parties Scheme (LTPS). Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises. "

1.17 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 0.10% in real terms for early retirement and injury benefit provisions only.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Foundation Trust has developed a detailed

formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Sustainability and Carbon Reduction Commitment (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Foundation Trust has registered with the CRC scheme, and therefore, is required to surrender to the Government an allowance for every tonne of CO2 emitted during the financial year. Accordingly, the Foundation Trust has recognised a liability (and related expense) in respect of this obligation for CO2 emissions.

The carrying amount of the liability at 31 March 2018 reflects the CO2 emissions that have been made during this financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be paid out at the rate of £17.70 per tonne allowance.

1.19 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 36 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 36, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.20 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the DHSC (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.21 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Corporation Tax

The NHS Foundation Trust has carried out a review of corporation tax liability of its non-healthcare activities. At present, all activities are either ancillary to the Trust's patient care activity or are below the de minimus level at which corporation tax is due. Therefore, the Trust has determined that it has no liability for corporation tax. Further guidance is awaited from NHS Improvement, the HM Treasury and the Inland Revenue.

The Trust will incur corporation tax through its wholly owned subsidiary WebV Solutions Limited and this has been estimated at £0.03m.

1.23 Foreign Exchange

The functional and presentational currencies of the Foundation Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Foundation Trust does not have any assets or liabilities denominated in a foreign currency at the

Statement of Financial Position date.

1.24 Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 45) to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.25 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 42 is compiled directly from the losses and compensations register which is prepared on an accrual basis with the exception of provisions for any future losses.

1.26 Financial Instruments – Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the NHS Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.

De-Recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.26 Financial Instruments – Financial Assets and Financial Liabilities

Classification and Measurement

Financial assets are classified into the following categories:

- Financial assets at fair value through income and expenditure;
- Loans and receivables;
- Available for sale financial assets.

Financial liabilities are classified as:

- Fair value through income and expenditure, or as
- Other financial liabilities.

Financial Assets and Financial Liabilities at Fair Value through Income and Expenditure

Financial assets and financial liabilities at "fair value through income and expenditure are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not "closely-related to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains and losses in the Statement of Comprehensive Income.

Loans and Receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

The Foundation Trust's loans and receivables comprise of, cash and cash equivalents, NHS debtors, accrued income and "other receivables".

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments/ receipts

through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and charged/ credited to the Statement of Comprehensive Income.

Available for Sale Financial Assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Foundation Trust intends to dispose of them within 12 months of the date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of "other comprehensive income. When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "Finance Costs" in the Statement of Comprehensive Income.

Other Financial Liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred and measured subsequently at amortised cost using the effective interest method, except for loans from DHSC, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

The Foundation Trust has reviewed all its main contracts and any derivatives the contracts many have with other contracts are 'closely-related' and therefore, does not warrant separate accounting or disclosure.

Determination of Fair Value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from using a number of appropriate techniques including quoted market prices, independent professional appraisals, discounted cash flow analysis, and previous trends and experiences.

Impairment of Financial Assets

At the end of the reporting period, the Foundation Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

In line with policy, the Foundation Trust has undertaken a review of all outstanding debts and suitable provisions are recognised within these statements for bad and doubtful debts.

1.27 Transfers of Functions to / from Other NHS Bodies / Local Government Bodies

For functions that have been transferred to the Foundation Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts

are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.28 Accounting Standards, amendments and interpretations that have been adopted early

No new accounting standards or revisions to existing standards have been adopted early in 2017/18.

1.29 Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM / DHSC GAM does not require the following Standards and Interpretations to be applied in 2017/18. The impact of IFRS 9 relating to the impairment for financial assets would increase the Trust's bad debt provision by £0.65m. The application of the remaining Standards as revised is not expected to have a material impact on the accounts for 2017/18, were they applied in that year.

IFRS 9

Financial Instruments – Assets/ Liabilities

Expected to be effective from 2018/19.

IFRS 15

Revenue from Contracts with Customers

Expected to be effective from 2018/19.

IFRS 16

Leases

Expected to be effective from 2019/20.

IFRS 17

Insurance Contracts

Expected to be effective from 2021/22.

IFRS 22

Foreign Currency Transactions and Advance Consideration

Effective from 2018/19

IFRC 23

Uncertainty over Income tax Treatments

Effective from 2019/20

Note 2 Operating Segments

The NHS Foundation Trust's major activity is healthcare and therefore is treated as a single segment.

The operating results of the Foundation Trust are reviewed monthly by the Foundation Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes non-executive directors. For 2017/18, the Board of Directors reviewed the financial position of the Foundation Trust as a whole in their decision making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		Total	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
Income	346,498	344,889	346,498	344,889
Deficit before impairments and Restructuring	33,097	31,448	33,097	31,448
Restructuring costs	1,088	49	1,088	49
Impairment reversals relating to market value changes included in expenses	3,136	1,237	3,136	1,237
Impairments relating to market value changes charged to expenses	(285)	(1,909)	(285)	(1,909)
Retained Deficit	37,036	30,825	37,036	30,825
Segment net assets	27,907	58,833	27,907	58,833

2.1 Income Generation Activities

The Foundation Trust undertakes certain activities with an aim of break even or achieving a small profit, which is then used to support patient care.

Some of these activities are essential for providing the right level of service to patients and visitors and the profit element, if any, is incidental to the service provision.

The following table provides details of activities for which gross income exceeded £1m.

	2017/18	2016/17
	£000	£000
Income	2,058	2,288
Direct costs	(874)	(887)
Surplus before indirect costs	1,184	1,401
Indirect Costs	(837)	(651)
Surplus	347	750

i) Car Parking Services

Car parking services is a managed service operated by ISS Mediclean. The income is received by the Foundation Trust and is accounted for gross within the financial statements.

ii) Staff Accommodation

Staff accommodation amounted to £1.10m (£1.13m 2016/17) during the year. However, the costs associated with the income generation form part of the costs of the total provision of accommodation and property rental.

Note 3 Operating Income from Patient Care Activities

Note 3.1 Income from Patient Care Activities (by nature)

	Group	
	2017/18	2016/17
	£000	£000
Acute services		
Elective income	41,056	42,464
Non elective income	72,858	70,453
First outpatient income	18,168	19,415
Follow up outpatient income	20,755	23,734
A & E income	16,455	14,739
High cost drugs income from commissioners (excluding pass-through costs)	26,653	25,001
Other NHS clinical income *	108,420	106,352
Community services		
Community services income from CCGs and NHS England	-	-
Income from other sources (e.g. local authorities)	665	-
All services		
Private patient income	1,008	1,033
Other clinical income	1,733	1,982
Total Income from Activities	**307,771**	**305,173**

* Other NHS clinical income includes income from non-tariff services relating to activity such as Pathology, Radiology, Imaging, Therapy, Community etc.

Note 3.2 Income from Patient Care Activities (by source)

	Group	
Income from Patient Care Activities Received from:	2017/18	2016/17
	£000	£000
NHS England	23,786	20,114
Clinical Commissioning Groups	264,013	265,455
Other NHS providers	15,761	14,293
NHS other	23	-
Local Authorities	1,447	2,116
Non-NHS: private patients	1,008	1,033
Non-NHS: overseas patients (chargeable to patient)	154	266
NHS injury scheme (was RTA)*	912	1,165
Non NHS: other	667	731
Total Income from Activities	**307,771**	**305,173**
Of which:		
Related to continuing operations	**307,771**	**305,173**
Related to discontinued operations	-	-

* Injury cost recovery income is subject to a provision for impairment of receivables of 25%, which is 2.16% more than the recommended DHSC rate, to reflect expected rates of collection based on historical trend.

Note 3.3 Overseas Visitors (relating to patients charged directly by the NHS Foundation Trust

	Group	
	2017/18	2016/17
	£000	£000
Income recognised this year	154	266
Cash payments received in-year	46	74
Amounts written off in-year	6	61

The remaining balance in each year is accounted for across accounts receivable and allowance for doubtful debt.

Note 4 Other Operating Income

	Group	
	2017/18	2016/17
	£000	£000
Research and development	660	705
Education and training	9,455	9,203
Receipt of capital grants and donations	281	91
Non-patient care services to other bodies *	20,285	18,428
Sustainability and transformation fund income	2,286	5,391
Charitable fund incoming resources	1,803	561
Other income **	3,957	5,337
Total Other Operating Income	**38,727**	**39,716**
Of which:		
Related to continuing operations	38,727	39,716
Related to discontinued operations	-	-

* Non Patient Care Services to other bodies includes £10.4m (£10.3m 2016/17) income from United Lincolnshire Hospitals NHS Trust for Pathology services, £2.0m (£2.1m 2016/17) from other providers for Pathology Services, and £5.0m (£5.3m 2016/17) relates to other provider to provider agreements.

** Other income includes £2.06m (£2.28m 2016/17) for car parking, £0.02m (£0.67m 2016/17) for catering and £1.10m (£1.13m 2016/17) for staff accommodation.

Note 4.1 Income from activities arising from commissioner requested services

Under the terms of its provider licence, the NHS Foundation Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table right:

	Group	
	2017/18	2016/17
	£000	£000
Income from services designated as commissioner requested services	297,570	295,058
Income from services not designated as commissioner requested services	10,201	10,115
Total	**307,771**	**305,173**

Note 4.2 Profits and losses on disposal of property, plant and equipment

	Group	
	2017/18	2016/17
	£000	£000
Gains on disposal of land and buildings	7	2,359
Gains on disposal of other property plant and equipment	57	40
Losses on disposal of land and buildings	(108)	(63)
Losses on disposal of other property plant and equipment	(18)	(18)
Total gains / (losses) on disposal of assets	**(62)**	**2,318**

Note 5.1 Operating Expenses

	Group	
	2017/18	2016/17
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	5,486	6,322
Purchase of healthcare from non-NHS and non-DHSC bodies	5,577	4,925
Staff and executive directors costs	256,120	247,763
Remuneration of non-executive directors	134	125
Supplies and services - clinical (excluding drugs costs)	31,465	31,693
Supplies and services - general	4,504	4,654
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	32,287	32,508
Consultancy costs	3,231	548
Establishment	2,888	3,155
Premises	15,038	17,213
Transport (including patient travel)	2,850	2,585
Depreciation on property, plant and equipment	6,682	7,046
Amortisation on intangible assets	395	403
Net impairments	(2,851)	672
Increase/(decrease) in provision for impairment of receivables	(26)	70
Increase/(decrease) in other provisions	(1,361)	-
Change in provisions discount rate(s)	-	482
Audit fees payable to the External Auditor		
audit services- statutory audit	54	66
other auditor remuneration (external auditor only)	9	10
Internal audit costs	119	83
Clinical negligence	13,038	11,842
Legal fees	502	392
Insurance	370	369
Research and development	481	475
Education and training	1,408	1,296
Rentals under operating leases	331	373
Early retirements	95	60
Redundancy	-	(29)
Hospitality	48	58
Losses, ex gratia & special payments	29	15
Other NHS charitable fund resources expended	314	31
Other	902	381
Total	**380,119**	**375,586**
Of which:		
Related to continuing operations	380,119	375,586
Related to discontinued operations	-	-

Note 5.2 Other Auditor Remuneration

	Group	
	2017/18	2016/17
	£000	£000
Other auditor remuneration paid to the External Auditor:		
1. Audit of accounts of any associate of the NHS Foundation Trust	-	-
2. Audit-related assurance services	9	10
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	**9**	**10**

Note 5.3 Limitation on Auditor's Liability

The limitation on auditor's liability for external audit work is £1m (2016/17: £1m).

Note 6 Impairment Assets

	Group	
	2017/18	2016/17
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Other	(2,851)	672
Total net impairments charged to operating surplus / deficit	**(2,851)**	**672**
Impairments charged to the revaluation reserve	763	779
Total net impairments	**(2,088)**	**1,451**

Note 7 Employee Benefits

	Group	
	2017/18	2016/17
	Total	Total
	£000	£000
Salaries and wages	188,996	187,830
Social security costs	19,435	17,184
Apprenticeship levy	999	-
Employer's contributions to NHS pensions	21,458	21,436
Temporary staff (including agency)	26,247	22,428
Total gross staff costs	257,135	248,878

Note 7.1 Retirements due to ill health

During 2017/18 there were 6 early retirements from the trust agreed on the grounds of ill-health (7 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £206k (£524k in 2016/17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 7.2 Directors' Remuneration

The aggregate amounts payable to Directors were:

	Group	
	2017/18	2016/17
	Total	Total
	£000	£000
Salary	1,466	1,284
Employer's National Insurance	183	159
Employer's pension contributions	139	164
Total	**1,788**	**1,607**

Note 7.3 Management costs

	Group	
	2017/18	2016/17
	Total	Total
	£000	£000
Management Costs	**16,769**	15,608
Income	**345,504**	344,896
Management Costs as a % of income	**4.85%**	4.50%

The above is excluding Charitable income and costs.

Note 8 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Scheme. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it was a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting Valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM

interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full Actuarial (funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

Note 9 Operating Leases

Note 9.1 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs renewable on an annual basis. These are operating leases and the rental from these leases is recognised on a straight line basis within these financial statements.

Note 9.2 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessee

The Foundation Trust's operating leases predominantly relate to lease cars:

	Group	
	2017/18	2016/17
	£000	£000
Operating lease expense		
Minimum lease payments	331	373
Total	**331**	**373**

	31 March 2018	31 March 2017
	£000	£000
Future minimum lease payments due:		
- not later than one year;	1,403	1,481
- later than one year and not later than five years;	1,158	1,296
- later than five years.	-	-
Total	**2,561**	**2,777**
Future minimum sublease payments to be received	-	

- The balance of the lease payments is expended through expenditure with the remaining balance through an employee salary sacrifice and deduction scheme.

Note 10 Finance Income

Finance income represents interest received on assets and investments in the year.

	Group	
	2017/18	2016/17
	£000	£000
Interest on bank accounts	46	32
NHS charitable fund investment income	75	67
Total	**121**	**99**

Note11.1 Finance Expenses

Finance expenditure represents interest and other charges involved in the borrowing of money.

	Group	
	2017/18	2016/17
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	2,886	1,187
Finance leases	7	14
Total interest expense	**2,893**	**1,201**
Unwinding of discount on provisions	5	13
Total finance costs	**2,898**	**1,214**

Note11.2 The Late Payment of Commercial Debts (Interest) Act 1998

	Group	
	2017/18	2016/17
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note11.3 Gains/losses on disposal of non-current assets

	Group	
	2017/18	2016/17
	£000	£000
Profit on disposal of non-current assets	64	2,399
Loss on disposal of non-current assets	(126)	(81)
Net profit/(loss) on disposal of non-current assets	**(62)**	**2,318**

Note12 Revaluation of Assets (property, plant and equipment_ Sushman & Wakefield Valuations Summary

	Group	
	2017/18	2016/17
Impairments	**£000**	**£000**
Impairments charged to Revaluation Reserve	(763)	(779)
Impairments charged to Statement of Comprehensive Income	(285)	(1,909)
Total Impairments due to Market Changes	**(1,048)**	**(2,688)**

	Group	
	2017/18	2016/17
Revaluation gains	**£000**	**£000**
Revaluation gains credited to Revaluation Reserve	5,973	2,522
Revaluation gains relating to previous impairments credited to Statement of Comprehensive income	3,136	1,237
Total Revaluation gains due to Market Changes	**9,109**	**3,759**

Note13 Corporation Tax

	2017/18	2016/17
	£000	**£000**
UK corporation tax expense	30	-
Adjustments in respect of prior years	-	-
Current tax expense	**30**	**-**
Origination and reversal of temporary differences	-	-
Adjustments in respect of prior years	-	-
Change in tax rate	-	-
Deferred tax expense	-	-
Total income tax expense in Statement of Comprehensive Income	**30**	**-**
Reconciliation of effective tax charge		
Effective tax charge percentage	20%	20%
Effect of:		
Surpluses not subject to tax	-	-
Non-deductible expenses	-	-
Adjustments in respect of prior years	-	-
Share of results of joint ventures and associates	-	-
Change in tax rate	-	-
Other	30	-
Total income tax charge for the year	**30**	**-**

Note14 Discontinued Operations

	2017/18	2016/17
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	-	-

Note15 Intangible assets

Note15.1 Intangible assets - 2017/18

Group	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2017 - brought forward	**6,245**	**6,245**
Additions	379	379
Disposals/derecognition	(91)	(91)
Valuation / gross cost at 31 March 2018	**6,533**	**6,533**
Amortisation at 1 April 2017 - brought forward	**5,380**	**5,380**
Provided during the year	395	395
Disposals / derecognition	(91)	(91)
Amortisation at 31 March 2018	**5,684**	**5,684**
Net book value at 31 March 2018	**849**	**849**
Net book value at 1 April 2017	**865**	**865**

Note15.2 Intangible assets - 2016/17

Group	Software licences	Total
	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**6,129**	**6,129**
Additions	116	116
Valuation / gross cost at 31 March 2017	**6,245**	**6,245**
Amortisation at 1 April 2016 - as previously stated	**4,977**	**4,977**
Provided during the year	403	403
Amortisation at 31 March 2017	**5,380**	**5,380**
Net book value at 31 March 2017	**865**	**865**
Net book value at 1 April 2016	**1,152**	**1,152**

Note16 Property, plant and equipment

Note16.1 Property, plant and equipment - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2017 - brought forward	**9,934**	**136,876**	**3,523**	**1,162**	**41,872**	**138**	**10,520**	**803**	**-**	**204,828**
Additions	-	2,671	376	6,668	1,922	-	527	5	-	12,169
Impairments	(501)	-	(262)	-	-	-	-	-	-	(763)
Revaluations	630	5,337	6	-	-	-	-	-	-	5,973
Reclassifications	-	189	5	(194)	-	-	-	-	-	-
Disposals / derecognition	(69)	-	(180)	-	(3,037)	-	(542)	(14)	-	(3,842)
Valuation/ gross cost at 31 March 2018	**9,994**	**145,073**	**3,468**	**7,636**	**40,757**	**138**	**10,505**	**794**	**-**	**218,365**
Accumulated depreciation at 1 April 2017 - brought forward	**598**	**14,901**	**676**	**-**	**34,834**	**103**	**7,092**	**649**	**-**	**58,853**
Provided during the year	-	2,714	253	-	2,569	13	1,080	53	-	6,682
Impairments	91	81	113	-	-	-	-	-	-	285
Reversals of impairments	(1)	(3,135)	-	-	-	-	-	-	-	(3,136)
Disposals / derecognition	-	-	(23)	-	(3,019)	-	(542)	(14)	-	(3,598)
Accumulated depreciation at 31 March 2018	**688**	**14,561**	**1,019**	**-**	**34,384**	**116**	**7,630**	**688**	**-**	**59,086**
Net book value at 31 March 2018	**9,306**	**130,512**	**2,449**	**7,636**	**6,373**	**22**	**2,875**	**106**	**-**	**159,279**
Net book value at 1 April 2017	**9,336**	**121,975**	**2,847**	**1,162**	**7,038**	**35**	**3,428**	**154**	**-**	**145,975**

Note16.2 Property, plant and equipment 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Charitable fund PPE assets	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016 - as previously stated	**9,892**	**128,693**	**3,601**	**2,110**	**41,080**	**138**	**8,626**	**753**	**-**	**194,893**
Additions	-	5,899	-	504	1,491	-	1,617	50	-	9,561
Impairments	(34)	(691)	(54)	-	-	-	-	-	-	(779)
Revaluations	268	1,800	454	-	-	-	-	-	-	2,522
Reclassifications	-	1,175	-	(1,452)	-	-	277	-	-	-
Disposals / derecognition	(192)	-	(478)	-	(699)	-	-	-	-	(1,369)
Valuation/gross cost at 31 March 2017	**9,934**	**136,876**	**3,523**	**1,162**	**41,872**	**138**	**10,520**	**803**	**-**	**204,828**
Accumulated depreciation at 1 April 2016 - as previously stated	**940**	**11,035**	**494**	**-**	**32,437**	**88**	**6,260**	**595**	**-**	**51,849**
Provided during the year	-	2,805	264	-	3,076	15	832	54	-	7,046
Impairments	1	1,900	8	-	-	-	-	-	-	1,909
Reversals of impairments	(343)	(839)	(55)	-	-	-	-	-	-	(1,237)
Disposals/ derecognition	-	-	(35)	-	(679)	-	-	-	-	(714)
Accumulated depreciation at 31 March 2017	**598**	**14,901**	**676**	**-**	**34,834**	**103**	**7,092**	**649**	**-**	**58,853**
Net book value at 31 March 2017	**9,336**	**121,975**	**2,847**	**1,162**	**7,038**	**35**	**3,428**	**154**	**-**	**145,975**
Net book value at 1 April 2016	**8,952**	**117,658**	**3,107**	**2,110**	**8,643**	**50**	**2,366**	**158**	**-**	**143,044**

Note16.3 Property, plant and equipment financing - 2017/18

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018									
Owned - purchased	9,306	127,687	2,449	7,636	5,821	22	2,861	106	**155,888**
Finance leased	-	-	-	-	54	-	-	-	**54**
Owned - donated	-	2,825	-	-	498	-	14	-	**3,337**
NBV total at 31 March 2018	**9,306**	**130,512**	**2,449**	**7,636**	**6,373**	**22**	**2,875**	**106**	**159,279**

Note16.4 Property, plant and equipment financing - 2016/17

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2017									
Owned - purchased	9,336	119,343	2,847	1,162	6,504	35	3,402	151	142,780
Finance leased	-	-	-	-	153	-	-	-	153
Owned - donated	-	2,632	-	-	381	-	26	3	3,042
NBV total at 31 March 2017	**9,336**	**121,975**	**2,847**	**1,162**	**7,038**	**35**	**3,428**	**154**	**145,975**

Note17 Donations of property, plant and equipment

The Foundation Trust received charitable contributions to support capital purchases as follows:

	2017/18	2016/17
	£000	£000
Buildings ex Dwellings	10	-
Plant and machinery	271	91
Information Technology	-	-
	281	**91**

Note18 Revaluations of property, plant and equipment

The NHS Foundation Trust's property have been revalued on a Modern Equivalent Asset basis. At the 31 March 2018, the Foundation Trust's Valuers, Cushmann & Wakefield completed a revaluation of the estate which resulted in a net valuation increase. The results of this valuation have been included in these financial statements.

The property asset lives are as stated in the revaluation by the Foundation Trust Valuers.

In line with the Foundation Trust's Estates Strategy and Rationalisation programme some of the non specialised building assets have been declared non-operational and these assets have been valued by the Foundation Trust Valuers to the land value. These are predominantly on the north side of the Diana, Princess of Wales Hospital, Grimsby site and have been earmarked for demolition as per the Estates Strategy. The impairments relating to these assets are charged to the Statement of Comprehensive Income.

Basis of Valuation

The valuations have been carried out primarily on the basis of Market Value Existing Use using the depreciated replacement cost (DRC) methodology on a modern substitute basis. Non-operational property, including surplus land, has been valued to Market Value Alternate Use.

Unless otherwise stated, the assumption has been made that the properties valued will continue to be in the occupation of the Foundation Trust for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

Method of Valuation

Depreciated Replacement Cost (DRC) is the method of valuation adopted for arriving at the value of specialised operational property for financial accounting purposes as recommended by UK GAAP, the Royal Institution of Chartered Surveyors and HM Treasury.

DRC is based on an estimate of the market value for the existing use of the land, plus the current gross replacement (reproduction) costs of the improvements, less allowances for physical deterioration and all relevant forms of obsolescence and optimisation.

Where the actual use of the property is so special that it proves impossible to categorise it in general market terms, land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site. In these circumstances, the Market Value for the Existing Use (MVEU) of the land has been arrived at having regard to the cost of purchasing a notional replacement site in the same locality that would be equally suitable for the existing use and of the same size, with normally the same physical

and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use.

The NHS Foundation Trust Valuers completed a valuation of the Property Assets at 31 March 2018 and concluded that there were changes to the Value of Property Assets. The Foundation Trust identified that these changes are material and therefore, the results have been incorporated into these financial statements. The outcome from the valuation was that, on all three sites, some of the assets suffered revaluation gains whilst other assets had an impairment. The Foundation Trust continues to progress its Estates Strategy and Rationalisation programme. The approximate net impact of the Foundation Trust's valuations are given below.

Note 19 Property valuations summary by Cushmann and Wakefield

Site	Description	Net Change in Valuation (increase) Decrease £000	Charged to Expenses £000	Impairment Reversals Credited to Expenses £000	Changes to Revaluation Reserves £000
Diana, Princess of Wales Hospital, Grimsby	Land and Buildings	(3,830)	166	(2,489)	(1,508)
Scunthorpe General Hospital	Land and Buildings	(3,765)	118	(550)	(3,334)
Goole District Hospital	Land and Buildings	(466)	-	(97)	(369)
Other	Land and Buildings	-	-	-	-
	Total	**(8,061)**	**285**	**(3,136)**	**(5,210)**

All the above changes relate to properties in the Foundation Trust's main healthcare segment.

Note 20.1 Other investments

Group	2017/18 £000	2016/17 £000
Carrying value at 1 April - brought forward	**2,032**	**1,787**
Movement in fair value	(54)	245
Carrying value at 31 March	**1,978**	**2,032**

The above investments relate to the Foundation Trust's Charitable Funds which have been consolidated into these accounts.

Note 20.2 Other investments

Group	31 March 2018 £000	31 March 2017 £000
Carrying value at 1 April 2017	-	-
At start of year for new FTs	-	-
Share of profit/(loss)	-	-
Carrying value at 31 March 2018	-	-

Note 21 Charitable Fund Reserves

The Northern Lincolnshire and Goole NHS Foundation Trust Board is the Corporate Trustee of the NHS Charitable Funds and therefore, the charitable funds represents a subsidiary of the Foundation Trust on the basis that it:

- has control over the NHS charitable fund (as determined by IRFS 10) and
- benefits from the NHS charitable fund.

From 2013/14 Northern Lincolnshire and Goole NHS Foundation Trust has consolidated the NHS charitable funds into its accounts.

For 2017/18, the NHS Charitable Funds balances is as follows:

	31 March 2018 £000	31 March 2017 £000
Unrestricted funds:		
Unrestricted income funds	2,958	2,112
Restricted funds:		
Restricted income funds	29	49
	2,987	**2,161**

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 22 Disclosures of Interests in Other Entities

The NHS Foundation Trust entered into a cooperation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operated from Ward 4 at Goole District Hospital. The joint venture provided both NHS Care and care independent to the NHS but within an NHS location.

The joint venture ceased on 31st August 2017. The Trust includes within its financial statements its share of the activities, assets, liabilities and any transactions relating to the termination of this agreement.

The Foundation Trust owns 100% of a subsidiary company called WebV Solutions Limited. The accounting year end for WebV Solutions Limited is 31 March. The registered office is, Diana, Princess of Wales Hospital, Scartho Road, Grimsby. This was established to provide innovative software solutions.

Note 23 Inventories

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Drugs	952	914	952	914
Consumables	1,482	1,387	1,482	1,387
Energy	15	71	15	71
Other	324	286	324	286
Total inventories	**2,773**	**2,658**	**2,773**	**2,658**

Inventories recognised in expenses for the year were £30,817k (2016/17: £31,466k). Write-down of inventories recognised as expenses for the year were £0k (2016/17: £0k).

Note 24.1 Trade and other receivables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade receivables	11,219	8,940	11,132	8,940
Provision for impaired receivables	(610)	(699)	(610)	(699)
Prepayments (non-PFI)	2,744	2,675	2,742	2,675
PDC dividend receivable	199	89	199	89
VAT receivable	482	513	462	491
Other receivables *	8,576	8,937	8,576	8,968
NHS charitable funds: trade and other receivables	39	116	-	-
Total current trade and other receivables	**22,649**	**20,571**	**22,501**	**20,464**
Non-current				
Other receivables	-	224		224
Total non-current trade and other receivables	**-**	**224**	**-**	**224**

* Other receivables includes £1.86m (2016/17 £1.98m) relating to Injury Cost Recovery, the balance relates to non NHS debtors.

Note 24.2 Provision for Impairment of Receivables

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April as previously stated	699	733	699	733
Increase in provision	140	224	140	224
Amounts utilised	(63)	(104)	(63)	(104)
unused amounts reversed	(166)	(154)	(166)	(154)
At 31 March	**610**	**699**	**610**	**699**

The provision for bad debt has been calculated following a detailed review of all outstanding invoices as at 31 March 2018. The Injury Cost Recovery provision for bad debt is 25% based on the recovery trend in the past years and the level of potential cancellations.

Note 24.3 Analysis of Financial Assets

Group	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0-30 days	194	-	137	-
30-60 Days	27	-	63	-
60-90 days	53	-	422	-
90-180 days	414	-	312	-
Over 180 days	1,319	-	1,250	-
Total	**2,007**	**-**	**2,184**	**-**
Ageing of non-impaired financial assets past their due date				
0-30 days	940	-	1,400	-
30-60 Days	515	-	853	-
60-90 days	846	-	1,011	-
90-180 days	369	-	1,205	-
Over 180 days	1,722	-	1,923	-
Total	**4,392**	**-**	**6,392**	**-**

Trust	31 March 2018		31 March 2017	
	Trade and other receivables	Investments & Other financial assets	Trade and other receivables	Investments & Other financial assets
Ageing of impaired financial assets	**£000**	**£000**	**£000**	**£000**
0-30 days	194		137	
30-60 Days	27		63	
60-90 days	53		422	
90-180 days	414		312	
Over 180 days	1,319		1,250	
Total	**2,007**	**-**	**2,184**	**-**
Ageing of non-impaired financial assets past their due date				
0-30 days	940		1,400	
30-60 Days	515		853	
60-90 days	846		1,011	
90-180 days	369		1,205	
Over 180 days	1,722		1,923	
Total	**4,392**	**-**	**6,392**	**-**

Note 25 Other Assets

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Net pension scheme asset	-	-	-	-
Other assets	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 26 Other Financial Assets

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Non-current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	**-**	**-**	**-**	**-**
Current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	**-**	**-**	**-**	**-**

Note 27 Non-current Assets for Sale and Assets in Disposal

At the Statement of Financial Position date the NHS Foundation Trust does not have any assets held for sale.

Note 28 Liabilities in Disposal Groups

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Categorised as:				
Provisions	-	-	-	-
Trade and other payables	-	-	-	-
Other	-	-	-	-
Total	-	-	-	-

Note 29.1 Cash and Cash Equivalents

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2017/18	2016/17	2017/18	2016/17
	£000	£000	£000	£000
At 1 April	**7,672**	**5,348**	**7,469**	**5,201**
Prior period adjustments	-	-	-	-
At 1 April (restated)	**7,672**	**5,348**	**7,469**	**5,201**
Net change in year	4,883	2,324	3,901	2,268
At 31 March	**12,555**	**7,672**	**11,370**	**7,469**
Broken down into:				
Cash at commercial banks and in hand	1,430	376	245	287
Cash with the Government Banking Service	11,125	7,296	11,125	7,182
Total cash and cash equivalents as in SoFP	**12,555**	**7,672**	**11,370**	**7,469**
Total cash and cash equivalents as in SoCF	**12,555**	**7,672**	**11,370**	**7,469**

Note 29.2 Third Party Assets

Northern Lincolnshire and Goole NHS Foundation Trust held cash and cash equivalents which relate to monies held by the NHS Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2018	31 March 2017
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	-	-

Note 30.1 Trade and Other Payables

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Trade payables	20,689	18,295	19,350	18,136
Capital payables	5,012	2,689	5,012	2,689
Accruals	13,797	11,536	13,735	11,516
Other taxes payable	5,692	5,079	5,692	5,079
Accrued interest on loans	908	159	908	159
Other payables	2,664	2,823	3,968	2,982
NHS charitable funds: trade and other payables	105	85		
Total current trade and other payables	**48,867**	**40,666**	**48,665**	**40,561**
Non-current				
Total non-current trade and other payables	-	-	-	-
Of which payables from NHS and DHSC group bodies:				
Current	6,203	7,963	6203	7963
Non-current	-	-	-	-

Note 30.2 Early Retirements in NHS Payables Above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March 2018	31 March 2018	31 March 2017	31 March 2017
	£000	Number	£000	Number
- number of cases involved	-	6	-	7
- outstanding pension contributions	206	-	524	-

Note 31 Other Liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Deferred income	177	133	177	133
Total other current liabilities	**177**	**133**	**177**	**133**
Non-current				
Total other non-current liabilities	-	-	-	-

Note 32 Borrowings

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Loans from DHSC	2,091	1,859	2,091	1,859
Obligations under finance leases	55	101	55	101
Total current borrowings	**2,146**	**1,960**	**2,146**	**1,960**
Non-current				
Loans from DHSC	115,282	70,320	115,282	70,320
Obligations under finance leases	-	55	-	55
Total non-current borrowings	**115,282**	**70,375**	**115,282**	**70,375**

Note 33 Other Financial Liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Current				
Total	-	-	-	-
Non-current				
Total	-	-	-	-

Note 34 Finance Leases

Note 34.1 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessor

The Foundation Trust has arrangements with other NHS and non NHS bodies whereby the Foundation Trust receives income for the premises rented to these bodies. These arrangements are covered by annual service level agreements and are normally for a term of one year, renewable at the end of each year by mutual agreement. This income is included within this year's operating income shown in these financial statements. These arrangements are not classed as leases.

Note 34.2 Northern Lincolnshire and Goole NHS Foundation Trust as a Lessee

Obligations under finance leases where Northern Lincolnshire and Goole NHS Foundation Trust is the lessee. The leases relate to medical equipment.

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Gross lease liabilities	**56**	**165**	**56**	**165**
of which liabilities are due:				
- not later than one year;	56	109	56	109
- later than one year and not later than five years;	-	56	-	56
- later than five years.	-	-	-	-
Finance charges allocated to future periods	(1)	(9)	(1)	(9)
Net lease liabilities	**55**	**156**	**55**	**156**
of which payable:				
- not later than one year;	55	101	55	101
- later than one year and not later than five years;	-	55	-	55
- later than five years.	-	-	-	-
Total of future minimum sublease payments to be received at the reporting date	-	-	-	-

There are no sub lease or contingent rents.

Note 35.1 Provisions for Liabilities and Charges Analysis

	Pensions - early departure costs	Other legal claims	Re-structuring	Other	Total
	£000	£000	£000	£000	£000
At 1 April 2017	**2,372**	**188**	**1,554**	**3,916**	**8,030**
Arising during the year	95	142	179	419	835
Utilised during the year	(270)	(103)	(298)	(1,036)	(1,707)
Reversed unused	-	(94)	(1,267)	(98)	(1,459)
Unwinding of discount	2	-	-	3	5
At 31 March 2018	**2,199**	**133**	**168**	**3,204**	**5,704**
Expected timing of cash flows:					
- not later than one year;	269	133	168	438	1,008
- later than one year and not later than five years;	1,050	-	-	524	1,574
- later than five years.	880	-	-	2,242	3,122
Total	**2,199**	**133**	**168**	**3,204**	**5,704**

Other provisions include £0.306m of Carbon Reduction commitment provision and £2.898m of injury benefit relating to named individuals' payments

Note 35.2 Clinical Negligence Liabilities

At 31 March 2018, £137,367k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Northern Lincolnshire and Goole Hospitals NHS Foundation Trust (31 March 2017: £99,253k).

Note 36 Contingent Assets and Liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(98)	(98)	(98)	(98)
Gross value of contingent liabilities	**(98)**	**(98)**	**(98)**	**(98)**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**(98)**	**(98)**	**(98)**	**(98)**
Net value of contingent assets	-	-	-	-

Note 37 Contractual Capital Commitments

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
Property, plant and equipment	10,069	63	10,069	63
Intangible assets	-	38		38
Total	**10,069**	**101**	**10,069**	**101**

Note 38 Defined Benefit Pension Scheme

The Trust has no defined benefit pension schemes.

Note 39 On-SoFP PFI, and Other Service Concession Arrangements

The Foundation Trust does not have any PFI or LIFT schemes at 31 March 2018.

Note 40 Off-SoFP PFI, LIFT and Other Service Concession Arrangements

The NHS Foundation Trust does not have any Off-SOFP PFI or LIFT schemes at 31 March 2018.

Note 41 Financial Instructions

Note 41.1 Provisions for Liabilities and Charges Analysis

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities.

Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities.

Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply.

The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the Finance Directorate, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to regular review by the Finance and Performance Committee and the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust currently has borrowings of £117.373m, the following table provides details of the interest rates, purpose of the loan and outstanding balance.

Loan - Purpose	Interest Rate %	Balance at 31 March 2018 £000
DoH Land	0.00%	762
Residential Accommodation DPoW	2.06%	7,078
Energy Performance Contract	2.39%	7,780
Diagnostics Scanners*	1.68%	300
Interim Revenue Support	1.50%	15,000
Interim Working Capital Support	3.50%	26,054
Uncommitted Interim Revenue Support	1.50%	13,646
Uncommitted Interim Revenue Support *	6.00%	46,753
Total		**117,373**

* These facilities were drawn down in 2017/18.

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers and investments held by the charitable fund as shown note 20.1, as disclosed in the Trade and other receivables note 24.1.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament . The Trust funds its capital expenditure from internally generated funds and funds obtained from Department of Health or Independent Financing Facility loans. The Trust has in place Liquidity Support Funding agreed with the Department of Health and the Independent Financing Facility for short term working capital support. This gives the Trust liquidity assurance to cover the period prior to regulator approval of future plans and to manage normal variations in cashflow.

Note 41.2 Financial Assets

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018	-	-	-	-	
Embedded derivatives	-	-	-	-	
Trade and other receivables excluding non financial assets	18,507	-	-	-	**18,507**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	11,480	-	-	-	**11,480**
Consolidated NHS Charitable Fund financial assets	-	3,053	-	-	**3,053**
Total at 31 March 2018	**29,987**	**3,053**	**-**	**-**	**33,040**

Group	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives	-	-	-	-	-
Trade and other receivables excluding non financial assets	16,242	-	-	-	**16,242**
Other investments / financial assets	-	-	-	-	-
Cash and cash equivalents	7,558	-	-	-	**7,558**
Consolidated NHS Charitable Fund financial assets		2,146	-	-	**2,146**
Total at 31 March 2017	**23,800**	**2,146**	**-**	**-**	**25,946**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2018					
Embedded derivatives					-
Trade and other receivables excluding non financial assets	18,507				**18,507**
Other investments / financial assets					-
Cash and cash equivalents	11,370				**11,370**
Total at 31 March 2018	**29,877**	-	-	-	**29,877**

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2017					
Embedded derivatives					
Trade and other receivables excluding non financial assets	16,242				
Other investments / financial assets					
Cash and cash equivalents	7,469				
Total at 31 March 2017	**23,711**	-	-	-	**23,711**

Note 41.3 Financial Liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	117,373	-	**117,373**
Obligations under finance leases	55	-	**55**
Trade and other payables excluding non financial liabilities	43,247	-	**43,247**
Provisions under contract	3,505	-	**3,505**
Consolidated NHS charitable fund financial liabilities	105	-	**105**
Total at 31 March 2018	**164,285**	-	**164,285**

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	72,179	-	**72,179**
Obligations under finance leases	156	-	**156**
Trade and other payables excluding non financial liabilities	35,635	-	**35,635**
Provisions under contract	5,658	-	**5,658**
Consolidated NHS charitable fund financial liabilities	85	-	**85**
Total at 31 March 2017	**113,713**	-	**113,713**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2018			
Borrowings excluding finance lease and PFI liabilities	117,373		**117,373**
Obligations under finance leases	55		**55**
Trade and other payables excluding non financial liabilities	43,070		**43,070**
Other financial liabilities	177		**177**
Provisions under contract	3,505		**3,505**
Total at 31 March 2018	**164,180**	-	**164,180**

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total book value
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2017			
Borrowings excluding finance lease and PFI liabilities	72,179		**72,179**
Obligations under finance leases	156		**156**
Trade and other payables excluding non financial liabilities	33,820		**33,820**
Other financial liabilities	133		**133**
Provisions under contract	5,658		**5,658**
Total at 31 March 2017	**111,946**	-	**111,946**

Note 41.4 Maturity of Financial Liabilities

	Group		Trust	
	31 March 2018	31 March 2017	31 March 2018	31 March 2017
	£000	£000	£000	£000
In one year or less	46,237	39,854	46,132	38,087
In more than one year but not more than two years	15,156	2,975	15,156	2,975
In more than two years but not more than five years	92,337	59,074	92,337	59,074
In more than five years	10,555	11,810	10,555	11,810
Total	**164,285**	**113,713**	**164,180**	**111,946**

Note 42 Losses and Special Payments

Group and Trust	2017/18 Total number of cases	2017/18 Total value of cases	2016/17 Total number of cases	2016/17 Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	4	-
Bad debts and claims abandoned	542	69	321	85
Stores losses and damage to property	17	50	2	18
Total losses	**559**	**119**	**327**	**103**
Special payments				
Ex-gratia payments	25	25	21	12
Total special payments	**25**	**25**	**21**	**12**
Total losses and special payments	**584**	**144**	**348**	**115**
Compensation payments received		-		-

There were no cases exceeding £0.30m in this year and prior years.

Note 43 Events after the Reporting Date

There are no post balance sheets in the reporting year.

Note 44 Related Parties

During the year none of the DHSC Ministers, NHS Foundation Trust Board Members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Lincolnshire and Goole NHS Foundation Trust.

The DHSC is regarded as a related party. During the year, this NHS Foundation Trust has had a significant number of material transactions with other entities for which the DHSC is regarded as the parent department. These entities are:

NHS England, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts and NHS Resolution.

In addition, the NHS Foundation Trust has had a number of material transactions with other Government departments and other central and Local Government bodies.

The NHS Foundation Trust has also received revenue and capital payments from a number of charitable funds. The trustees of the charitable funds are also members of the NHS Foundation Trust Board.

	2017/18 Income £000	2017/18 Expenditure £000	31 March 2018 Receivables £000	31 March 2018 Payables £000
Calderdale & Huddersfield NHS Foundation Trust		95		
Care Quality Commission		289		
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	74	245	25	161
East Riding of Yorkshire Council		229		
Health Education England	9,501	32	136	
Harrogate & District NHS Foundation Trust	230	18	87	7
Hull and East Yorkshire Hospitals NHS Trust	2,524	2,075	1,517	1,585
Humber NHS Foundation Trust	2	(59)	1	24
Leeds Teaching Hospital NHS Trust	4	471	1	168
Lincolnshire Community Health Services NHS Trust	1,014	2	326	1
Lincolnshire Partnership NHS Foundation Trust	145		25	
NHS Bassetlaw CCG	123			
NHS Blood & Transplant		1,625		149
NHS Doncaster CCG	983			
NHS East Riding of Yorkshire CCG	16,218		328	98
NHS England	27,601	14	2,899	18
NHS Hull CCG	299		37	
NHS Improvement	603		505	
NHS Lincolnshire East CCG	29,929		553	212
NHS Lincolnshire West CCG	11,022		152	25
NHS North East Lincolnshire CCG	104,487		935	615
NHS North Lincolnshire CCG	106,889		1,386	581
NHS Pension Scheme		21,458		2,963
NHS Property Services		445		449
NHS Resolution		13,286		
NHS Scarborough & Ryedale CCG	423		113	
NHS Sheffield CCG	100			14
NHS South Lincolnshire CCG	1,355			
NHS South West Lincolnshire CCG	2,921		102	
NHS Vale of York CCG	503			
NHS Wakefield CCG	172			
North East Lincolnshire Council	166	920	108	
North Lincolnshire Council	1,281	866	98	
North West Anglia NHS Foundation Trust	29	239	11	73
Nottingham University Hospitals NHS Foundation Trust	91	150	46	36
Portsmouth Hospitals NHS Trust		92		
Public Health England	23	346	18	61
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	216	203	104	33
Sheffield Children's NHS Foundation Trust	52	191	11	67
Sheffield Teaching Hospitals NHS Foundation Trust	570	546	144	385
United Lincolnshire Hospitals NHS Trust	10,637	1,047	960	308

University Hospitals Birmingham NHS Foundation Trust		143		36
University Hospitals of Leicester	105	46	77	11
York Hospitals NHS Foundation Trust	2	25	6	14
Other (Total)	1,704	660	508	174
Total Related Parties	**331,998**	**45,699**	**11,219**	**8,268**
HM Revenue and Customs (Taxes and Duties)	-	20,464	482	5,692
Other Government Departments	**-**	**20,464**	**482**	**5,692**
Comparatives 2016/17				
Total Related Parties	**332,301**	**46,813**	**9,029**	**11,010**
Other Government Departments	**-**	**17,184**	**513**	**5,079**

Note 45 Third Party Assets

The Foundation Trust held £420 (2016/2017 £0) cash and cash equivalents which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Northern Lincolnshire & Goole NHS Foundation Trust

Annual Quality Account

2017/18

CONTENTS

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

On my appointment as the Chief Executive for Northern Lincolnshire & Goole (NLAG) NHS Foundation Trust, in August 2017, the challenges were obvious. Alongside many other NHS organisations up and down the country, the Trust's financial position was a concern. However, what concerned me most were the challenges that faced the Trust with regard to the provision of high quality care and responding to the 'inadequate' rating for safety from the Care Quality Commission following their last visit in 2016.

Since my appointment, the Trust has continued to face challenges. The Trust's performance with national indicators demonstrates room for improvement, winter surges in demand during the last few months have further stretched services and I hear from the organisation's workforce that they feel this pressure and sometimes feel unable to do their jobs to the level they would wish, often as a result of staff shortages.

Despite all of these challenges, the Trust's workforce – my colleagues – work tirelessly with commitment, dedication and professionalism to provide local people with good care. Daily this Trust provides care to around 2,000 people, and for the most part those cared for by the Trust report satisfaction with their care. From this, I look at the challenges that the Trust faces with optimism, having full confidence in what we can achieve together.

The Trust has focussed much attention over the last year to the re-launch of its quality improvement programme that epitomises the Trust's determination in its name – 'Improving Together'. This programme sets out five key areas that will lead the Trust out of special measures. These areas are:

- Quality and safety – providing effective, high quality care;
- Access and flow – providing safe, effective and efficient care at the right time and in the right place for our patients;
- Organisational development and culture – how we engage with our staff, our partners and wider stakeholders;
- Service strategy – working with the wider health and care system to determine the long term future of our services;
- Finance – getting our expenditure under control and making sure that our services are as efficient as possible to the public purse.

This programme of work is ongoing now, being overseen and supported by the Trust Board and other external stakeholders such as local commissioners and national bodies including NHS Improvement. While it is still early days, the Trust is beginning to see improvements from the various strands of work including improvements in the admissions pathway through the emergency department, increased staffing and greater financial grip. This annual quality account, will further outline the Trust's achievements, but also demonstrate that improvement is still needed to meet local and national indicators. To the best of my knowledge the information contained within this report is accurate.

The Trust and I are determined to continue the focus on improving further, together and realise the Trust's quality aspirations, to consistently provide high quality care, with respect and with common values.

Dr Peter Reading,

Chief Executive Officer

April 2018

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 in Northern Lincolnshire. In summary these services are:

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

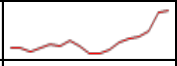
The Trust was originally established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. 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**.

Executive summary of key points

2017/18 Quality Priority Themes and the Trust's Approach

- During 2017/18, the Trust's approach to Quality Improvement was strengthened with the continual development of the 'Improving Together' quality improvement programme, and the development of a dedicated improvement team to support delivery of the programme.
- As the programme has developed over 2017/18, the Trust's traditional approach to setting and monitoring quality priorities has changed accordingly.
- The following summary of 'at a glance' performance provides an overview of performance against the quality priority 'themes' set at the end of 2016/17.

Quality Priority: Theme 1: Reducing Mortality

Indicator		Time period / RAG	Comparator	Trending	Target
Clinical Effectiveness: THEME 1: Reducing Mortality		Most recent data	Previous data	Trending	
1	Summary Hospital-Level Mortality Indicator (SHMI) (Oct 16-Sep 17)	119.1 R	118.5		100
	HED 'Provisional' SHMI data (Jan 17 - Dec 17)	117 R	115		100
	Position vs peers	Higher than expected R	Within expected range		Within expected range

NB: For more information/detail, see section two of this report

- The Trust's mortality position has remained in the 'higher than expected' range for the official mortality indicator – the Summary Hospital-Level Mortality Indicator (SHMI). This indicator includes all deaths in hospital and those occurring within 30 days of hospital discharge.
- The SHMI is a statistically risk adjusted indicator. From an examination of this data at individual site level, Diana, Princess of Wales Hospital in Grimsby has a higher level than that of Scunthorpe General Hospital.
- The Trust have restructured its approach to mortality oversight and included this area within the Trust's improvement programme (Improving Together). The Trust continues to focus on and seek to improve this area by:
    - Focus on other related aspects of care and organisation including access to and flow through the Trust's hospitals, to better enable the Trust meet the increasing demands, especially during seasonal pressures.
    - Ensure a programme of mortality case review work is in place to aid the Trust's focus on understanding quality of care provided during patient's stay in hospital services and an understanding of specific areas where improvement is required.
    - Specific work streams have been initiated based on previous learning. These work streams include a focus on deteriorating patient, sepsis and recording of fluid balance.
    - Continued work with primary and community services to understand if service configuration in the community can support appropriate groups of patients, preventing admission to hospital and understand further mortality post-hospital discharge (within 30 days).
- A greater overview of mortality is included in section two of this report.

Quality Priority: Theme 2: Increase Harm Free Care

Patient Safety: THEME 2: Increase Harm Free Care			Mar-18		Feb-18	Target achieved	Target
1	Safety Thermometer	Acute	90.4%	R	92.20%		95.0%
		Community	96.2%	G	97.60%		95.0%
2	Care of the deteriorating patient	Vital signs (NEWS) recorded in accordance with planned	No data: Data collection method being designed				95.0%
		Appropriate clinical response been actioned	No data: Data collection method being designed				95.0%
			Sep-17		Aug-17	Target achieved	
3	Nutrition and Hydration	Fluid management chart completed accurately/fully in line with plan	85.7%	R	87.9%		100.0%
		Food record chart completed accurately/fully in line with plan	100.0%	G	93.3%		100.0%
			Mar-18		Feb-18	Target achieved	
4	Safe Nurse Staffing	% Substantive nursing posts vacant	9.8%	R	9.2%		6.0%
		Nursing agency spend £000s	588		503		No target
5	Infection Prevention and Control	C Diff (Monthly) (YTD: 37)	3		5		No target
		C Diff (Lapse in care) (YTD: 6)	0	G	1		21
		MRSA (YTD: 1)	0	G	0		0

NB: For more information/detail, see section two of this report

- During 2017/18, the Trust has monitored performance against the NHS Safety Thermometer, which provides a 'temperature check' on harm, assessing a sample of patients each month receiving care within the Trust. This is broken down into the four most common harms in healthcare: pressure ulcers, falls, urinary tract infection (for those patients with a catheter) and venous thromboembolism (VTE). The Trust has not yet achieved the target of 95% of patients to receive harm free care. This remains an area of focus for the Trust, particularly the prevention of new hospital-acquired pressure ulcers and VTE. Actions taken include: undertaking clinical review of cases of pressure damage to identify root causes; targeted training on hotspot ward areas; review and pilot of revised pressure area prevention and management documentation; mattress audits and replacement programme; and review of the process for documenting VTE risk assessment in acute admission wards.
- As part of the mortality improvement project, the indicators around care of the deteriorating patient are being redesigned ensuring that this indicator represents all patients, not simply a snapshot sample. This indicator will report the recording of the National Early Warning Score (NEWS) and the action taken in response. This was previously monitored and reported within the Trust's Nursing Dashboard, however, the sample was deemed to be too small to provide the Trust with the needed assurance. Work to report this is underway.
- Another part of the mortality improvement project is the monitoring of and recording of fluid balance. This was previously monitored as part of the Nursing Dashboard snapshot audit/evaluation work. This had to be suspended during September to support nursing staff involved in the collation of this data to help and support ward areas during the period of operational pressure faced by the Trust during the winter period. Work is underway to capture this information to enable future monitoring and oversight. The Trust is receiving support from NHS Improvement as part of a national improvement collaborative in relation to nutrition and hydration. The senior nursing team are promoting the importance of fluid management through the embedding of safety huddles and are also in the process of reviewing the bedside documentation.
- The Trust's quality priorities for 2017/18 and recommended for continuation within

2018/19 included safe staffing. Two areas have been included and both indicators demonstrate improvement during 17/18. The percentage of vacant substantive posts has reduced to 9.8% from a peak of 12.1%. Work continues to focus on improving both recruitment and retention of staff. See section two for more detailed information.

- The Trust has met the national target set for C Diff (lapses in care) and continues to focus on learning lessons when infections are identified and reported. The Trust has not achieved the target of zero MRSA infections, with having 1 reported during 17/18.

Quality Priority: Theme 3: Providing Care Resulting in a Positive Experience

Patient & Staff Experience: THEME 3: Providing Care Resulting in a Positive Experience			Mar-18		Feb-18	Target achieved	Target
1	Patient experience	Emergency Care	72.5%	R	78.0%		98%
		Community	99.6%	G	99.1%		
		Day Case	99.1%	G	99.3%		
		Inpatient	99.0%	G	97.8%		
		Maternity	97.1%	A	100.0%		
			2017 Survey		2016 Survey	Target achieved	Target
2	Staff experience	NHS National Staff Survey: "Recommend Trust to work in"	43.0%	R	50.0%		63%

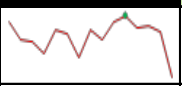
NB: For more information/detail, see section two of this report

- During 2017/18, overall, feedback has been positive as demonstrated by the trend of friends and family test scores achieving the 98% target. The Trust's two A&E departments have both had low feedback scores in terms of experience. This has been particularly so during recent months where the Trust, alongside many other NHS Trusts, have faced severe pressures on beds and A&E waiting times have unfortunately increased as a result. The services have been working closely with the Trusts Improvement Team to address operational flow issues which will deliver improved sustainable performance in 18/19 as well as improving the overall experience for our patients.
- The staff experience has been measured by the two NHS National Staff Survey's reported during 2016/17 and 2017/18, using the question: "Would staff recommend the Trust to work in?" The most recent staff survey demonstrated deterioration in the response to this question. The 2017 survey was completed by 33.6% of staff, mostly during the month of September 2017 and along with other responses, demonstrated low morale at that time. Whilst the Trust are disappointed by this indicator, the results were not surprising, and action had already been taken, prior to the release of the national survey report in March 2018. The Trust have included organisational culture within the Trust's improvement programme (Improving Together) and have been working to improve this area using the following:
    - Invested in the Listening into Action (LIA) programme, with dedicated support to empower Trust staff to be able to make changes and bring their improvement ideas to life.
    - A new approach to apprenticeships enabling staff to study up to master's degree level in a range of clinical and non-clinical subjects. The Trust has been recognised as a national exemplar site for this initiative, with 27 programmes up and running. Whilst early, there has been some good progress made.
    - A new 'Pride and Respect (our anti-bullying campaign)' project has been launched to provide staff with access to an advice line to help them raise concerns where unacceptable behaviours or poor professional standards are demonstrated along with a dedicated oversight group, facilitators and training programme.
    - The Trust has also appointed a Freedom to Speak Up Guardian to again be on hand to provide staff with a confidential route to raise concerns about

anything in the Trust.

- A key finding from the NHS Staff Survey was in connection with a lack of staff. The Trust have continued to use innovative ways to recruit to posts that are challenging to fill. This has included the creation of new roles. The Trust are also focussing on retention of staff also and this has led to the creation of a dedicated retention strategy.

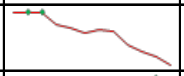
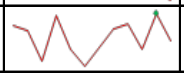
Quality Priority: Theme 4: Outpatient Services

Patient Experience: THEME 4: Outpatient Services			Mar-18		Feb-18	Target achieved	Target
1	Patient experience	Feedback from the Out-Patient FFT is 'Extremely likely' or 'Likely'	66.6%	R	88.0%		98%

NB: For more information/detail, see section two of this report

- Satisfaction as reported via the Outpatient friends and family test has shown improvement from October 2017, with a number of months reported satisfaction exceeding 90%.
- Over the course of the year as a result of the implementation of call and text reminding, and mutually agreeing appointments with patients, the Trust has seen a reduction in the number of patients that do not attend (DNA). This has enabled the Trust to improve utilisation and thus get patients seen as soon as practicably possible.
- There has been significant focus on enabling GP's to electronically send referrals to us, and directly book appointments for their patients at the point of referral, this is now available across 18 specialties. We have also significantly reduced the number of patients that are unable to book into an appointment as a result of capacity. The Appointment Slot Issue (ASI) list has reduced throughout the course of the year suggesting that more slots are available for the patient to choose to attend.
- Although referrals have reduced the numbers on the trust waiting list have increased steadily throughout the year. This is largely due to the vacancy rates amongst doctors and the resulting reliance on locums as well as the lack of capacity in some specialties to meet the demand. Some specialties are under extreme pressure which has required joint solutions with neighbouring trusts to deliver services. Close working with the STP continues to ensure services are delivered. Additionally the Trust is in the process of reviewing all demand and capacity within specialties to support improved decision making going forward.

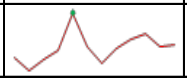
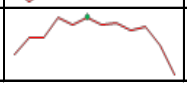
Quality Priority: Theme 5: Discharge & Transfer

Clinical Effectiveness: THEME 5: Discharge and Transfer			Mar-18		Feb-18	Target achieved	Target
1	Patient Flow	% of patients waiting less than 4 hours in A&E	79.50%	R	83.42%		90%
		Non Elective length of stay	4.8	A	4.9		4.7
2	Timely access	% patients on incomplete RTT pathways waiting <18 wks from referral	66.20%	R	68.10%		92%
		% receiving treatment for cancer following referral within 62 days (Post)	65.90%	R	78.80%		85%

NB: For more information/detail, see section two of this report

- The Trust's performance against the A&E 4 hour target during the latter half of 2017 has improved allowing the Trust to meet the 90% target during quarter 3. This is especially challenging during the seasonal pressures faced by the Trust and neighbouring organisations. The Trust is 12th most improved in the UK compared to last winter. Work continues, alongside stakeholders, to ensure effective and timely admission.
- The Trust's focus on ensuring effective flow through its hospitals has continued resulting in significant improvement in the length of hospital stay for those patients admitted as an emergency. Work continues to be focussed on this area, and this remains a quality improvement priority for 2018/19.
- Timely access remains a challenge in light of the recent winter pressures in Quarters 3 and 4. Coupled with vacancy and sickness rates, the Trust complied with the national directive to cancel non-urgent inpatient treatment to ensure urgent care was prioritised. This has had an expected detrimental effect on the non-urgent waiting list which will present a challenge in 18/19. The Trust continues to monitor this area and prioritise patients by urgency.

Quality Priority: Theme 6: Medical Quality Indicators

Patient Safety: THEME 6: Medical Quality Indicators			Mar-18		Feb-18	Target achieved	Target
1	Venous Thromboembolism (VTE)	% of patients screened for VTE on admission	90.3%	R	93.4%		95%
2	Safe Medical Staffing	% Substantive medical posts vacant	23.59%	R	23.45%		14.17%
		Medical agency spend £000s	1,508		1,952		None

NB: For more information/detail, see section two of this report

- The Trust is not yet consistently meeting the target of screening 95% of new patients for VTE on admission. Work is underway, led by the Trust's Medical Director, to understand processes in place and key clinical locations where procedures for screening new patients within 24 hours need strengthening.
- Safe medical staffing featured as a quality priority and has been monitored by the Workforce committee. The number of vacant substantive posts remains a challenge for the Trust and currently the rate is above the 14% target set. The Trust continues to focus on recruitment and have used a number of innovative approaches which have helped recruit to hard to fill vacancies. Where efforts remain unsuccessful, the Trust have where possible, looked to work differently and mitigate the risk by developing new roles, for example the Advanced Clinical Nurse Practitioner role.

The following quality improvement priorities have been set to support the Trust's focus on quality improvement, linking in and supporting the 'Improving Together' improvement programme projects as well as supporting other more 'business as usual' quality monitoring, focus and improvement activities and supporting the Trust's refined and strengthened quality governance framework.

The Trust's Quality Improvement Priority Themes for 2018/19 were shared with the Trust's Leadership Community in January 2018 and slightly modified in April 2018 to ensure these reflected the Trust's priorities around quality. They consist of the following 5 priority **quality and safety themes**:

1. Safety (specific focus on recognition of deteriorating patients; continued focus on mortality (including sepsis and AKI); pressure ulcers)
2. Safe staffing and engagement (specific focus on vacancy rates; staff engagement)
3. Safe emergency care (specific focus on urgent and emergency care; SAFER patient flow bundle)
4. Safe maternity care
5. Planned care (specific focus on cancer care; 52 week waiters; clinical harm reviews)

Whilst the Trust views the above 5 themes as the over-arching **quality and safety** priorities for the organisation during 2018/19, to ensure these are harmonised against other local, regional and national reporting, these have been further grouped within the 5 Domains of the CQC Fundamental Standards, these are presented as follows, with supportive narrative:

Quality Priority Themes grouped within the 5 CQC Fundamental Standards

SAFE	
KEY Quality Indicators to support executive Quality Management Reporting:	
QUALITY PRIORITY THEME 1: Safety (specific focus on pressure ulcers)	
Infection prevention and control (Clostridium Difficile / MRSA / Gram Negative Bacterial Infection (GNBI)	NHS Safety Thermometer: specific focus on pressure ulcers
Falls (per 1,000 bed days) / number of	Pressure Ulcers (per 1,000 bed days) / number of
QUALITY PRIORITY THEME 3: Safe emergency care (Specific focus on urgent and emergency care; SAFER patient flow bundle)	
National Early Warning Score in A&E	Emergency department safety checklist
Length of Stay (LOS) – non-elective	Length of Stay (LOS) non-elective – Medicine
Stranded patients (7 days / 21 days)	Red to Green
4 hour A&E wait	
QUALITY PRIORITY THEME 4: Safe maternity care	
Ratio of midwives to births	Monthly average Fill rate midwives (Day/Night)
Monthly compliance with CTG monitoring (Mandatory training / monthly fresh eyes audit)	Number of maternity SIs / rates
Rolling still birth rate	Customised growth charts
Local Safety Standards in Invasive Procedures (LOCSSIPs) in Maternity	1:1 care in labour

For more information on how these priorities are set, see section 2.1g of this report

Rationale:

- Included in the Quality priority theme indicators are **pressure ulcers** both the rate of ulcers locally and benchmarked against other organisations.

- The Trust has chosen **safe emergency care as one of its quality priority themes** again related to the Trust's mortality and deteriorating improvement project, and linked to the wider Improving Together Improvement Programme focussing on access and flow arrangements.

- The focus on the **SAFER patient flow bundle as a quality improvement priority** recognises the link between quality outcomes and the organisation and management of flow throughout the Trust's hospitals.

- The SAFER patient flow bundle includes:

    - **S –** Senior Review: before midday, management and discharge decisions.
    - **A –** All Patients: will have an Expected Date of Discharge (EDD) and Clinical Criteria for Discharge (CCD), assuming ideal recovery and no unnecessary waiting.
    - **F –** Flow: of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
    - **E –** Early Discharge: 33% of patients will be discharged from base inpatient wards before midday.
    - **R –** Review: A systematic multi-disciplinary team (MDT) review of patients with extended lengths of stay (>7 days – also known as 'stranded patients') with a clear 'home first' mind set.

      (NHS Improvement: Rapid Improvement Guide to the SAFER patient flow bundle: https://improvement.nhs.uk/uploads/documents/the-safer-patient-flow-bundle.pdf)

- The underpinning indicators identified above are designed to monitor and manage the outcomes of the SAFER patient flow bundle in regard to moving patients appropriately through the hospital, with a minimum amount of unnecessary waiting, to ensure the Trust is able to best utilise available capacity.

- There are differences between the two sites with regard to access and flow indicators. This links to the Trust's Mortality Improvement project.

- Another **quality priority theme relates to the provision of safe maternity care.** This priority links into the Trust's Improving Together Programme and also supports a focus on other related themes arising from previous mortality improvement work, specifically still births and links into other ongoing work.

EFFECTIVE	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 1: Safety (specific focus on recognition of deteriorating patients; continued focus on mortality (including sepsis and AKI))	
Summary-Hospital Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
National Early Warning Score (NEWS) – vital signs recorded	National Early Warning Score (NEWS) – appropriate clinical response actioned
Number of adult cardiac arrests	Cardiac call vs survival rates
Venous Thromboembolism (VTE)	Sepsis bundle compliance

For more information on how these priorities are set, see section 2.1g of this report

Rationale:

- **There is a continued focus on mortality and the deteriorating patient.** The above indicators will again be used to support internal monitoring of and reporting for action and assurance as part of the Trust's strengthened quality management structure.

- The underpinning data will be used to support the understanding and action needed to support the Trust's mortality improvement programme, a part of the Trust's Improving Together Programme.

CARING	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 2: Safe Staffing and Engagement (specific focus on staff engagement)	
Friends and family test	Complaints analysis
Mixed sex accommodation	Staff experience
Outcomes from Listening into Action	Pride and Respect (our anti-bullying campaign)

For more information on how these priorities are set, see section 2.1g of this report

Rationale:

- Patient and staff experience are important indicators of the quality of services provided by the Trust. Where possible and available, experience indicators will be used to support assessment of the 5 quality and safety priority themes. The caring domain features specific indicators of experience designed to provide an over-arching understanding and ongoing monitoring.

RESPONSIVE	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 5: Planned care (specific focus on cancer care; 52 week waiters; clinical harm reviews)	
Underpinning Quality Indicators to be reported:	
WHO surgical safety checklist	Patient waiting <62days from urgent GP referral to first definitive treatment
Size of the incomplete patient target list (PTL) – based on 31 March 18	Number of patients waiting in excess of 52 weeks
Proportion of clinical harm reviews outstanding – by specialty	
Diagnostics waiting times and activity (tests over 6 weeks for routine) encompassing:	☐ MRI ☐ CT ☐ Endoscopy – site specific ☐ Cardiology – Angiographies

For more information on how these priorities are set, see section 2.1g of this report

Rationale:

- Quality priority theme 5 ensures the Trust continues to focus on improvements to the provision of **planned care and review of any harm as a result of patients on waiting lists.** The Trust therefore wanted to ensure that these areas a reflected within the quality improvement priorities.

- The above outlined indicators are designed to provide a key outline of the data available to the Trust that relates to this theme and that will support the Chief Nurse and Medical Director focus relevant resource on improvement work needed following receipt and assessment as part of the Trust's newly strengthened Quality Management Structure.

WELL LED	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 2: Safe Staffing & Engagement (specific focus on vacancy rates)	
Medical: % fill rate locums to establishment	Nursing: % fill rate for registered nurses
Medical: % substantive medical posts vacant (consultant / non-consultant)	% fill using substantive staff
Medical: Agency spend £000's (above budget)	% substantive nursing posts vacant (registered nurses / HCA)
Medical: Number of specialities who have had an establishment review	Nursing agency spend £000's (above budget)
	Number of wards who have an establishment review

For more information on how these priorities are set, see section 2.1g of this report

Rationale:

- The Trust recognises that safe staffing is a critical component of providing safe and effective care. The Trust therefore proposes to focus on **safe staffing as a quality and safety priority theme.** The underpinning quality indicators outlined above are designed to support the Trust's Chief Nurse and Medical Director monitor progress in this area and seek additional action as necessary to support in providing ongoing assurance.

- The above indicators will be used to populate the revised quality section contained in the integrated performance report, overseen as part of the Trust's revised and strengthened quality management structure, reporting for action to the Quality Governance Group and the associated management sub-groups and reporting for assurance to the Quality & Safety Assurance Sub-Committee and Trust Board.

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

2.1 Priorities for improvement: overview of the quality of care against 2017/18 quality priorities

Information reported within Part 2

Due to the timings necessary to compile the Annual Quality Account, the most recent information available presented is not always to the end of the financial year. Despite this at least 12 months trending information is presented where available.

Priorities for improvement

This section of the report highlights progress during 2017/18 towards achieving the Trust's quality priorities.

During 2017/18, the process by which quality performance was monitored was changed to ensure this was seen within the context of other performance and financial indicators. This was accomplished by the Trust's integrated performance report replacing the Trust's quality report, ensuring a more holistic view of the Trust's activity and performance was presented.

The integrated performance report provided an overview of performance to all the Trust's sub-committees and a further summarised version was presented to the Trust Board on a monthly basis, supported by narrative from the Chief Nurse and Medical Director.

The quality improvement priorities for 2018/19 are then outlined again in a fourth section of this report, namely: Section 2.1d Quality priorities for the 2017/18 financial year.

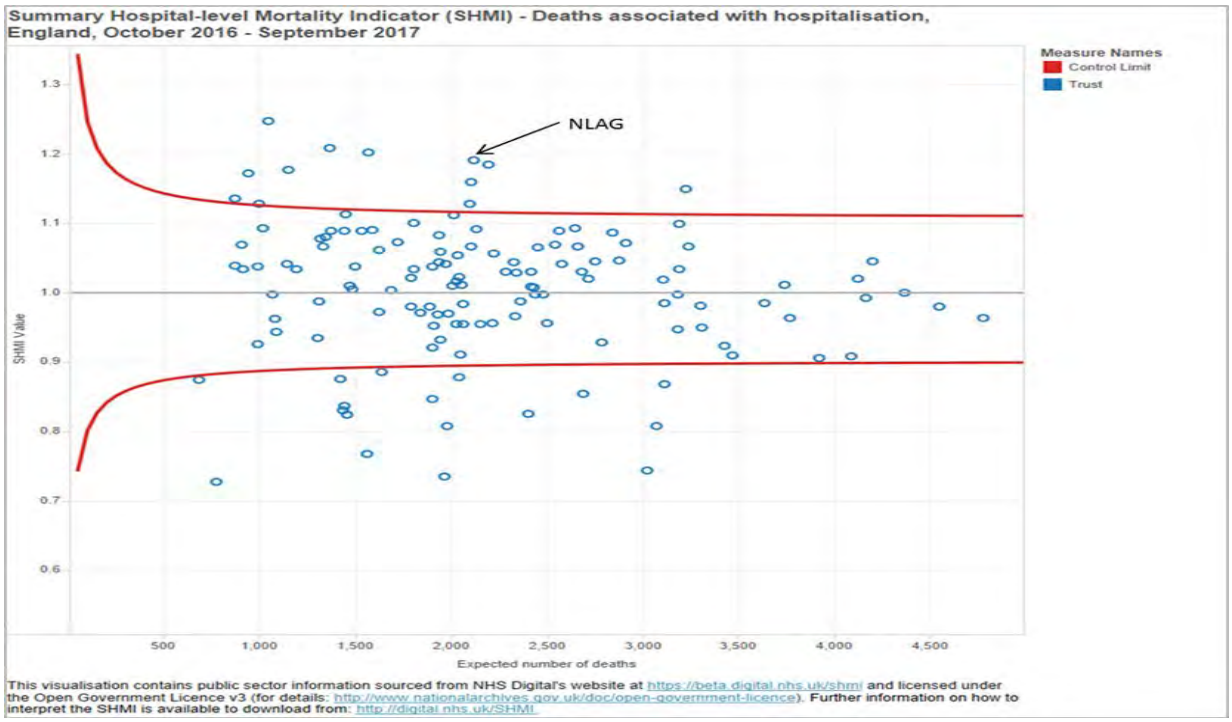
2.1a Theme 1: Reducing Mortality

*(**NB:** For a greater understanding as to how mortality is measured, how this information should be interpreted and key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): Using the latest 'official' SHMI indicator published in March 2018, the Trust is currently 'higher than expected'. The SHMI is published quarterly and due to its inclusion of deaths outside of hospital, within 30 days of discharge, is always some months behind present day. The data presented below therefore covers the period of October 2016 to September 2017.

The Trust's official SHMI in national context

The following chart illustrates the Trust's most recent SHMI score and ranking in relation to those of all Trusts nationally.



Source: Information Services based on the Health and Social Care Information Centre's data

Key to abbreviations: SHMI – Summary Hospital Mortality Indicator
NLAG – Northern Lincolnshire and Goole NHS Foundation Trust

Comment:

- The Trust's SHMI score was 119.
- This ranks the Trust as "higher than expected".
- For a more detailed review of the Trust's performance with mortality indicators and greater detail of the work underway see section 2.3a of this report.

Progress monitored, measured and reported: Performance against mortality indicators is monitored, measured and reported in detail within the Trust's mortality report which is reported to the Board. A dedicated sub-committee of the Trust Board, the Mortality Assurance & Clinical Improvement Committee (MACIC), provided oversight on mortality performance during 2017/18. As part of the strengthened quality management structure, mortality will be overseen by a management sub-group that will report into the Executive led Quality Governance Group, which will be responsible for providing assurance to the Trust Board.

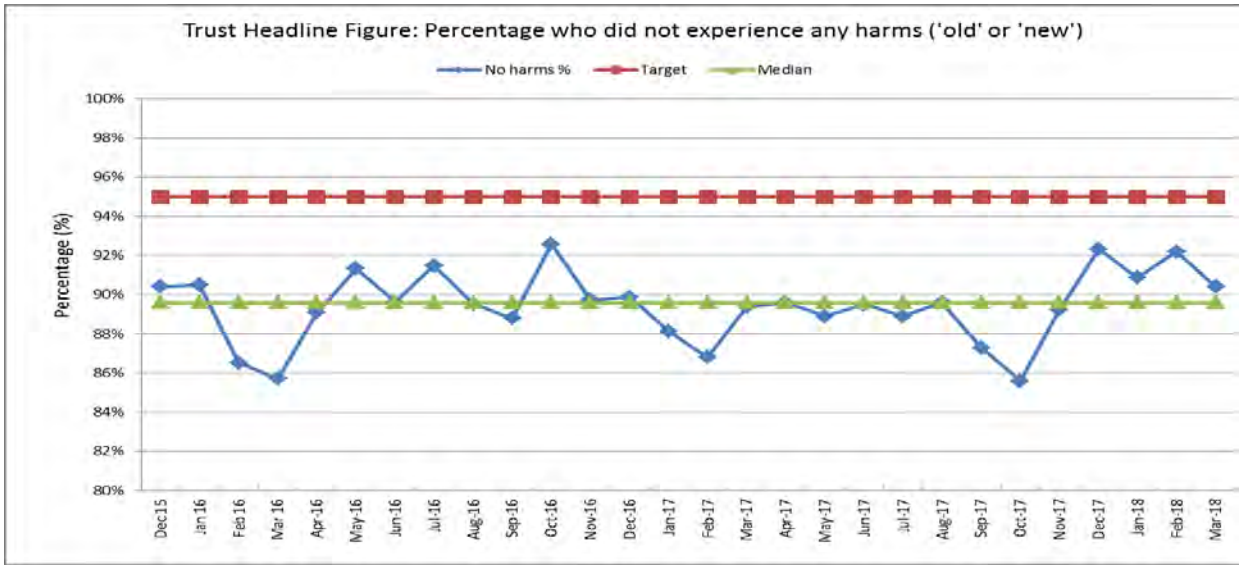
Relationship to 2018/19 Quality Improvement Priorities: This subject remains a quality improvement priority theme for 2018/19.

2.1b Theme 2: Increase Harm Free Care

Classic NHS Safety Thermometer

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): The percentage of acute patients without any harm (including 'old' harms, present prior to hospital admission) is not presently meeting the 95% target. The community safety thermometer is routinely exceeding the 95% target.



Source: NLAG NHS Safety Thermometer, as reported within the Open and Honest initiative, NHS England

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust
'Old' harms – harms prior to admission (i.e. community acquired pressure ulcer
'New' harms – harm attributable to hospital care (i.e. a new VTE)
Median – the middle value in a series of numbers

Comment:

- The chart above demonstrates that since December 2015, the Trust's average (median) performance has been 89.6%.
- The chart includes patients with 'old' harms, i.e. those with a pre-existing harm prior to hospital admission (i.e. a community acquired pressure ulcer).
- Targeted work has been undertaken to increase understanding of contributing factors and actions taken in response, e.g. targeted training, pilot of new pressure area prevention and management documentation, monitoring of hotspot wards, "Stop the Pressure" local conference.
- A pressure ulcer management action plan is subject to regular discussion and challenge with a named non-executive director.
- A review of the Tissue Viability Nursing service is to commence in April 2018.
- The Quality Matrons have rolled out education for ward leaders to ensure accuracy of data collection.

Progress monitored, measured and reported: Progress against the classic NHS safety thermometer is monitored by the Quality & Safety Committee, contained within the Trust's integrated performance report.

Relationship to 2018/19 Quality Improvement Priorities: Relationship to 2018/19 Quality Improvement Priorities: This indicator continues to feature within the 'key' underpinning data quality indicators, alongside the component elements: falls, pressure ulcers and VTE.

Care of the Deteriorating Patient

Progress Made: (April 2017 – March 2018): The Trust have been unable to measure performance with regard to the monitoring and action taken in response to National Early Warning Scores (NEWS) as the methodology for measuring and reporting this is still being developed.

The Trust has previously reported this from data obtained from routine snapshot audit samples, but recognised that there was a danger in obtaining false assurances from what was a very small snapshot audit sample, given there are thousands of NEWS observations recorded each month. Work is currently underway to embed routine reporting into ward level dashboards, from the Trust's WebV system. This will support the Trust's ongoing mortality improvement project.

Comment: The implementation plan for improving care of the deteriorating patient and early diagnosis and management of sepsis is monitored by the Improving Together Board and includes actions such as: roll out of electronic hand-held devices to record observations; launch of a new escalation policy (including a focus on NEWS2); updated training programmes; safety huddles and the development of ward-based dashboards for local oversight of progress and ownership by clinicians and ward leaders.

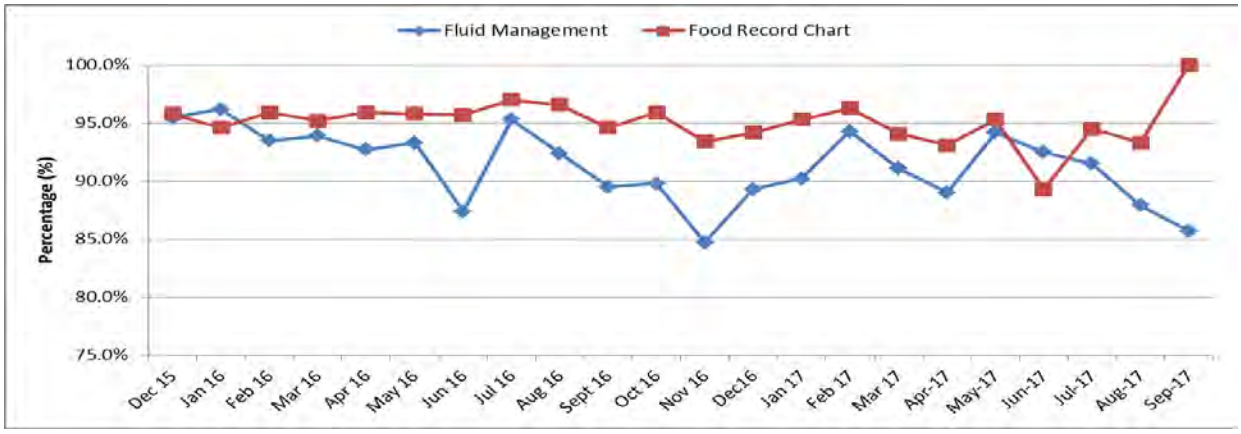
Progress monitored, measured and reported: At present performance is not currently monitored. Once this information is routinely available at ward level from the Trust's WebV system, this will be monitored and reported as part of the Trust's strengthened quality management structure, specifically to the Executive led Quality Governance Group and the management sub-group focussing on mortality improvement.

Relationship to 2018/19 Quality Improvement Priorities: This indicator features as one of the quality improvement priority themes for 2018/19.

Nutrition and Hydration

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): The chart demonstrates that the documentation and recording of fluid balance has not achieved the target being aimed for. This remains a quality priority for 2018/19.



Source: Nursing Dashboard

Key to abbreviations: Fluid management - chart completed accurately/fully in line with plan
Food record chart - completed accurately/fully in line with plan

Comment:

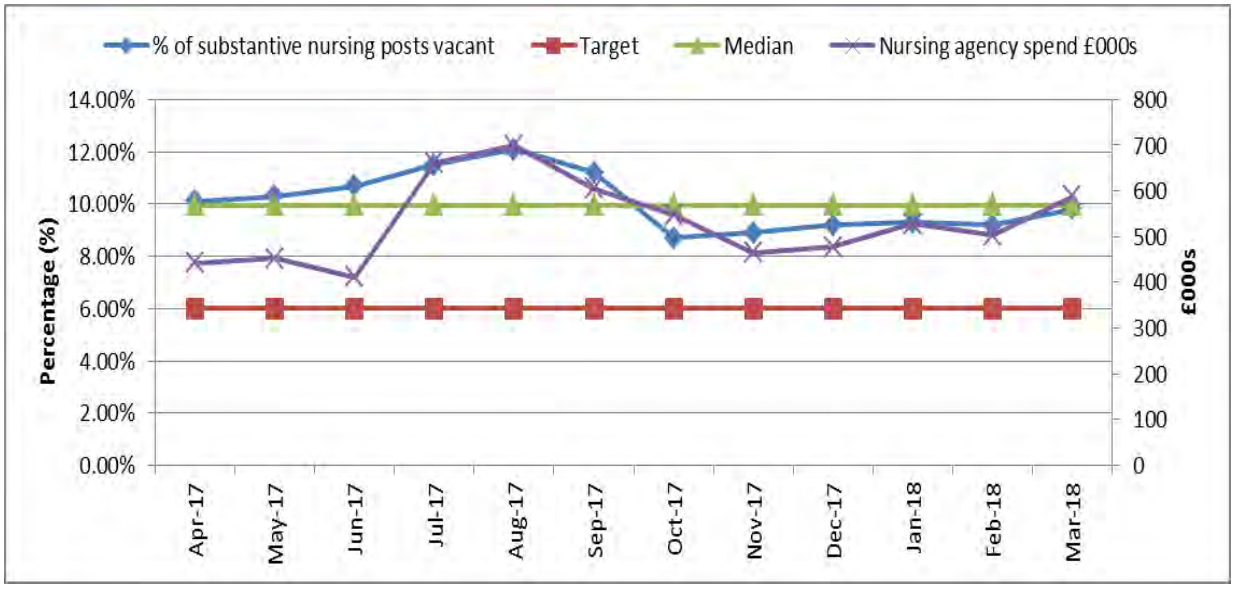
- The chart above demonstrates that Trust performance with fluid management or food record chart completion has not yet achieved the 100% compliance target.
- Performance with these indicators was routinely monitored as part of the Trust's nursing dashboard, however, in September 2017, use of the dashboards to monitor this were suspended to ensure that nurses involved in the collation of this data were able to support clinical areas during the period of operational pressure faced during the winter period.
- The Trust is also taking part in a national improvement collaborative supported by NHS Improvement to drive improvements in nutrition and hydration. Collaborating with other organisations will help the Trust to learn from the best practice employed in other areas. This work is in its infancy and baseline information is being collated so that we can track progress throughout 2018/19. A Trust-wide review of nutrition has been undertaken by the Assistant Director of nursing and the development of a nutrition team has been approved.

Progress monitored, measured and reported: Progress against these indicators was monitored by the Chief Nurse Directorate, as part of the Nursing Dashboard. Since September 2017 performance against these indicators has been suspended, plans are being developed to ensure this is monitored during 2018/19 as this area remains as a quality priority.

Relationship to 2018/19 Quality Improvement Priorities: Whilst these indicators have not been monitored as part of the Nursing Dashboard audits, a lack of fluid balance monitoring has been identified from other work undertaken by the Trust as being an area needing improvement, and documentation and recording of fluid balance will therefore feature as part of the mortality improvement project and as part of the Trust's 2018/19 quality improvement priorities.

Safe Nurse Staffing

Progress Made: (April 2017 – March 2018): The percentage of substantive nursing posts vacant has decreased during the 2017/18 period, but has not yet achieved the target rate of 6%.



Source: Improving Quality & Safety, Improving Together Programme KPIs

Key to abbreviations: % substantive nursing posts vacant – the number of substantive nursing posts vacant
Median – the middle value in a series of numbers

Comment:

- The chart above demonstrates that the Trust levels of substantive nursing posts vacant has reduced, but is still above the target of 6%. The average (median) vacancy rate is 9.95%. The nursing agency spend reflects the vacancy rate showing increasing spend when vacancy rates have increased and reduced expenditure as vacancy rates have decreased. This has been compounded over the winter period due to the high demand for inpatient beds and the subsequent opening of escalation beds.
- The Trust are actively working to improve nurse staffing availability and reduce the vacancy position and the labour turnover rate. A number of specific actions are being taken including:
    - Targeted newly qualified recruitment campaign has started for nurses in training, hoping to qualify in Sept 2018,
    - Recruitment videos featuring ward/department staff for areas with high vacancy rates,
    - Attendance at careers fairs to advertise the Trust,
    - Reviewing overseas recruitment and looking to support overseas nurses to obtain the English language test (ILETS) which is a mandatory requirement from the Nursing & Midwifery Council (NMC),
    - NLAG is part the NHS Improvement retention collaborative. Through this the Trust have developed a retention plan to look at focussed efforts to support retaining current staff which will help to reduce the vacancy position. The plan includes measures to offer additional flexibility, e.g. retire and return contracts, night preference contracts as well as career development opportunities and staff benefits. These ideas have been generated through staff engagement,
    - The Chief Nurse is actively developing plans for new nursing roles, including trainee Nursing Associates and the use of apprenticeships to widen entry routes into the profession.

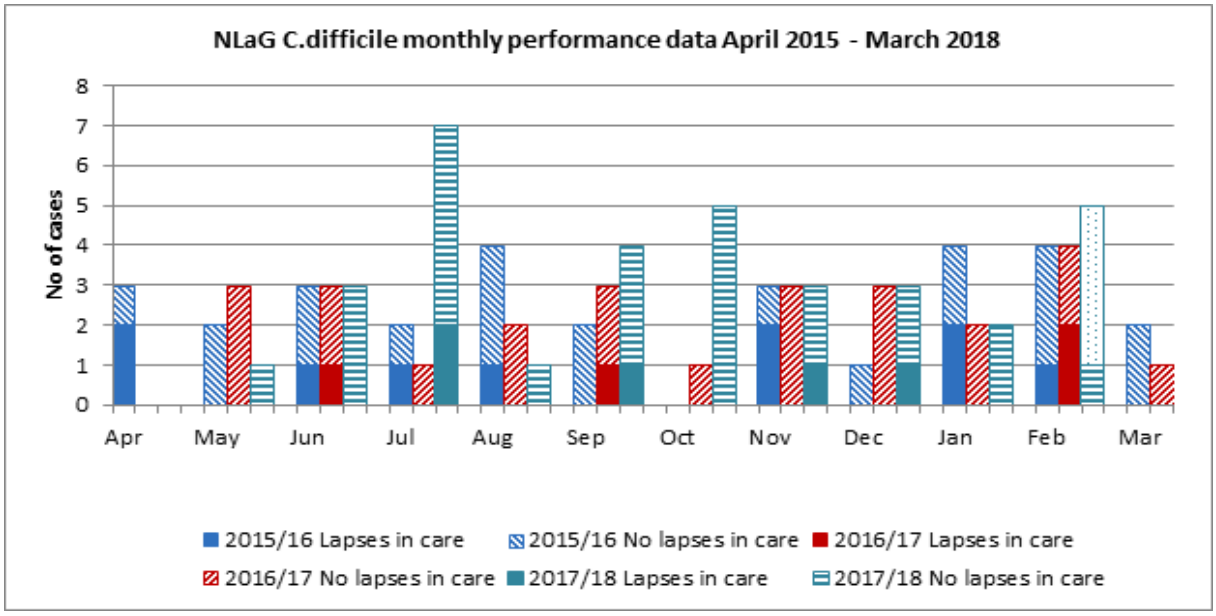
Progress monitored, measured and reported: Progress with this indicator is monitored within the Improving Together Quality & Safety work stream by the senior responsible officer, the Chief Nurse, as part of the Improving Together Programme's key performance indicators (KPIs).

Relationship to 2018/19 Quality Improvement Priorities: This indicator, along with other safe staffing metrics, will be included as part of the 2018/19 quality improvement priorities.

Infection Prevention and Control

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): The Trust have achieved the national targets set for C difficile (no more than 21 lapses in practice or care). The Trust has not achieved the national target for MRSA infections (target of zero) with 1 MRSA infection during 17/18, although this is an improvement on the previous year.



Source: Infection Control Team, NLAG

Key to abbreviations: NLAG – Northern Lincolnshire & Goole NHS Foundation Trust
'lapses in care' – the number of c difficile infections resulting from potentially preventable care issues

Comment:

- The chart demonstrates that the Trust has had a total of 37 c difficile infections within the period of April 2017 to January 2018. 6 of these, within this time frame, have been as a result of a lapse in care.
- The data shows the majority of cases of C. difficile infection occur on the DPOW site. This is partially down to the poor cohort / isolation and hygiene facilities available which will result in environmental dissemination of the organism. Work is now planned to address the lack of isolation capacity by a radical overhaul of the C floor which will ultimately enhance isolation capacity and hygiene facilities for patients.

Progress monitored, measured and reported: Progress with this indicator is monitored within the integrated performance report and as such is reported to the Quality & Safety committee.

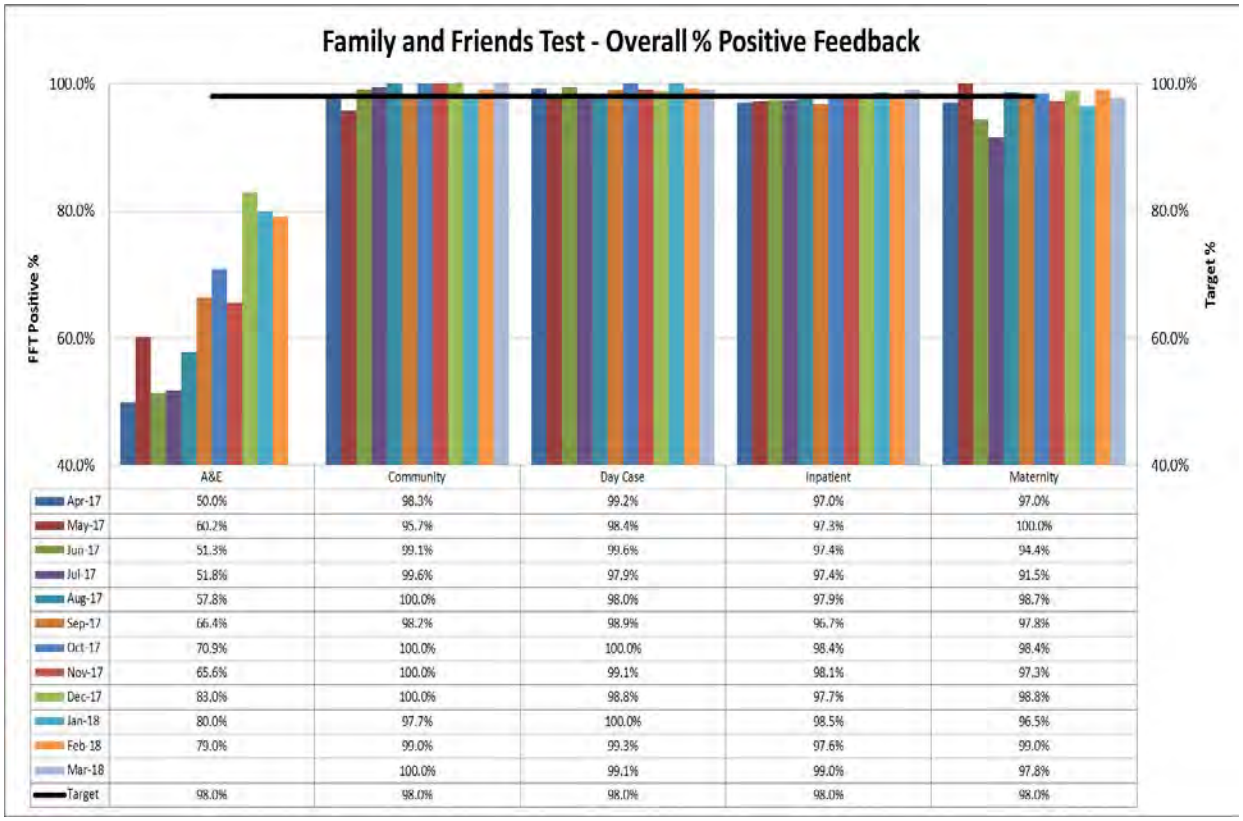
Relationship to 2018/19 Quality Improvement Priorities: Whilst these indicators do not feature within the 18/19 quality improvement priorities, they will continue to be reported as national performance indicators within the integrated performance report.

2.1c Theme 3: Providing Care Resulting in a Positive Experience

Patient Experience

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): The Trust has largely achieved the 98% positive feedback target from the friends and family test. The exception to this is the feedback received from the Trust's two Accident & Emergency departments.



	A&E	Community	Day Case	Inpatient	Maternity
Apr-17	50.0%	98.3%	99.2%	97.0%	97.0%
May-17	60.2%	95.7%	98.4%	97.3%	100.0%
Jun-17	51.3%	99.1%	99.6%	97.4%	94.4%
Jul-17	51.8%	99.6%	97.9%	97.4%	91.5%
Aug-17	57.8%	100.0%	98.0%	97.9%	98.7%
Sep-17	66.4%	98.2%	98.9%	96.7%	97.8%
Oct-17	70.9%	100.0%	100.0%	98.4%	98.4%
Nov-17	65.6%	100.0%	99.1%	98.1%	97.3%
Dec-17	83.0%	100.0%	98.8%	97.7%	98.8%
Jan-18	80.0%	97.7%	100.0%	98.5%	96.5%
Feb-18	79.0%	99.0%	99.3%	97.6%	99.0%
Mar-18		100.0%	99.1%	99.0%	97.8%
Target	98.0%	98.0%	98.0%	98.0%	98.0%

Source: Information Services, Friends & Family Test Dashboard

Key to abbreviations: FFT – Friends & Family Test

Comment:

- The chart demonstrates that the Trust's A&E departments have received low overall positive feedback.
- An improvement plan is in place and being implemented in relation to improving the quality of care and experience of patients in the Emergency Department. As many of the comments received relate to waiting times, the work being actively progressed to improve flow through the department should aim to realise benefits. In addition the departments have introduced an ED patient safety checklist which prompts frequent reassessment of patients and care delivery, which includes improved communication/provision of information.

Progress monitored, measured and reported: Progress with this indicator is monitored within the integrated performance report and as such is reported to the Quality & Safety committee.

Relationship to 2018/19 Quality Improvement Priorities: These indicators will be monitored and support the Trust's understanding of patient experience alongside the Trust's quality improvement priorities.

Staff Experience

Progress Made: (April 2017 – March 2018): The Trust has measured the staff experience primarily using the National NHS Staff Survey based on the findings from the 2016 survey (reported in March 2017) and the 2017 survey (published in March 2018). The 2017 survey demonstrates that the Trust's performance has deteriorated from 50% in 2016 to 43% in 2017.

Comment:

- The NHS Staff Survey, amongst others, asks a specific experience based question: "Would staff recommend the Trust to work in?"

- Whilst the Trust are disappointed, the results of the survey once shared with the Trust during early 2018 were not surprising, and action had already commenced. The Trust have included organisational culture within the Trust's improvement programme (Improving Together) and have been working to improve this area using the following:
    - Invested in the Listening into Action (LIA) programme, with dedicated project support to empower Trust staff to be able to make changes and bring their improvement ideas to life.
    - A new approach for apprenticeship programme enabling staff to study up to degree level in a range of clinical and non-clinical subjects for free. The Trust has been recognised as a national exemplar site for this initiative, with 27 programmes up and running. Whilst early, there has been some good progress made.
    - A new 'Pride and Respect (our anti-bullying campaign)' project has been launched to provide staff with access to an advice line to help them raise concerns where unacceptable behaviours or poor professional standards are demonstrated.
    - The Trust has also appointed a Freedom to Speak Up Guardian (FTSUG) to again be on hand to provide staff with a confidential route to raise concerns about anything in the Trust.
    - An undercurrent from the NHS Staff Survey was in connection with a lack of staff. The Trust have continued to use innovative ways to recruit to posts that are challenging to fill. This has included the creation of new roles. The Trust are also focussing on retention of staff also and this has led to the creation of a dedicated retention strategy.

Progress monitored, measured and reported: Progress with this indicator is monitored within the Improving Organisational Development and Culture work stream by the senior responsible officer, the Director of People and Organisation Effectiveness, as part of the Improving Together Programme's key performance indicators (KPIs).

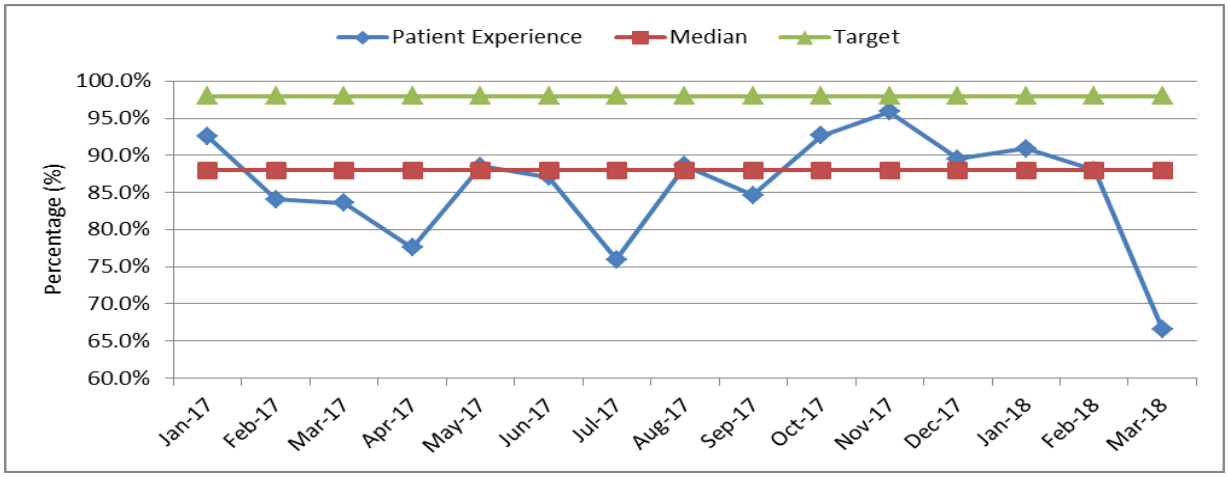
Relationship to 2018/19 Quality Improvement Priorities: This indicator, alongside other experience based indicators, will be monitored and support the Trust's understanding of staff experience alongside the Trust's quality improvement priorities during 2018/19.

2.1d Theme 4: Outpatient Services

Patient Experience

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018): The percentage of patients responding to the outpatient friends and family test and responding positively to the question asked regarding whether they would recommend the Trust's services has not yet achieved the 98% target, with the Trust average (median) 88.0%.



Source: Information Services based on the Health and Social Care Information Centre's data

Key to abbreviations: Patient experience – as measured as part of the FFT – Friends & Family Test
Median – the middle number in a series of data

Comment:

- It should be noted that the response rate to the friends and family test in outpatients is low and therefore not proportionate to the number of patients receiving care within the Trust's outpatient services.
- The Trust are looking at how best to increase response rates across our outpatient services by expanding our Friends and Family SmS text use to cover outpatients. However we also acknowledge that this is only one part of feedback methodology and are encouraging teams to use local surveying to understand what matters to them. This is also supported by our partners Healthwatch who have conducted visits to our outpatients departments and provided valuable feedback.
- Over the course of the year as a result of the implementation of call and text reminding, and mutually agreeing appointments with patients, the Trust has seen a reduction in the number of patients that do not attend (DNA). This has enabled the Trust to improve utilisation and thus get patients seen as soon as practicably possible
- There has been significant focus on enabling GP's to electronically send referrals to us, and directly book appointments for their patients at the point of referral, this is now available across 18 specialties. We have also significantly reduced the number of patients that are unable to book into an appointment as a result of capacity. The Appointment Slot Issue (ASI) list has reduced throughout the course of the year suggesting that more slots are available for the patient to choose to attend.

Progress monitored, measured and reported: This information is monitored by the Trust's Patient Experience team.

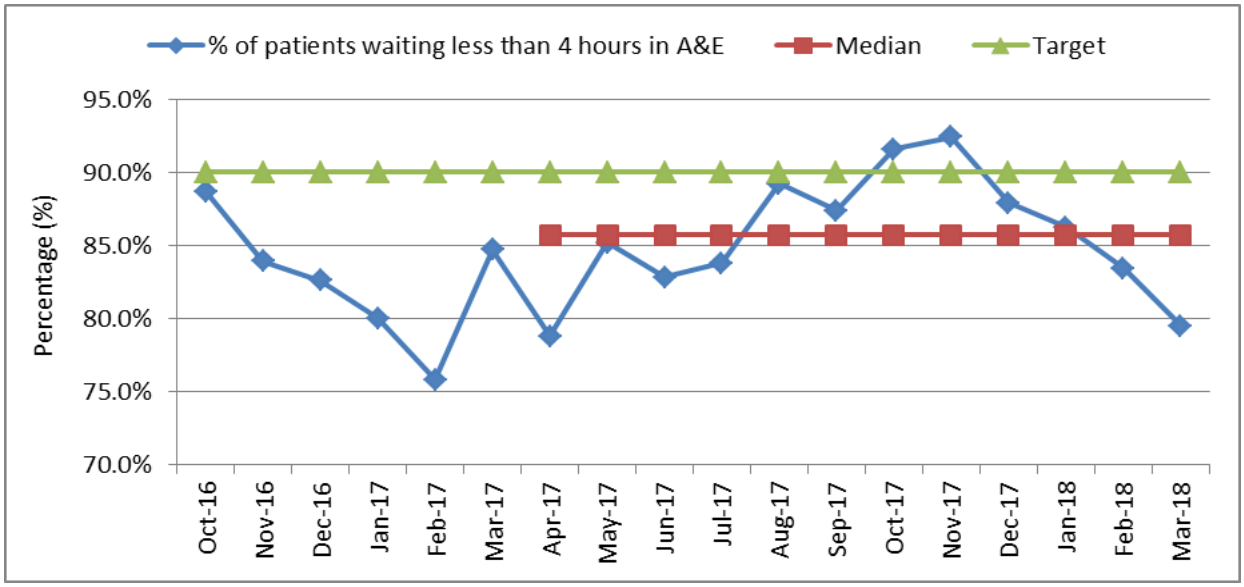
Relationship to 2018/19 Quality Improvement Priorities: This indicator, alongside other experience based data, will be monitored and used to support the Trust's understanding of experience alongside the Trust's quality improvement priorities during 2018/19.

2.1e Theme 5: Discharge & Transfer

Patient Flow

Progress Made: (April 2017 – March 2018):

- As a result of the Trust being in a segment 4 system the Trust needed to meet 90% of patients to be seen within 4hrs of arrival at A&E. The Trust have achieved an average (median) of 85.7% during the 2017/18 calendar year. The Trust achieved the 90% target for quarter 3.
- The Trust's non-elective length of stay has reduced during the 2017 calendar year.



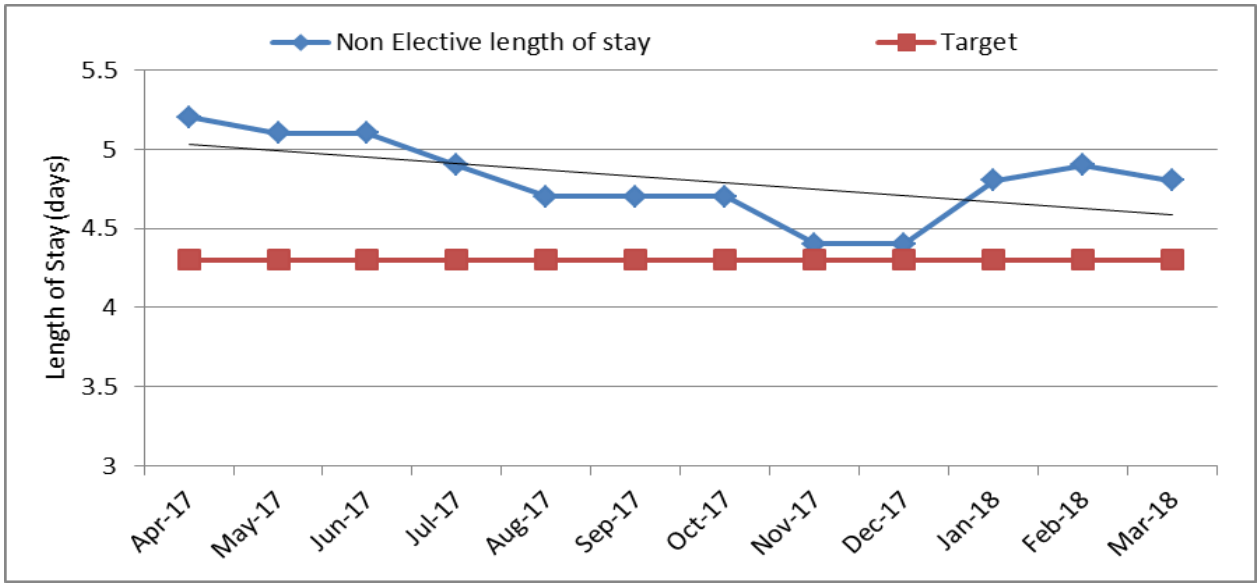
Source: Information Services based on the NHS England data

(This indicator has been subject to external assurance Ⓐ*)*

Key to abbreviations: Median – the middle number in a series of data

Comment:

- The chart demonstrates improvement in the A&E four hour target with previous months performance and during winter pressures faced during 2016/17. Whilst performance reduces during December – February 2018, this is during severe operational pressures, weather and a flu outbreak. The Trust have compared favourably to national performance, ranking as 12th most improved in the UK from last winter.
- During 2017/18 and especially during the operational pressures faced during the winter, the Trust reprioritised and resourced provision of care for those patients attending A&E as a non-elective attendance (i.e. unplanned, often as a result of an emergency). This approach resulted in healthcare professionals being redeployed to support the provision of direct care and with the support of new models of care at the DPoW site including the Medical Ambulatory Care unit, the Trust were able to maintain a flow of patients through its hospitals, amidst the severe weather faced and a national epidemic of flu. The Trust also, following a directive from NHS England, cancelled all non-urgent inpatient elective care (day case work continued), to enable further redeployment of clinical staff to support caring for non-elective admissions.
- The Trust have already started planning for 2018/19 winter and the operational pressures to be faced. Planning includes further service changes and new models of care, working collaboratively with local and national partners to further reduce pressures on hospital beds and services and maximising care able to be delivered in the community.



Source: Information Services

Key to abbreviations: Non-elective length of stay – patients requiring unplanned, often emergency, care in hospital

Comment:

- The chart demonstrates improvement in reducing the non-elective length of stay from a peak of 5.2 days (average) to 4.8 days (average). A slight increase is seen during January and February. The context for this rise is likely related to operational pressures, compounded by a period of very challenging weather conditions.
- Specific initiatives have supported this progress being made, including the opening on the Diana, Princess of Wales hospital site of a medical and a surgical ambulatory care to support provision of emergency care to those who are medically fit to return home again on the same day.
- Work will continue as part of the SAFER patient flow bundle to reduce length of stay still further, towards the target set.
- Additional initiatives are also planned to better support the care of patients attending Trust services unplanned including frail elderly services on the DPoW site, urgent care centres with primary care support and looking to determine what capacity is needed to meet emergency demand. Planning for winter 2018/19 has already commenced.

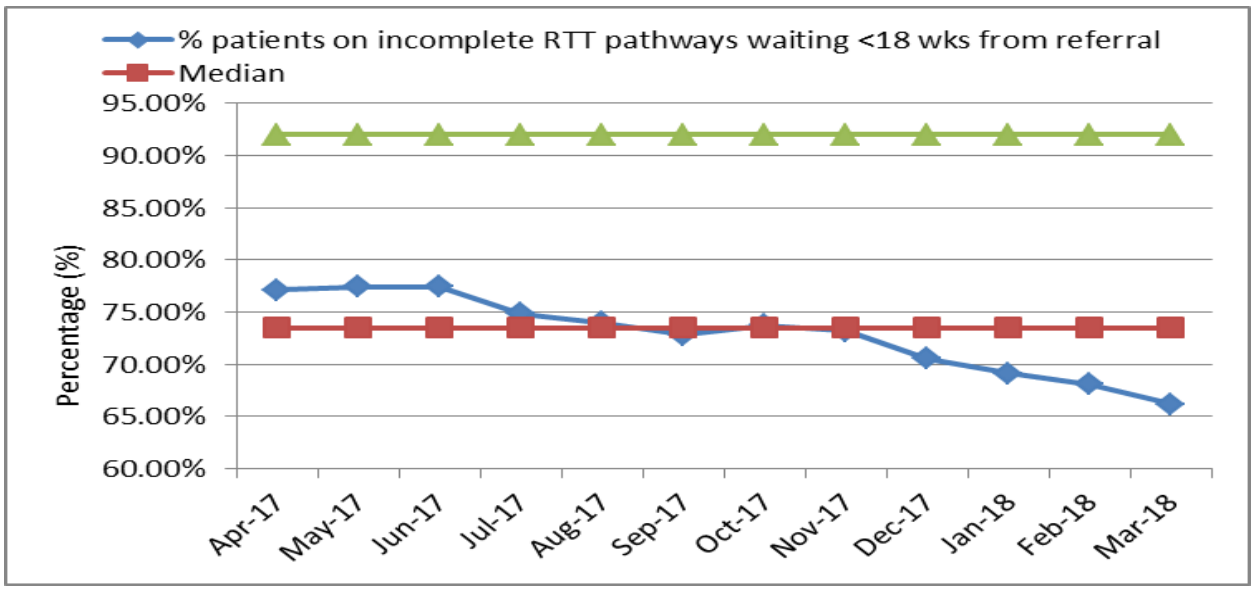
Progress monitored, measured and reported: Progress with these indicators is monitored within the Improving Access & Flow work stream by the senior responsible officer, the Deputy Chief Executive, as part of the Improving Together Programme's key performance indicators (KPIs) and also reported in the integrated performance report to the Trust Board.

Relationship to 2018/19 Quality Improvement Priorities: Both indicators will remain within the 2018/19 quality improvement priorities as they link to the Trust's priorities around access and flow and safe emergency department care.

Timely Access

Progress Made: (April 2017 – March 2018):

- The Trust is not yet achieving the target around referral to treatment within 18 weeks.
- The Trust's performance with referral to treatment has been affected significantly by the refocussing of resource (in line with the activation of the NHS England Winter Pressures Protocol) to focus on providing care for unplanned, non-elective attendances and admissions to the Trust's hospitals. Non-urgent planned care was deferred through to mid-February 2018 which was further complicated by a period of poor weather.
- The Trust is not yet meeting the target set for patients receiving treatment for cancer following referral within 62 days. Work is currently underway to focus on identifying and ensuring prioritisation for those patients waiting the longest.



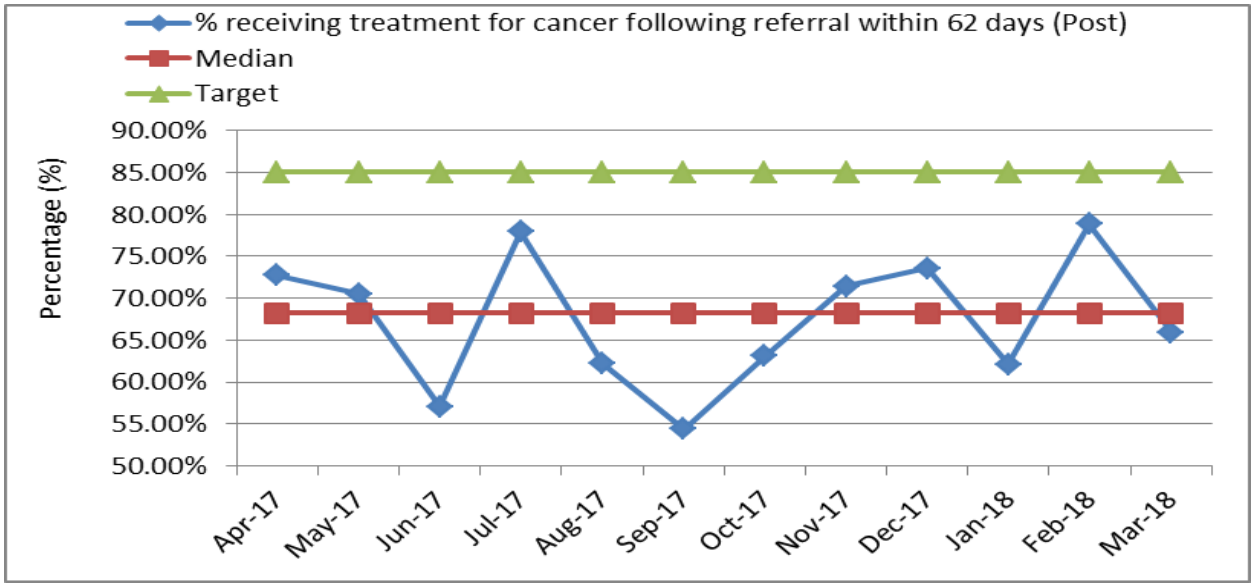
Source: Information Services based on the NHS England data

(This indicator has been subject to external assurance Ⓐ*)*

Key to abbreviations: Median – the middle number in a series of data

Comment:

- The deferral of non-urgent (inpatient) planned care, following the central NHS Winter Pressures Protocol has resulted in deteriorating performance against this target. Patients within this number are being prioritised according to health needs and plans in place to see and treat these going forward.
- This deferral on non-urgent planned care was with the intention of ensuring patients needing unplanned, non-elective care, received so in a timely manner, with Trust staff and other resource refocussed from planned care to unplanned care.
- The Trust has a risk based recovery plan to see those patients who are clinically urgent as a priority.
- The Trust has commenced planning for 2018/19 winter pressures and is looking at the implementation of different care models to further alleviate pressure on non-elective services.
- In addition the Trust is working with commissioners to fully understand the demand on services and the capacity available to meet the demand. This increased understanding will support further planning for 2018/19 for the Trust and the wider system.



Source: Information Services

Key to abbreviations: Non-elective length of stay – patients requiring unplanned, often emergency, care in hospital

Comment:

- The chart above illustrates that the Trust are not presently achieving this target. This is one of 8 key cancer targets. At present the Trust is achieving 6 of the 8 targets and is committed to achieving this particular target by June 2018.
- The Trust is currently focussed on identifying and treating those patients who have waited the longest which will ensure urgent treatments are prioritised. This may result in performance overall slipping, but will ensure that those most at risk are prioritised appropriately.
- The Trust is also focussed on ensuring that urgent GP referrals are seen urgently as part of the two week wait and urgent 6 week wait timescales. Focus on these groups of patients will support the Trust's risk based recovery plan. As stated previously, work is ongoing with commissioners regarding available capacity within the Trust and wider system to meet the demands on services.

Progress monitored, measured and reported: Progress with these indicators is monitored within the Improving Access & Flow work stream by the senior responsible officer, the Deputy Chief Executive, as part of the Improving Together Programme's key performance indicators (KPIs) and also reported in the integrated performance report to the Trust Board.

Relationship to 2018/19 Quality Improvement Priorities: Both indicators will remain within the 2018/19 quality improvement priorities as they link to the Trust's priorities around access and flow and planned care.

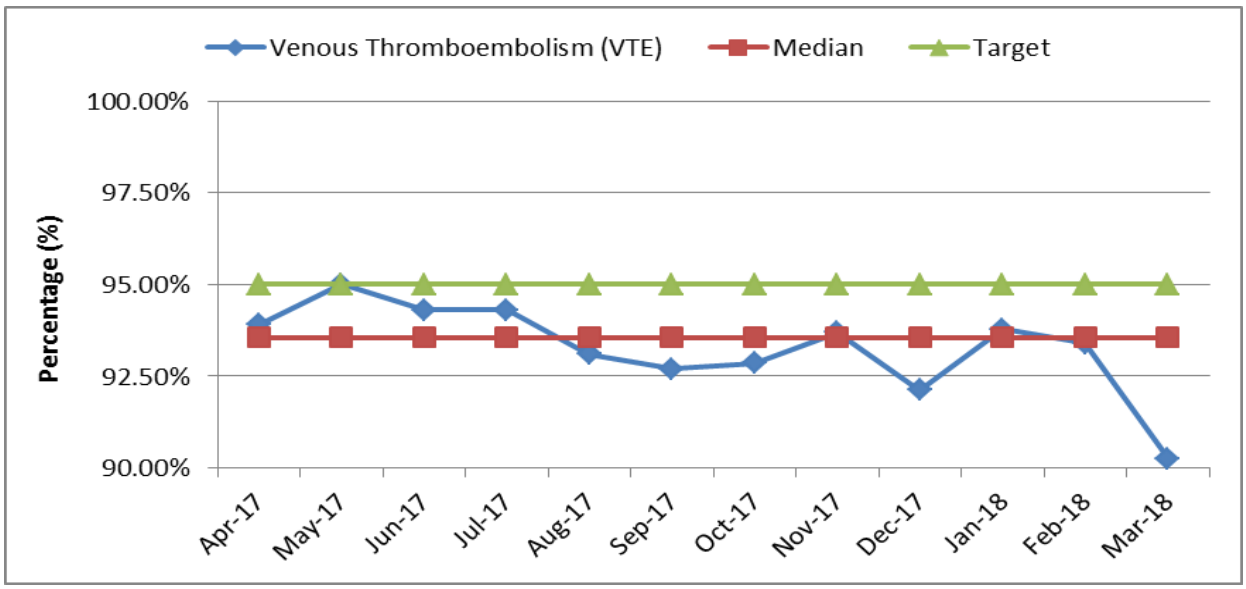
2.1f Theme 6: Medical Quality Indicators

Venous Thromboembolism (VTE)

*(**NB:** For a greater understanding of key definitions, please refer to the glossary section of this report)*

Progress Made: (April 2017 – March 2018):

- The Trust had not achieved consistently the target of screening 95% of patients on admission for Venous Thromboembolism.



Source: Information Services

Key to abbreviations: VTE – Venous Thromboembolism
Median – the middle number in a series of numbers

Comment:

- The chart demonstrates that performance with this indicator deteriorated during the summer months. The Trust are currently reviewing the processes in place to collate this information and understand specific areas where admission procedures are needing to be tightened. The Trust's Medical Director is leading this work which focusses on the above indicator and related aspects of care.

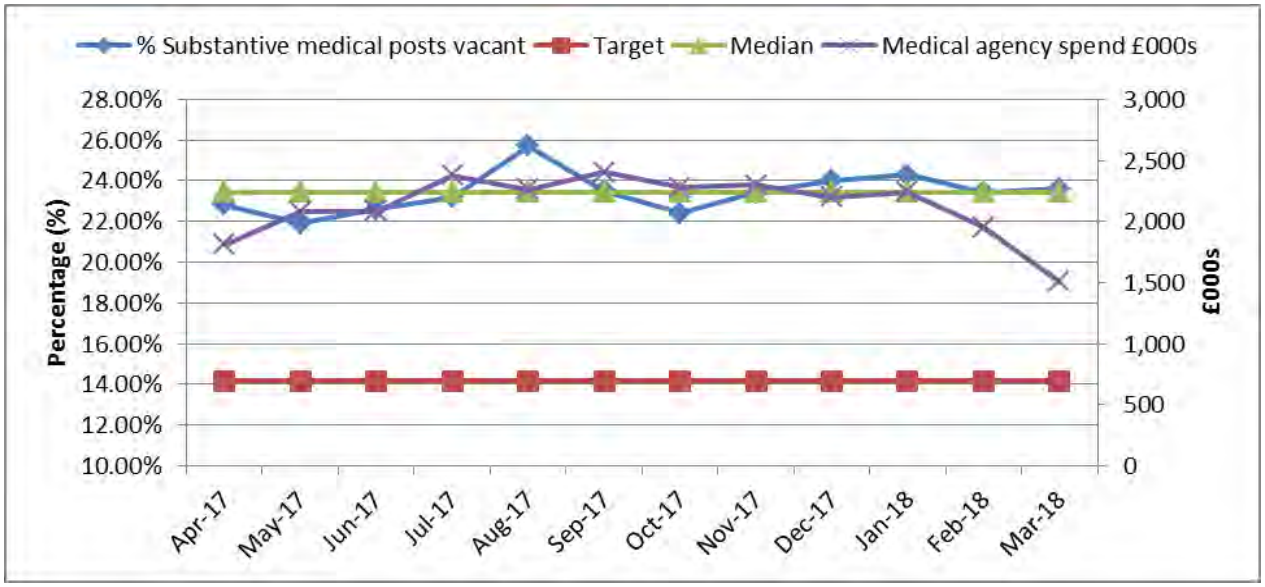
Progress monitored, measured and reported: Progress with this indicator is monitored within the integrated performance report and as such is reported to the Quality & Safety committee.

Relationship to 2018/19 Quality Improvement Priorities: This indicator will remain as a quality improvement priority during 2018/19 and be monitored within the quality reporting.

Safe Medical Staffing

Progress Made: (April 2017 – March 2018):

- The Trust have not yet achieved the target set in this area of having a 14% or less substantive medical vacancy rate.



Source: Workforce Data, Northern Lincolnshire & Goole NHS Foundation Trust

Comment:

- The above chart demonstrates that the substantive medical vacancy rate has remained above the 14% target set for this area. The average (median) substantive medical vacancy rate during 2017/18 has been 23.43%. As a consequence of this, the medical agency expenditure has remained static during the year, but not recent reductions.
- The Trust has focussed throughout the year on medical and nursing recruitment and retention. During 2017/18, the Trust used many different innovative and targeted strategies to fill substantive medical posts including moving more towards clinician led recruitment. Where recruitment efforts have been unsuccessful for hard to recruit to areas, where possible, different roles have been considered to mitigate these shortfalls. An example of this is the development of the Advanced Clinical Nurse Practitioner role that has been designed and recruited to in order to work differently in response to vacancy and recruitment challenges.

Progress monitored, measured and reported: Performance against this and other related workforce issues has been monitored during 2017/18 by the Workforce committee. This important area is also a part of the Trust's Improving Together programme to ensure that this forms a core part of the Trust's quality improvement plan.

Relationship to 2018/19 Quality Improvement Priorities: This area will remain as a quality improvement priority, being monitored and acted upon as part of the Improving Together work stream, and reporting, for assurance, to the Quality & Safety Committee.

2.1g: Quality priorities for 2018/19

Rationale for quality priorities:

The Trust's Quality Improvement Priority Themes consist of the following 5 priority **quality and safety themes**:

1. Safety (specific focus on recognition of deteriorating patients; continued focus on mortality (including sepsis and AKI); pressure ulcers)
2. Safe staffing and engagement (specific focus on vacancy rates; staff engagement)
3. Safe emergency care (specific focus on urgent and emergency care; SAFER patient flow bundle)
4. Safe maternity care
5. Planned care (specific focus on cancer care; 52 week waiters; clinical harm reviews)

Whilst the Trust views the above 5 themes as the over-arching **quality and safety** priorities for the organisation during 2018/19, to ensure these are harmonised against other local, regional and national reporting, these have been further grouped within the 5 Domains of the CQC Fundamental Standards, these are presented as follows, with supportive narrative:

Quality Priority Themes grouped within the 5 CQC Fundamental Standards

SAFE	
KEY Quality Indicators to support executive Quality Management Reporting:	
QUALITY PRIORITY THEME 1: Safety (specific focus on pressure ulcers)	
Infection prevention and control (Clostridium Difficile / MRSA / Gram Negative Bacterial Infection (GNBI)	NHS Safety Thermometer: specific focus on pressure ulcers
Falls (per 1,000 bed days) / number of	Pressure Ulcers (per 1,000 bed days) / number of
QUALITY PRIORITY THEME 3: Safe emergency care (Specific focus on urgent and emergency care; SAFER patient flow bundle)	
National Early Warning Score in A&E	Emergency department safety checklist
Length of Stay (LOS) – non-elective	Length of Stay (LOS) non-elective – Medicine
Stranded patients (7 days / 21 days)	Red to Green
4 hour A&E wait	
QUALITY PRIORITY THEME 4: Safe maternity care	
Ratio of midwives to births	Monthly average Fill rate midwives (Day/Night)
Monthly compliance with CTG monitoring (Mandatory training / monthly fresh eyes audit)	Number of maternity SIs / rates
Rolling still birth rate	Customised growth charts
Local Safety Standards in Invasive Procedures (LOCSSIPs) in Maternity	1:1 care in labour

EFFECTIVE	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 1: Safety (specific focus on recognition of deteriorating patients; continued focus on mortality (including sepsis and AKI))	
Summary-Hospital Mortality Indicator (SHMI)	Hospital Standardised Mortality Ratio (HSMR)
National Early Warning Score (NEWS) – vital signs recorded	National Early Warning Score (NEWS) – appropriate clinical response actioned
Number of adult cardiac arrests	Cardiac call vs survival rates
Venous Thromboembolism (VTE)	Sepsis bundle compliance

CARING	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 2: Safe Staffing and Engagement (specific focus on staff engagement)	
Friends and family test	Complaints analysis
Mixed sex accommodation	Staff experience
Outcomes from Listening into Action	Pride and Respect (our anti-bullying campaign)

RESPONSIVE	
Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 5: Planned care (specific focus on cancer care; 52 week waiters; clinical harm reviews)	
Underpinning Quality Indicators to be reported:	
WHO surgical safety checklist	Patient waiting <62days from urgent GP referral to first definitive treatment
Size of the incomplete patient target list (PTL) – based on 31 March 18	Number of patients waiting in excess of 52 weeks
Proportion of clinical harm reviews outstanding – by specialty	
Diagnostics waiting times and activity (tests over 6 weeks for routine) encompassing:	☐ MRI ☐ CT ☐ Endoscopy – site specific ☐ Cardiology – Angiographies

WELL LED

Underpinning Quality Indicators to be reported:	
QUALITY PRIORITY THEME 2: Safe Staffing & Engagement (specific focus on vacancy rates)	
Medical: % fill rate locums to establishment	Nursing: % fill rate for registered nurses
Medical: % substantive medical posts vacant (consultant / non-consultant)	% fill using substantive staff
Medical: Agency spend £000's (above budget)	% substantive nursing posts vacant (registered nurses / HCA)
Medical: Number of specialities who have had an establishment review	Nursing agency spend £000's (above budget)
	Number of wards who have an establishment review

These quality improvement priorities for 2018/19 will support the Trust's focus on quality and the strengthened approach to quality governance with the establishment of an executive led Quality Governance Group overseeing the reporting of progress against the above key over-arching quality improvement priorities for the organisation, as well as receiving reported updates from governance groups sitting at individual divisional level, which in turn receive service level updates in relation to safety, effectiveness and experience.

How the Quality Improvement Priorities are consulted on and agreed:

The priorities for 2018/19 have been discussed and approved by the Quality and Safety Committee (Q&S). They have been identified via a number of mechanisms including the following:-

- Discussions with the governors and Non-Executive Directors,
- Feedback from commissioners as part of quality contract meetings,
- The findings from the national surveys and experience measures,
- Findings from patient satisfactions surveys that are undertaken by the Trust including Friends and Family Tests results,
- The data provided by our clinical systems where we are identified as being an outlier,
- Information from incidents and complaints,
- Comments received from local Healthwatch organisations as a result of discussions around previous year's Quality Accounts and other dialogue,
- Feedback received and work undertaken to improve as a result of the various external visits or inspections,
- As a result of links to other priority Trust areas,
- From themes identified from external inspections, i.e. CQC visits.

How progress will be monitored and measured:

Progress against these indicators will be reported monthly using the monthly quality section of the Integrated Performance report. This reporting will be supported by the Trust's Chief Nurse and Medical Director providing supportive narrative to ensure the Trust Board remains sighted on quality performance.

A selection of methods will be employed to support the Chief Nurse and Medical Director measure and report on quality including statistical process control (SPC) charts, tables and graphs. The Executive led Quality Governance Group will receive this report and provide key points to the Quality & Safety Committee (Q&S) and the Trust Board.

To ensure our governors are involved, this reporting will also be received by the Governors as part of the quarterly Governor led Quality Review Group (QRG). This reporting will also be shared with the Trust's commissioners and form the basis for ongoing quality monitoring with commissioner.

PART 2: Priorities for improvement, statements of

assurance from the Board and reporting against core indicators

2.2 Statements of assurance from the Board

2.2a Information on the review of services

During 2017/18 Northern Lincolnshire and Goole NHS Foundation Trust provided and/or sub-contracted 25 relevant health and care services.

Northern Lincolnshire and Goole NHS Foundation Trust has reviewed all the data available to them on the quality of care in 25 of these relevant health and care services.

The income generated by the relevant health services reviewed in 2017/18 represents 100% of the total income generated from the provision of relevant health and care services by the Trust for 2017/18.

2.2b Information on participation in clinical audits and national confidential enquires

During 2017/18, 45 national clinical audits and 5 national confidential enquires covered relevant health services that Northern Lincolnshire and Goole NHS Foundation Trust provides.

During that period the Trust participated in 93% of the national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2017/18 and those in which it participated in are as follows:

NB: The table which follows lists:

- The name of the national clinical audits and national confidential enquiries listed in HQIP's quality account resource,
- Which ones the Trust were eligible to participate in,
- The number of cases submitted for each audit against the number required, also expressed as a percentage (%),
- If action planning is taking place or has been completed to improve processes and practice following publication of findings.

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Acute care					
Case Mix Programme (CMP)	Yes	Yes	727	46%	Project not yet completed
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	415/432	96%	Reporting
National Emergency Laparotomy Audit (NELA)	Yes	Yes	157	79%	Awaiting Publication of Results
National Joint Registry (NJR)	Yes	Yes	773	100%	Yes, to be agreed
Blood and Transplant					
National Comparative Audit of Blood Transfusion programme					
National Audit of Patients at Risk of Transfusion Associated Circulatory Overload (TACO)	Yes	Yes	40/40	100%	Awaiting Publication of Results
Re-audit of the 2017 audit of red cell and platelet transfusion in adult haematology patients	Yes	Yes	37/37	100%	Awaiting Publication of Results
Cancer					
Bowel cancer (NBOCAP)	Yes	Yes	253	91%	Project not yet completed
Head and Neck Cancer Audit (HANA)	Yes	Yes	61	100%	Awaiting National Report
Lung cancer (NLCA)	Yes	Yes	382	100%	Yes
National Audit of Breast Cancer in Older Patients (NABCOP)	Yes	Yes	263	100%	Awaiting National Report
National Prostate Cancer Audit	Yes	Yes	279	100%	Yes
Oesophago-gastric cancer (NAOGC)	Yes	Yes	111	100%	Actions to be agreed
Heart					
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	142/365 (Deadline 25/05/18)	39%* to date – work still ongoing	Yes
Adult Cardiac Surgery (NICOR)	No	N/A	N/A	N/A	N/A
Cardiac Rhythm Management (CRM)	Yes	Yes	253	100%	Awaiting Publication of Results
Congenital Heart Disease (CHD)	No	N/A	N/A	N/A	N/A
Coronary Angioplasty/National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	62/88 (Deadline 31st March 2018)	70%	Awaiting Publication of Results

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
National Cardiac Arrest Audit (NCAA)	Yes	Yes	165	97%	Project still underway
National Heart Failure Audit	Yes	Yes	205/475 Deadline 08/06/2018	43%** to date – work still ongoing	Awaiting Publication of Results
National Vascular Registry	No	N/A	N/A	N/A	N/A
Long term conditions					
National Diabetes Audit - Adults (National Core Diabetes Audit)	Yes	Yes	753	100%	Awaiting Publication of Results
National Diabetes Audit – Adults :National Diabetes Foot Care Audit	Yes	Yes	138	100%	Yes
National Diabetes Inpatient Audit – Adults (NADIA)	Yes	Yes	108	100%	Yes
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	227	100%	Awaiting National Report
National Pregnancy in Diabetes Audit (NPID)	Yes	Yes	14 to date (delivered in 17/18)	100%	Not yet complete
Inflammatory Bowel Disease (IBD) programme – Biologicals Audit	Yes	Yes	132 16/17/18	100%	Awaiting Publication of Results
National COPD Audit	Yes	Yes	578/580	99% (Against Information Services data)	Yes
UK Parkinson's Audit	Yes	Yes	62	89%	Awaiting Publication of Results
Mental health					
Mental Health Clinical Outcome Review Programme (NCISH)	No	N/A	N/A	N/A	N/A
Prescribing Observatory for Mental Health (POMH)	No	N/A	N/A	N/A	N/A
Older people					
Falls and Fragility Fractures Audit Programme (FFFAP) • National Hip Fracture Database (submitted for all)	Yes	Yes	490	100%	Not yet complete
Falls and Fragility Fractures Audit Programme (FFFAP) • Fracture Liaison Service Database (FLS-DB)	Yes	Yes	707/967	73%***	For annual financial year
Fractured Neck of Femur (RCEM)	Yes	Yes	DPOW=50 SGH=55	100%	Awaiting national report

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Sentinel Stroke National Audit Programme (SSNAP) SSNAP Clinical Audit	Yes	Yes	522 to date	100%	Yes
National Audit of Dementia (NAD)	Yes	Yes	106	100%	Yes
Other or TBC					
Falls and Fragility Fractures Audit Programme (FFFAP) National Audit of Inpatient Falls	Yes	Yes	60	100%	Yes
Learning Disability Mortality Review Programme (LeDeR)	Yes	No	8	0%	Project still underway
Cystectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Nephrectomy Audit (British Association of Urological Surgeons)	Yes	Yes	29	64%	Project still underway
Percutaneous Nephrolithotomy (PCNL) (British Association of Urological Surgeons)	Yes	Yes	5	28%	Project still underway
Radical Prostatectomy Audit (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Female Stress Urinary Incontinence Audit (British Association of Urological Surgeons)	Yes	No****	0	0%****	Trust did not participate
Urethroplasty (British Association of Urological Surgeons)	No	N/A	N/A	N/A	N/A
Elective surgery (National PROMs Programme)	Yes	Yes	589	65%	Yes
National Audit of Intermediate Care	No	N/A	N/A	N/A	N/A
National Bariatric Surgery Registry (NBSR)	No	N/A	N/A	N/A	N/A
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	N/A	N/A	N/A
National Neurosurgery Audit Programme	No	N/A	N/A	N/A	N/A
National Ophthalmology Database Audit	Yes	Yes	815	100%	Awaiting Publication of Results
Neurosurgical National Audit Programme	No	N/A	N/A	N/A	N/A
Pain in Children (RCEM)	Yes	Yes	DPOW=23 SHG=56	100%	Awaiting Publication of Results
Procedural Sedation in Adults (care in emergency departments – RCEM)	Yes	Yes	DPOW=50 SGH=52	100%	Awaiting Publication of Results

National clinical audit title	Eligible for NLAG	NLAG participated	Number of cases submitted	% of number required	Action planning
Endocrine and Thyroid National Audit	Yes	No	0	0%	No
Women and Children's					
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Perinatal Mortality Surveillance Report (July 2017)	Yes	Yes	31/31	100%	Yes
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Perinatal Confidential Enquiry Report (Nov 2017)	Yes	Yes	18/18	100%	Yes
Maternal, New-born and Infant Clinical Outcome Review Programme (MBRRACE-UK) Saving Lives, Improving Mother's Care (Dec 17)	Yes	Yes	2	100%	Yes
National Maternity and Perinatal Audit (RCOG)	Yes	Yes	Still underway for 17/18 (16/17 4446 submitted)	100%	Awaiting Publication of Results
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	669	100%	Awaiting Publication of Results
Total:	**58**				
Eligible for NLAG participation:	**45**				
NLAG Participated in:	**42**				

* MINAP DPOW collected cases 165/210 (makes 81% Trust Wide – work underway to upload prior to project deadline),

** Heart Failure DPOW collected cases 153/282 (makes 75% Trust Wide – work underway to upload prior to project deadline),

*** Above national submission rate for Falls and Fragility Fractures, data submission figures up to January 2018,

****BAUS National Female Stress Urinary Incontinence audit: only 2 procedures were undertaken by Urology in 2017. No learning can be gained from auditing 2 cases and the procedure is not going to be undertaken by urologists at the Trust in the foreseeable future, therefore participation in the audit is not currently appropriate.

National confidential enquires 2017/18

Confidential enquiry	Eligible for NLAG	NLAG participated	Organisational Questionnaires	Number of cases submitted	% of number required	Action planning

Acute Heart Failure	Yes	Yes	N/A	11/11	100%	Gap Analysis stage
Young People Mental Health	Yes	Yes	4	5/5	100%	Awaiting Report
Cancer in Children, Teens and Young Adults	Yes	Yes	1	Study still open, figures not finalised, work still ongoing		
Perioperative Management of Surgical Patients with Diabetes	Yes	Yes	3	26	100%	Awaiting Report
Chronic Neurodisability	Yes	Yes	10	Not Applicable*		
Total:	**5**	**5**				
Eligible for NLAG participation:	**5**					

*Cases selected by NCEPOD for review were subsequently found not to be applicable for this study, therefore none were submitted.

The reports of 25 national clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Increased information to patients/carers – Summary of some actions taken:

- National Audit of Dementia - Carers are supported to remain on the ward at mealtimes to help their relative/friend with their nutritional needs.
- National Audit of Dementia - Use the Triangle of Care assessment tool to improve carer engagement.

Increased awareness and education of staff – Summary of some actions taken:

- MINAP/Heart Failure National Audits - Educational session took place at the Quality and Audit meeting as it was suspected patients are being diagnosed with heart failure when there is no evidence of confirmation diagnostics. The Trust is currently looking at methods to improve specialty in-reach.
- National Audit of Dementia – Continue and update Tier 2 Dementia training within the trust.
- National Audit of Dementia - Introduce 'this is me' on all wards within the trust.
- National Audit of Dementia - Roll out the Dementia Care Team poster so that staff are aware of how to contact the Dementia Clinical Nurse Specialists (CNS).
- National Parkinson's Audit – Royal College of Physicians cards distributed on the method for undertaking standing and lying Blood Pressure, patient pack with information from Parkinson's UK/referral to website being used, Healthcare Assistant (HCA) now weighing and measuring all patients pre-clinic to ensue BMI can be accurately assessed.
- BTS Smoking Cessation – Re-educated clinical staff on the need to assess smoking status and then give patients the opportunity to be referred to smoking cessation services.
- RCEM Sepsis - Sepsis Nurse regularly attends Nursing huddles in ECC/A&E to feedback on data and best practice regarding the Sepsis screening and action tool, E-Learning tool also put in place at the Trust.
- National Bowel Cancer Audit - Enhanced Recovery training to be rolled out to colorectal clinicians.
- National Head & Neck Cancer Audit – Reiterate to the clinicians the need to record 'WHO Performance status' and 'co-morbidity score' when completing MDT referral letters.
- SSNAP - Case reviews to be carried out for cases taking longer than 4 hours to be admitted to the stroke unit and those that did not receive a swallow assessment within 72 hrs in order to establish reasons why.

- MBRRACE Perinatal Mortality Surveillance – Human factors training to be arranged to raise awareness around situational awareness.
- MBRRACE Perinatal Mortality Surveillance – All multidisciplinary midwives and doctors in Maternity to attend mandatory CTG training (K2 Masterclass).
- National Pregnancy in Diabetes Audit (NPID) – Education of diabetic women with the potential to become pregnant to be provided through the following routes; posters to be displayed in GP practices, Facebook, Twitter and Radio.

Identified need for further evaluation/patient surveys – Summary of some actions taken:

- National Parkinson's Audit – increases submission rate of PREMS to over 60 from 10 in the previous audit.
- National Audit of Inpatient Falls – Amend/update the falls pathway to improve compliance with specific national standards
- National Bowel Cancer Audit – To identify those patients who die within 90 days, or are re-admitted within 30 days, for a review of these cases to determine any possible learning points.
- National Bowel Cancer Audit – To participate in the Dukes Collaborative Multi-Centre Closure of Ileostomy Timing Study.
- National cardiac Arrest Audit – To continue with root cause analysis on a monthly basis with a sample of patients by Resuscitation Officers.
- BAUS PCNL Audit – Urologist to review cases involving post-operative blood transfusions for possible learning points to disseminate to the group.
- SSNAP - Case reviews to be carried out for cases taking longer than 4 hours to be admitted to the stroke unit and those that did not receive a swallow assessment within 72 hrs in order to establish reasons why.

Changes to service/process – Summary of some actions taken:

- National Audit of Dementia - Ensure the use of My Life is embedded across the hospitals and used to plan individualised care.
- National Audit of Dementia - Finger food menu to be developed and then access to finger foods are available for ward staff to order.
- National Diabetes Foot Care Audit/National Diabetes Inpatient Audit – 2.8WTE staff recruited to the respective teams to increase foot risk assessments.
- National COPD Audit – Respiratory in-reach service introduced to improve specialist assessment of respiratory patients.
- SSNAP - Discussions with bed manager re improving repatriation of stroke patients to DPOW from SGH, Stroke pathway reviewed with the Stroke Group.
- RCEM Asthma - Revised pathway to be put in pit stop/triage and resus and ensure all staff are aware of pathway.
- ICNARC Case Mix Programme - A proposal is under development to increase the number of CCU beds.
- National Bowel Cancer Audit - Data collection to be undertaken live in MDTs. This will increase accuracy of the data recorded as it is visible to the MDT group.
- National Bowel Cancer Audit - The number of clinicians who can undertake laparoscopic surgery has now increased to 4.
- National Oesophago-Gastric Cancer Audit – To arrange a regular provision of data from Hull (where patients are referred) to increase the accuracy of our data submission.
- BAUS PCNL Audit – Implementation of a new on-call system which will help reduce length of stay by preventing patients waiting over the weekend until Monday for discharge. It will also allow more appropriate decisions to be taken regarding whether to transfuse patients.
- BAUS PCNL Audit – To increase the number of tubeless procedures, which will help reduce the length of stay.

- National Ophthalmology Database Audit – To ensure that all patients have a follow-up 4 weeks after a non-complex cataract procedure to increase the proportion of patients with refraction information available.
- MBRRACE Perinatal Mortality Surveillance – Repeat Co2 screening to be introduced and rolled out in the Trust between 26 and 28 weeks of pregnancy.
- MBRRACE Perinatal Mortality Surveillance – Local guideline to be implemented (once national guidance published) for management of the latent phase of labour and CTG classification in the antenatal / intrapartum period.
- MBRRACE Perinatal Mortality Surveillance – care pathways/leaflets relating to late fetal loss, stillbirth and neonatal loss.
- National Neonatal Audit Programme (NNAP) - Add 2 year follow to the neonatal collaborative document so that nursing staff highlight this on the badger discharge letter.

The reports of 24 local clinical audits were reviewed by the provider in 2017/18 and the Trust intends to take the following actions to improve the quality of healthcare provided:

Increased awareness and education of staff – Summary of some actions taken:

- Medicine Documentation Audit/ECC Documentation Audit - Results shared with Audit Leads and clinicians in all Medicine Specialities via Audit meetings; Business & Governance Meetings. Information Governance responsibilities discussed at ECC/A&E governance to raise awareness of need to have patient identifiable information on each page of the clinical record.
- Antibiotic Prescribing (Community Services) awareness to be raised with the Community Matrons and the Unscheduled Care Teams regarding the completion of documentation at time of prescribing with particular emphasis on documenting the required information such as the dose, route, site of administration and advice given to the patient in the patient's electronic record. Also regarding the need to provide a signature on the Patient Group Directive documentation and record the number of packs used.
- Maternity Documentation Audit - Results to be discussed at Team Managers (Midwifery) and cascaded by managers to all team members to highlight the importance of the following points: antenatal risk assessment to be completed at each contact, SBAR to be used at time of handover in labour (where appropriate), documenting the details of the time and volume of the first void.
- Five Steps to Safer Surgery Audit - Standard Operating Procedure (SOP) to be developed and implemented in to obstetric theatres to raise awareness of correct process.
- Five Steps to Safer Surgery Audit - Video demonstration to be recorded and made available to all staff on how to complete the Five Steps.
- Adult Resuscitation Trolleys - Patient safety midwives to publish results in the departmental newsletter and/ or displayed in the staff room for dissemination/information for all midwives.
- Antenatal CTG / Fresh Eyes Audit - results to be disseminated to all midwives to ensure they are aware of the expectations around antenatal CTG monitoring and Fresh Eyes monitoring.
- Antenatal CTG / Fresh Eyes Audit - quick reference guide to be developed and made available to midwives regarding CTG classification and escalation.
- NICU Documentation Audit - Ward manager to cover documentation policy within the learning lessons session on the neonatal unit to raise awareness of expectations.
- Asthma Action Plan - awareness to be raised amongst medical and nursing staff regarding the need to record in the notes and on the discharge summary that the patient has an asthma action plan in place.
- Post-Partum Haemorrhage Audit - Email to all consultants / midwifery managers to

ensure they are aware of the importance of adhering to the guideline in terms of the following: risk factors being highlighted in the notes, a management plan being discussed / documented and the consultant being made aware where the woman refuses blood products.

- Obstetric Early Warning Scores - Patient safety midwives to undertake Care Camps for new midwives.
- Obstetric Early Warning Scores - Patient safety midwife to feature results as part of the 'theme of the month' boards on the wards to keep staff informed of weekly audit results.
- Obstetric Early Warning Scores - Video on the deteriorating patient and the importance of the recognition of the sick woman to be developed to raise awareness amongst staff.
- Community Record Keeping Audit – Team Leads / Service leads to share results with individual teams to raise awareness where non-compliance is reported.
- Safe & Secure Audit – Results of the audit to be shared with staff via the Pharmacy newsletter, including the following; locking medicines away, monitoring drug fridges – new system, separating external meds and POD lockers and use of SAMPOD.

Changes to service/process – Summary of some actions taken:

- Local Audit Abdominal Aortic Aneurism (AAA) – Look to implement a AAA pathway to aid the early identification of cases.
- Emergency Care Centre NEWS Spot-check Audit - NEWs in A&E to be monitored via the new dashboard system with issues being addressed via NMAF and deteriorating patient groups.
- Emergency Care Centre NEWS Spot-check Audit - Continuous Nursing Audit dashboard set up to monitor and measure performance.
- Audit of Care Rounds - Trust wide SOP and ECC Nursing Assessment form put in place with clear requirements for timing and documentation of care rounds.
- Asthma Action Plan - BTS Asthma Discharge Care Bundle to be introduced into use and completed prior to discharge by the medical team and filed in the notes.
- Post-Partum Haemorrhage - Co-ordinators to ensure PPH proforma is available in all delivery rooms across the Trust.
- Obstetric Early Warning Scores – Hand held electronic devices to be introduced for the recording of maternal observations in the antenatal / postnatal period.
- JAG Flexi-sigmoidoscopy / OGD – Endosoft system to be amended to all further details to be entered therefore allowing all required standards to be measured.
- Safe & Secure Audit - Upgrade the lockers across the Trust to include key coded lock access to all POD lockers, commencing at DPOW then rolling out across site.
- Safe & Secure Audit - Biometric medicines cabinets to be installed in the emergency care Departments at DPOW and SGH.
- Safe & Secure Audit – Invest in Abloy CLIQ remote electronic locking system for all drug cabinets. Replace all cabinets that store drugs with drug cabinets that meet the BS2881 standard for safe and secure storage of medicines.

2.2c Information on participation in clinical research

The number of patients receiving relevant health services provided or sub-contracted by Northern Lincolnshire and Goole NHS Foundation Trust in 2017/18 that were recruited during that period to participate in research approved by a research ethics committee is 1,471. The Trust had to recruit 1,450 patients to meet the target of 1,453 by the 31 March 2018.

2.2d Information on the Trust's use of the CQUIN framework

A proportion of Northern Lincolnshire & Goole NHS Foundation Trust's income in 2017/18 was conditional on achieving quality improvement and innovation goals agreed between Northern Lincolnshire & Goole NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2017/18 and for the following 12-month period are available electronically at:

https://www.england.nhs.uk/nhs-standard-contract/cquin/

The areas of care which were included within the CQUIN scheme for 2017/18 included the following:-

- Staff health & wellbeing initiatives
- Antimicrobial resistance and sepsis
- Improving services for people with mental health needs who present to A&E
- Offering advice and guidance services for non-urgent GP referrals
- NHS e-referrals
- Supporting proactive and safe discharge
- Preventing ill health by risky behaviours – alcohol and tobacco
- Improving assessment of wound
- Personalised care and support planning
- Hospital medicines optimisation
- Dose banding
- Optimising chemotherapy decision making
- Implementing the Armed Forces Covenant

The amount of income in 2017/18 which was conditional upon achieving quality improvement and innovation goals was £6.447 million.

The monetary total value for 2016/17 CQUIN indicators was £6.427 million. The Trust received payment for £6.370 million during 2016/17.

2.2e Information on Never Events

The Trust reported 3 never events during 2017/18. These can be broken down into the following categories, including historical context and related incidents:

	2014/15	2015/16	2016/17	2017/18
Retained Foreign Object	0	2	1	1
Wrong implant	0	1	0	1
Wrong site nerve block	0	1	1	0
Misplaced nasogastric tube	0	0	0	1

NB: It should be noted that the never event categories are reviewed annually and therefore are subject to change, making historical comparison difficult.

Learning derived from incidents:

- The root causes for the 2017/18 never events related to:
    - Poor record keeping
    - Process lacking adequate fail-safes
    - Process not followed in line with policy
    - Two different swab packs used for different procedures
    - Staff working in unfamiliar environment/with unfamiliar team
    - Prosthesis sizes with same colour coding
    - Insufficient staff within theatre at crucial point in selection of prosthesis
    - Second checks not carried out to ensure correct selection of prosthesis
    - Insufficient patient identifiable information for diagnostic testing
    - Lack of robust Standard Operating Procedure

- As a result of these high-level summary of root causes, the following actions to prevent recurrence have been taken:
    - Pathway developed to outline clear management of patients with invasive devices, covering communication and documentation.
    - Audit programme in place to assess progress and effectiveness of new pathway over time and test embedding.
    - Robust standard operating procedure to be put in place.
    - Guideline for NG checking when no access to electronic systems.
    - Guideline for inserting and positioning of NG Tube to be updated with timings.
    - Spinal/ epidural packs now contain green swabs to reduce risk of mixing with other swabs in use
    - Whiteboards to be used in delivery rooms and theatres for counting swabs
    - Larger swabs with tabs built in to be used for delivery and suturing packs to reduce the risk significantly of a swab being left insitu due to the increased size.
    - Anaesthetists and Operating Department Practitioners to perform swab count at epidural and spinal procedures

How has learning been shared at all levels of the organisation and externally?

- These incidents have been brought to the attention of the clinical teams involved.
- These never events, along with other learning from incidents and complaints form a core part of the different clinical areas Quality & Safety meetings/sessions enabling senior and junior staff alike to share learning as a result to prevent recurrence.
- The learning from these incidents is also discussed in Specialty Business Meetings for clinicians and Ward Manager Meetings for cascade to nursing staff.
- The investigation and root cause analysis is shared with the various areas

management team to alert them to the issues identified for wider dissemination.

- Lessons are summarised in one page 'Learning the Lessons' documents which are shared on the intranet, in Learning Lessons folders located in ward areas and within Learning Lessons newsletters which are disseminated Trust wide.
- Educational video created for clinical staff with a focus on human factors to create awareness of how errors occur and how they can be avoided.
- Live drills undertaken to support learning and embedding of practice.

2.2f 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 Trust has no conditions on its registration.

The Care Quality Commission has taken enforcement action against the Trust during 2017/18. The Trust received a Section 29a notice in January 2017 asking for immediate improvements in maternity and A&E departments and in respect of the management of its waiting list. Improvements have and continue to be made as part of the Trust's improvement programme – Improving Together. These improvements will be tested as part of the Trust's next CQC inspection visit.

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

(From their last visit of the Trust in November 2016, of which the report was published on the 6 April 2017):

Overall rating for this trust	**Inadequate**
Are services at this trust safe?	Inadequate
Are services at this trust effective?	Requires improvement
Are services at this trust caring?	Good
Are services at this trust responsive?	Requires improvement
Are services at this trust well-led?	Inadequate

The Trust's view of the report's findings:

- The CQC found that the staff employed by the Trust are caring, citing evidence of dignity and respect being observed.
- The CQC's findings from 2016/17 resulted in the Trust being placed in 'quality special measures'. This does not mean that the Trust's services are unsafe, rather that in some areas high quality care is not consistent.
- The Trust received a further unannounced visit by CQC in June 2017. The outcome of this visit was fed back to the Trust and assurance was provided to CQC that work was underway to embed improvements. The CQC concluded that further action was not needed as a result of the improving nature of the Trust's performance in response to the actions agreed and the ongoing monthly and weekly engagement activities along with the CQC's attendance at the System Improvement Board (SIB).

Action taken to improve:

- The Trust's response to the CQC report was to take immediate action on those aspects requiring immediate response. The embedding of other quality improvements, related to the CQC visit's findings, and to other organisational

challenges has been addressed by the Trust's Improvement Programme - ***Improving Together.***

- Improving Together focusses on 5 key work streams:

    - **Improving Quality & Safety:**
        - Safe staffing,
        - Patient safety,
        - Clinical Effectiveness,
        - Patient Experience,
        - Mortality improvement.

    - **Improving access and flow:**
        - Planned care,
        - Unplanned care.

    - **Improving Organisational Development and Culture:**
        - Engagement and culture,
        - Training and development,
        - Leadership and management.

    - **Improving Finances:**
        - Central grip and control,
        - Non-clinical service redesign.

    - **Improving Service Strategy:**
        - Acute model,
        - Specialty models,
        - Placed based ACPs.

- This programme of work is supported by a dedicated Improvement Team in place to support the project management and delivery of the individual work stream action plans. This is further overseen by the Trust Board and by other external stakeholders. Support has been provided to the Trust, and gratefully received, from external partners including NHS Improvement and NHS England.

- During 2017/18, the Trust has also commissioned a number of other supportive external reviews including an assessment of the Trust's leadership and governance arrangements. Following on from these reviews, the Trust has made further changes to the organisation to enable more focused clinical governance arrangements to support more effective oversight and management of quality and safety issues. The Trust's Improving Together Programme key performance indicators (KPI) measures and the Trust's Quality Improvement Priorities, already outlined in this document, will support this focus on quality and safety.

Improvements to date:

- A selection of the changes and improvements made to date is summarised as follows:

    - Additional funding to increase resource within the Critical Care Outreach Team,

    - Deployment of mobile hand held devices to improve the efficiency and effectiveness and Trust ability to measure progress with patient observations and deteriorating patient indices,

    - Strengthened oversight arrangements for the Trust's strategic risks that threaten achievement of the Trust's strategic objectives,

    - Clear improvements in service provision within the Trust's emergency and maternity departments,

    - Improvements in maintaining and recording key details in relation to vital equipment to provide assurance that this equipment is safe for continued use

to care for and treat patients,

- Improved use of the WHO surgical safety checklist within the Trust's operating theatres,
- Evidence of learning following serious incidents.

2.2g How is Northern Lincolnshire & Goole NHS Foundation Trust implementing the duty of candour?

Duty of Candour, or being open with service users when harm is caused as a result of healthcare provision, is now included as a statutory obligation in the NHS standard contract as a result of the Francis report into the failings at Mid Staffordshire. This obligation requires NHS Trusts to ensure that patients, their families and carers are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and are supported to deal with the consequences. The Care Quality Commission (CQC) has also incorporated into their regulations and inspection regime a specific element focussing on duty of candour. How is the Trust working to implement duty of candour in everyday practice?

The Trust has a policy for reference to by all staff to ensure a standardised approach is taken to duty of candour best practice principles. This policy outlines clear responsibilities and accountabilities within the Trust and makes it clear that duty of candour (also referred to as 'being open') is not a one-off event, rather it is a process. The policy recognises that being open with patients, their relatives and carers following harm can be very difficult with staff involved feeling cautious for fear of saying the wrong thing, making the situation worse or being blamed for the mistake. With this in mind, the policy attempts to make the process of being open a framework supporting staff and the individual and their relatives involved.

The policy draws from and references the NHS Litigation Authority leaflet on the subject of 'Apologies and explanations', published in 2009. As a result the Trust approaches being open with the following key messages for those involved in patient safety incidents:

- **Timeliness:** Initial discussions with the patient, their family and carers should occur as soon as possible after recognition that something has gone wrong.
- **Explanation:** Patients, their families and carers should be provided with a step by step explanation of what happened, that considers their individual needs and is delivered openly.
- **Information:** Patients, their families and carers should receive clear, unambiguous information. They should not receive conflicting information from different members of staff. The use of medical jargon and acronyms, which they may not understand, should be avoided.
- **On-going support:** Patients, their families and carers should be given a single point of contact for any questions or requests they may have. They should also be provided with support in a manner appropriate to their needs. This involves consideration of special circumstances that can include a patient requiring additional support, such as an independent patient advocate or a translator.
- **Confidentiality:** Policies and procedures should give full consideration of, and respect for privacy and confidentiality for the patient, their family, carers and staff.
- **Continuity of care:** Patients are entitled to expect that they will continue to receive all usual treatment and continue to be treated with dignity, respect and compassion. If a patient expresses a preference for their healthcare needs to be taken over by another team, the appropriate arrangements should be made for them to receive treatment elsewhere.

Reference: NHS Litigation Authority, 2009. Circular: Apologies and Explanations. London. NHS Litigation Authority.

The above key messages provide a high-level summary of the principles that the Trust adheres to in initiating the being open or duty of candour process. The process then

continues for as long as is necessary, taking into account the patient specific factors and the needs of those involved.

The policy on being open also contains guidance for Trust managers to ensure that staff affected or involved in patient safety incidents also have access to support arrangements, recognising that they too are in need of care at such times, including access to the Freedom to Speak Up Guardian and Associate Guardians.

2.2h Information on quality of data

Northern Lincolnshire and Goole NHS Foundation Trust submitted records during 2017/18 to the Secondary Uses Service for inclusion in the hospital episode statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS Number was:

- 100.00 per cent for admitted patient care
- 99.9 per cent for outpatient care
- 98.9 per cent for accident and emergency care.

- Which included the patient's valid General Medical Practice Code was:

- 100.0 per cent for admitted patient care
- 100.0 per cent for outpatient care
- 100.0 per cent for accident and emergency care.

2.2i Information governance assessment report

The Trust's Information Governance Assessment Report overall score for 2017/18 was 67% and was graded green [satisfactory].

2.2j Information on payment by results clinical coding audit

The Trust was not subject to the payment by results clinical coding audit during 2017/18 by the Audit Commission.

2.2k Learning from Deaths

During 2017/18 1,557 of Northern Lincolnshire & Goole NHS Foundation Trust's patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 433 in the first quarter;
- 348 in the second quarter;
- 436 in the third quarter;
- 340 in the fourth quarter *[Jan-Feb 2018]*.

By 4 April 2018, 163 case record reviews and 9 investigations have been carried out in relation to 1,557 of the deaths included above.

In 1 case a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 55 in the first quarter;
- 25 in the second quarter;
- 39 in the third quarter;
- 44 in the fourth quarter.

1 representing 0.06% of the patient deaths during the reporting period are judged to be more

likely than not to have been due to problems in the care provided to the patient *[definition: using Royal College of Physicians (RCP) question: "Avoidability of death judgement score" for patients with a score of 3 or less – see narrative below for more information]*.

In relation to each quarter, this consisted of:

1 representing 0.23% for the first quarter;
0 representing 0% 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 Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from "definitely not avoidable" to "definitely avoidable". The above estimate includes all those deaths that were classified as scoring less than 3 on this 6 factor scale. This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary. It should be stressed that this data is not a reliable measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

Summary of what the Trust has learnt from case record reviews and investigations conducted in relation to the deaths identified during 2017/18

From these mortality case reviews and other audit work undertaken by the Trust, the following key themes have been identified:

- Routine monitoring of National Early Warning Scores (NEWS) that supports the identification of patients who are deteriorating could be strengthened with regard to the frequency of observations, in line with the Trust's policy, and escalation more effectively both in terms of staff understanding and also the increased use of technology to escalate care.
- Acute Kidney Injury (AKI) has been identified as a serious medical condition where improved pathways of care would benefit patients being flagged and care escalated.
- Sepsis has been identified as a priority condition to identify and treat early. The Trust's previous work on this has improved recognition on admission to the hospital and timely commencement of antibiotics, but further work for existing inpatients and other elements of the sepsis six care bundle is needed.
- Transfer and flow throughout the Trust's hospitals, particularly at the Diana, Princess of Wales Hospital in Grimsby, during periods of intense pressure has been identified as a contributory factor.
- Documentation and evidence of fluid balance monitoring has been identified as a theme for improvement.

Description of the actions which the Trust has taken and those proposed to be taken as a consequence of what has been learnt during 2017/18

The Trust has during 2017/18 strengthened its approach to mortality oversight and learning from case reviews undertaken. Actions having been undertaken/or in the process of being put into place can be summarised as follows:

- Mortality Improvement now features as a project within the Trust's Improving Together Quality Improvement programme with dedicated project management support to assist scoping of actions and oversight of progress, reporting and escalating to the Trust's Improving Together Board and externally, to the System Improvement Board where the Trust alongside local and national partners and

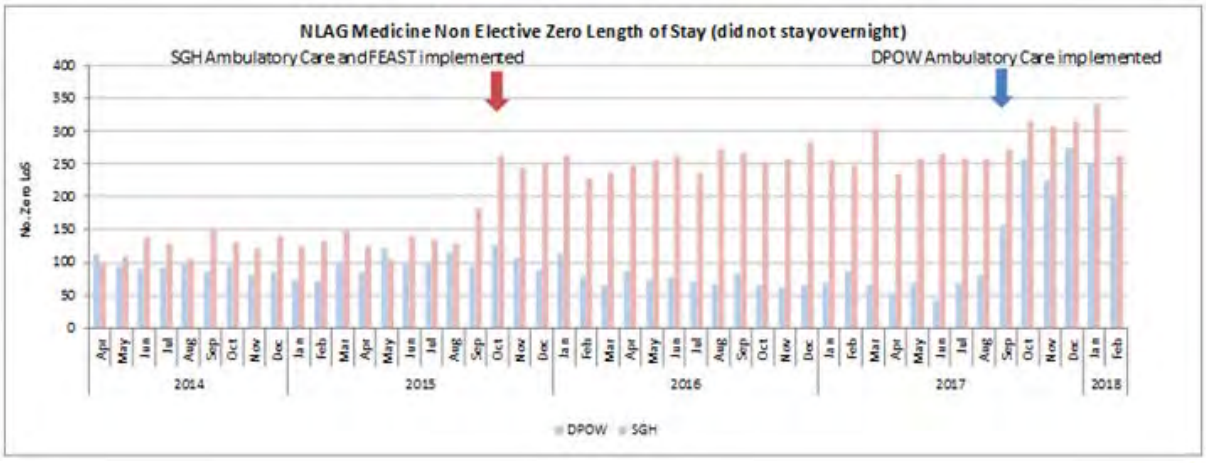
stakeholders.

- The Improving Together plan includes specific, clinically led work streams including:
    - Deteriorating patient and sepsis (including Acute Kidney Injury (AKI) and the Critical Care Outreach Team),
    - Hydration and nutrition,
    - Safety huddles (to support short, effective briefings at commencement of shifts focussed on safety and learning lessons),
    - The medical model (how medical teams are organised and structured to focus on early specialty in-reach, more effective and early intervention by senior doctors),
    - Multi-disciplinary Team review and learning from quality of care case reviews.
- Dedicated Mortality Improvement group to focus on overseeing the results from audit and evaluation work, mortality statistics and routine data reported to focus on improvement work needed as a result. Membership of this group includes
- Appointment of two dedicated mortality clinical leads, one on each of the Trust's main sites, to support with clinical engagement and sharing of key lessons learnt from mortality improvement work undertaken
- Patient access and flow are included as a dedicated work stream on its own within the Improving Together programme of work, focussed on looking two key elements:
    - Provision of alternative care arrangements when traditional hospital admission is not necessary, and where care packages can be arranged for a person in the community,
    - Ensuring that the care provision is effective and efficient, resulting in shorter lengths of stay in hospital.

An assessment of the impact of the actions taken by the Trust during 2017/18

Whilst many of the actions described are still underway, there has been some positive impact as a result of the actions taken already by the Trust. These are summarised as follows:

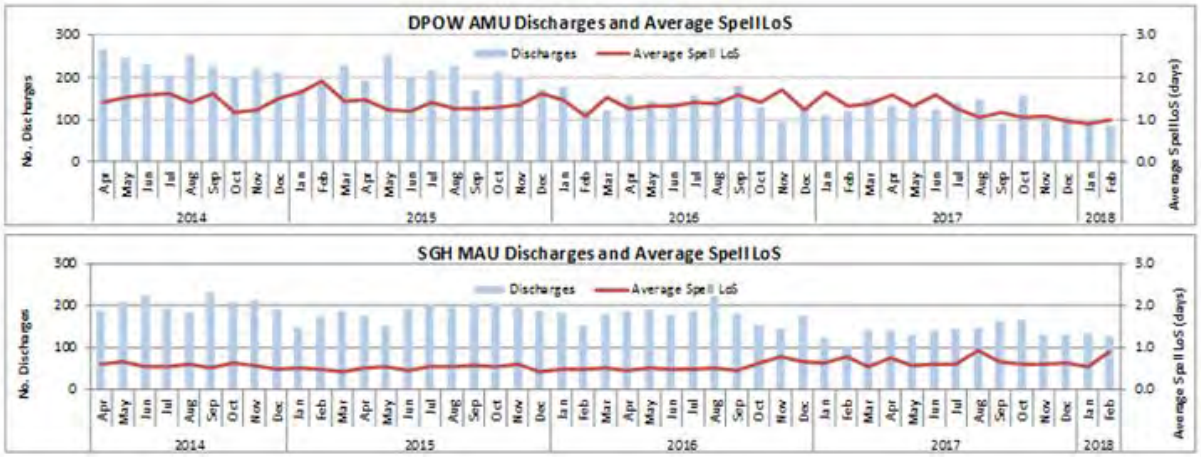
- **Access and flow: Improvements on the Diana, Princess of Wales Hospital site**
- During September 2017, Diana, Princes of Wales Hospital implemented an Ambulatory Care model, mirroring this service already available at Scunthorpe General Hospital. Ambulatory care is designed to ensure suitable patients are seen by a senior clinician for access to diagnostics to support quick decision making and the management of the patient as an out-patient, discharging them the same day, thereby reducing the number of patients admitted to hospital, therefore reducing some of the pressure on the hospital's finite number of beds and staffing.



Source: Northern Lincolnshire & Goole NHS Foundation Trust Information Services

Key to abbreviations: NLAG – Northern Lincolnshire and Goole NHS Foundation Trust,
SGH – Scunthorpe General Hospital
DPoW – Diana, Princess of Wales Hospital
Non-elective – unplanned admissions, often as a result of an emergency

- The above chart demonstrates that the number of patients being reviewed and discharged from hospital on the same day (or as a 'zero length of stay') has increased significantly since September 2017 and has helped reduce the pressures faced by the hospital during the seasonal pressures during the 2017/18 winter.



Source: Northern Lincolnshire & Goole NHS Foundation Trust Information Services

Key to abbreviations: SGH – Scunthorpe General Hospital
DPoW – Diana, Princess of Wales Hospital
AMU – Acute Medical Unit – the medical admissions unit at DPoW
MAU – Medical Admissions Unit – the medical admissions unit at SGH
LOS – Length of stay

- The above charts again demonstrate that the average length of stay on the admissions ward at DPoW has reduced since the opening of the ambulatory care unit in September 2017, further supporting new admissions be cared for and moved to specialty wards for further management.

- **Deteriorating patient & sepsis**
- The Trust uses its WebV system to record, monitor and display patient observations and their resulting National Early Warning Score (NEWS). To support this existing process and enable further innovation, the Trust has recently completed the roll-out of small mobile devices to enable ward staff to record NEWS observations more efficiently and direct to the patient's electronic record. This also now provides the ability for escalation notifications to be sent directly to mobile devices providing the opportunity for quicker escalation. Electronic observations are now possible throughout all wards and A&E departments.
- The Trust have also developed, in the absence of any recognised national scoring systems, Paediatric Early Warning Scores (PEWS). These are currently being completed on paper with plans to adopt these into WebV as part of the electronic patient record during the next year.
- The Trust are now in the process of rolling out, as a pilot initially, 38 larger tablet size mobile devices to further support a focus on screening patients for sepsis using the Trust's WebV system. Linking this to WebV and the already recorded NEWS observations will support staff proactively consider patients with signs suggestive of sepsis, by automatically flagging up as an aide memoir those patients with NEWS scores meeting the criteria for a sepsis screen to be undertaken. These 38 tablets will be provided to admitting units to begin with as part of the pilot. This will also enable real time monitoring and evaluation of performance against established best practice standards in connection with sepsis.

- The Trust have been and are remaining to raise awareness with staff regarding both the identification of the deteriorating patient and the signs and symptoms of sepsis. This continuous focus will be aided during April 2018 by the development of ward level dashboards demonstrating ward specific performance information outlining the frequency of observations, compared with the policy and other ward based deteriorating patient indicators. This will support ward staff understand compliance with best practice and enable ward specific improvement plans where needed.

51 case record reviews and 2 investigations completed after 01 April 2017 which related to deaths which took place before the reporting period.

3 representing 0.2% of the patient deaths before the reporting period [1,647 deaths during 01 April 2016 – 31 March 2017], are judged to be more likely than not to have been due to problems in the care provided to the patient. This number has been estimated using the Structured Judgement Review (SJR) which includes a 6 factor Likert scale ranging from definitely not avoidable to definitely avoidable. The above estimate includes all those deaths that were classified as scoring less than 3 on this 6 factor scale. This assessment is the initial reviewer's assessment from the retrospective assessment of the medical record. Any case reviews completed that identify that further understanding is needed is reviewed a second time by another clinician. This process links into the Trust's Serious Incident Framework if necessary. It should be stressed that this data is not a reliable measure of deaths that were avoidable, rather it is designed as an indicator to support local review and learning processes with the aim of helping improve quality of care.

3 representing 0.2% of the patient deaths during the previous reporting period [01 April 2016 – 31 March 2017] are judged to be more likely than not to have been due to problems in the care provided to the patient.

2.2l Clinical Standards for Seven day Hospital Services

Ten clinical standards for seven day services in hospitals were developed in 2013 through the Seven Day Services Forum, chaired by Sir Bruce Keogh and involving a range of clinicians and patients. The standards were founded on published evidence and on the position of the Academy of Medical Royal Colleges (AoMRC) on consultant-delivered acute care. With further input from the AoMRC, four of the ten standards were identified as priorities on the basis of their potential to positively affect patient outcomes. These key standards are:

- Standard 2: Time to first consultant review
- Standard 5: Access to diagnostic tests
- Standard 6: Access to consultant-directed interventions
- Standard 8: Ongoing review by consultant twice daily if high dependency patients, daily for others

More information can be found at: https://improvement.nhs.uk/resources/seven-day-services/.

NHS England are supporting the Trust (and other Acute NHS Trusts) work towards full compliance with the four key standards by 2020. The Trust monitors performance against these standards using audits undertaken twice a year. The next planned evaluation of performance against these key standards is scheduled during April 2018. The Trust's lead for this project is the Medical Director with support being provided by the Trust's Improvement Team and the Quality & Audit teams. As well as the ongoing audit support to the project, an improvement plan is being developed to support the implementation and changes needed to move the Trust further towards compliance. NHS England continue to provide full support to this project. The findings from the evaluation are being fed back to clinical teams to support ongoing engagement and change management.

2.3 Trust performance against core indicators

Since 2012/13 NHS foundation trusts have been required to report performance against a core set of indicators using data made available to the Trust by NHS Digital.

For each indicator the number, percentage, value, score or rate (as applicable) for at least the last two reporting periods should be presented. In addition, where the required data is made available by NHS Digital, the numbers, percentages, values, scores or rates of each of the NHS Foundation Trust's indicators should be compared with:

a) **The national average for the same and**

b) **Those NHS Trusts and the NHS Foundation Trusts with the highest and lowest of the same, for the reporting period.**

This information should be presented in a table or graph (as seems most appropriate).

For each indicator, the Trust will also make an assurance statement in the following form:

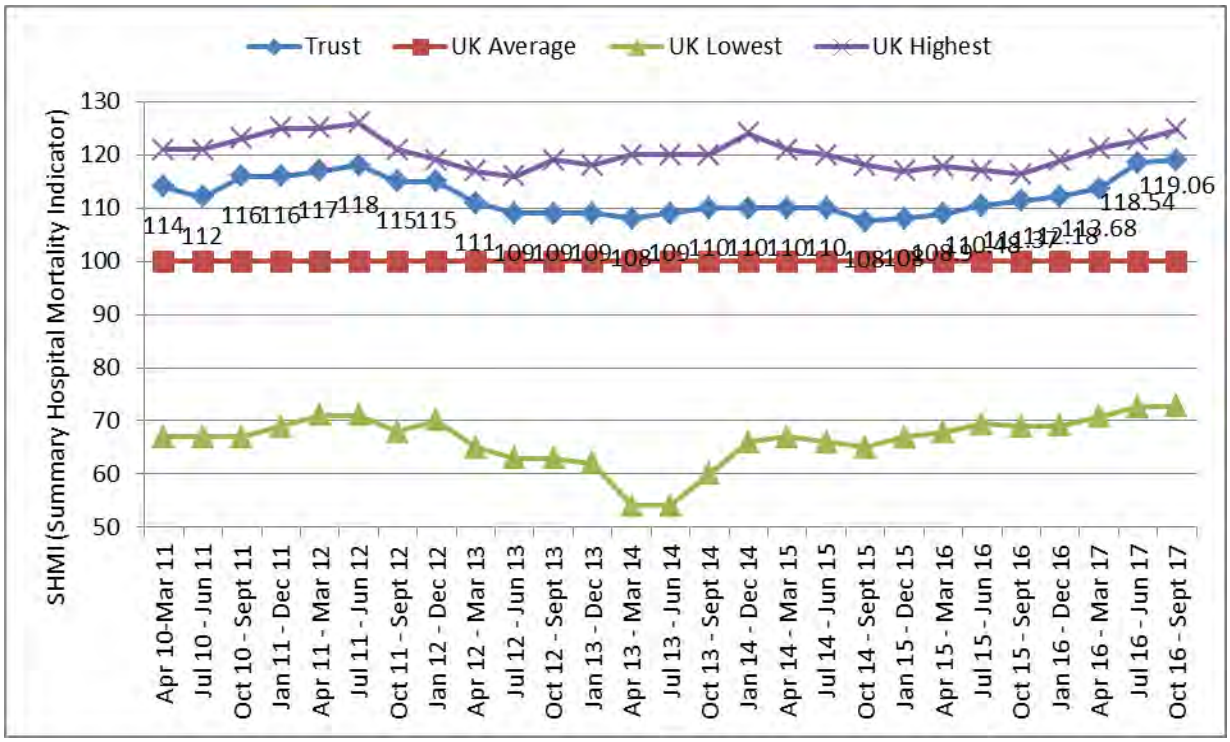
> The Trust considers that this data is as described for the following reasons *[insert reasons]*.
>
> The Trust *[intends to take or has taken]* the following actions to improve the *[indicator / percentage / score / data / rate / number]*, and so the quality of its services, by *[insert descriptions of actions]*.

Some of the mandatory indicators are not relevant to Northern Lincolnshire and Goole NHS Foundation Trust; therefore the following indicators reported on are only those relevant to the Trust.

2.3a Summary Hospital-Level Mortality Indicator (SHMI)

The data made available to the Trust by NHS Digital with regard to:

a) The value and banding of the summary hospital-level mortality indicator ('SHMI') for the Trust for the reporting period;

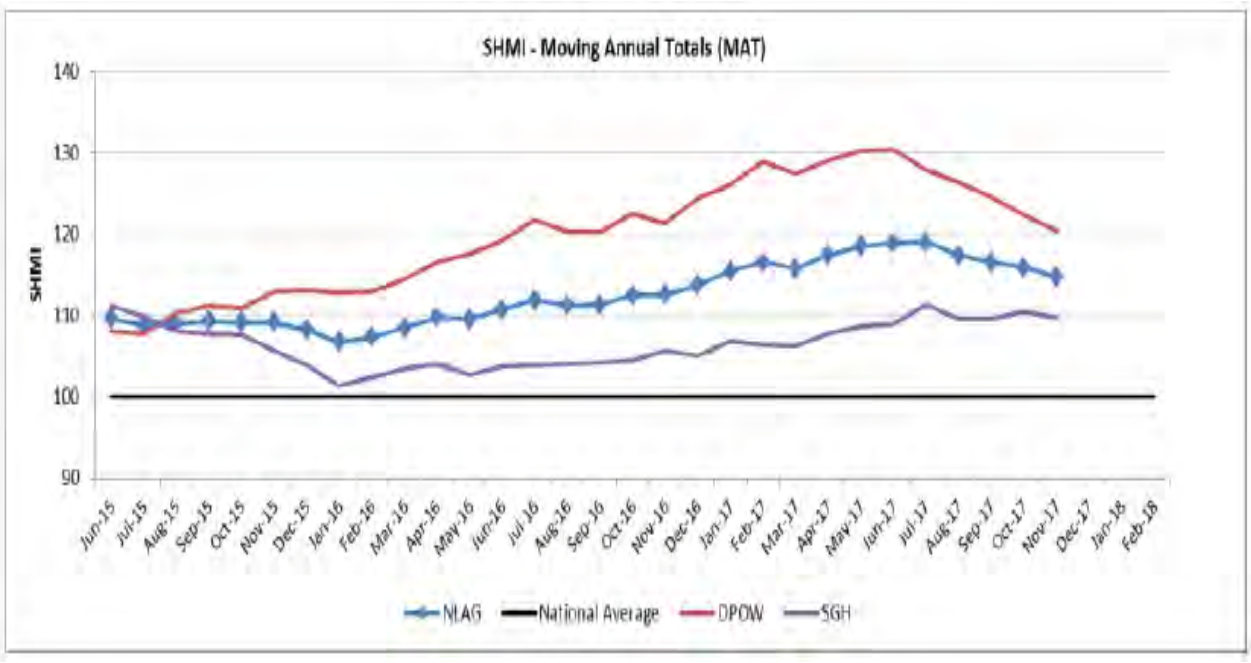


Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
UK average – The United Kingdom average,
UK lowest – The lowest SHMI scoring Trust/hospital/unit,
UK highest – The highest SHMI scoring Trust/hospital/unit.

Comments:

- The above chart illustrates the Trust's performance against the Summary Hospital Mortality Indicator (SHMI). The SHMI is a Standardised Mortality Ratio (SMR). SHMI is the only SMR to include deaths outside of hospital in the community (within 30 days of hospital discharge). This inclusion of community mortality means the information needed comes from the Office for National Statistics, this results in delay in the reporting of the SHMI. To illustrate the most recently available SHMI reports performance between October 2016 and September 2017.
- This delay in reporting makes it difficult for the Trust to continuously in real time monitor this area using SHMI alone, hence why the Trust uses this in collaboration with the 'provisional SHMI' indicator from the Healthcare Evaluation Data (HED). Using this 'provisional indicator' the Trust has access to more timely information which demonstrates further improvements with mortality performance, illustrated graphically as follows.



Source: Healthcare Evaluation Data (HED), information services team

Key to abbreviations: Moving Annual Total (MAT) – A moving annualised average, each months data includes that month plus the 11 months preceding, providing a more reliable presentation of trends over time,
National average – The United Kingdom average,
DPoW – Diana, Princess of Wales Hospital,
SGH – Scunthorpe General Hospital,
GDH – Goole District Hospital.

Comments:

- The above chart illustrates that the Trust's HED SHMI provisional mortality performance has reduced from the peak reported during April and May 2017.
- There are still differences between the Trust's individual hospital sites, with DPoW having a higher SHMI and there is a difference between the in-hospital element of the SHMI i.e. deaths taking place in hospital, and the out of hospital part of the indicator, i.e. those deaths that take place within 30 days of discharge in the community.
- While 100 is the national average and is commonly defined as 'expected' mortality, it is recognised that this statistical measure is not an absolute indicator of performance. As a result of this, NHS Digital publish an organisation's position nationally, determining the national lowest and highest, as well as a Trust banding, which illustrates if an organisation is statistically an outlier, using 95 per cent confidence intervals. This banding is illustrated as follows.

Publication date	Sample time frame	Trust value	Trust banding
October 2011	April 2010 – March 2011	1.14	1
January 2012	July 2010 – June 2011	1.12	2
April 2012	October 2010 – September 2011	1.16	1
July 2012	January 2011 – December 2011	1.16	1
October 2012	April 2011 – March 2012	1.17	1
January 2013	July 2011 – June 2012	1.18	1

April 2013	October 2011 – September 2012	1.15	1
July 2013	January 2012 – December 2012	1.15	1
October 2013	April 2012 – March 2013	1.11	2
January 2014	July 2012 – June 2013	1.09	2
April 2014	October 2012 – September 2013	1.09	2
July 2014	January 2013 – December 2013	1.09	2
October 2014	April 2013 – March 2014	1.08	2
January 2015	July 2013 – June 2014	1.09	2
April 2015	October 2013 – September 2014	1.10	2
July 2015	January 2014 – December 2014	1.10	2
October 2015	April 2014 – March 2015	1.11	1
January 2016	July 2014 – June 2015	1.10	2
March 2016	October 2014 – September 2015	1.08	2
June 2016	January 15 - December 15	1.08	2
September 2016	April 15 - March 16	1.09	2
December 2016	July 15 - June 16	1.10	2
March 2017	October 2015 – September 2016	1.11	2
June 2017	January 16 - December 16	1.12	1
September 2017	April 16 - March 17	1.14	1
December 2017	July 16 - June 17	1.19	1
March 2018	October 2016 – September 2017	1.19	1

Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

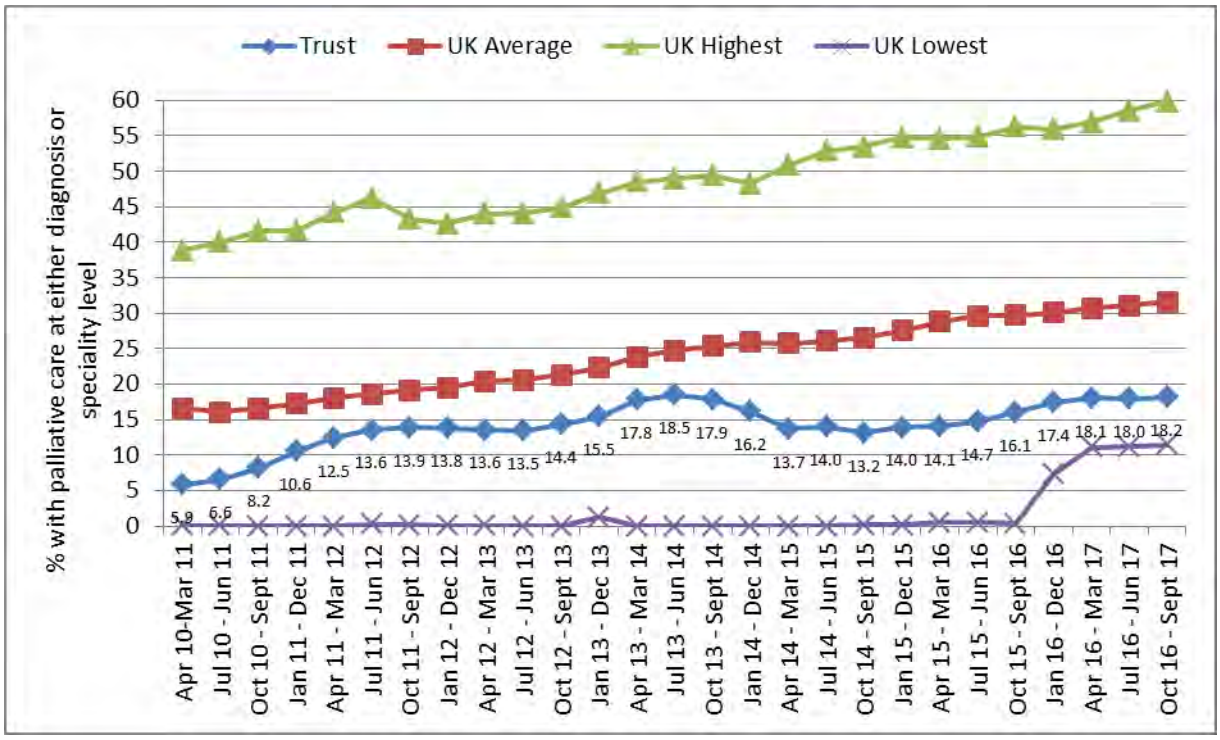
Key to abbreviations: Trust value – The Trust's SHMI score,

Trust banding – The Trust's banding – determining if it is an outlier using statistically calculated levels of confidence (95 per cent confidence intervals).

Comments:

- Banding numbers are based on a 95 per cent control limit, the bandings there mean:
    - 1 – higher than expected,
    - 2 – as expected,
    - 3 – lower than expected.
- The above table illustrates that the Trust is statistically within the 'higher than expected' range for its mortality performance.

b) The percentage of patient deaths with palliative care coded at either diagnosis or speciality level for the Trust for the reporting period.



Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
UK average – The United Kingdom average,
UK highest – The Trust/hospital reporting highest % levels of palliative care,
UK lowest – The Trust/hospital reporting lowest % levels of palliative care.

Comment:

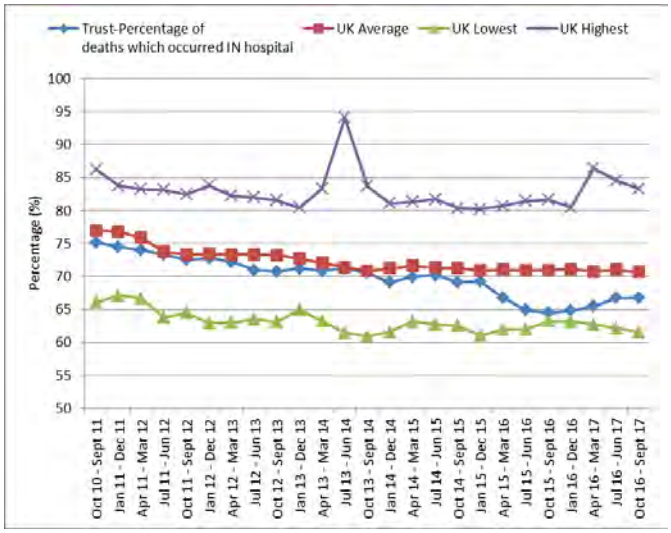
- The above chart illustrates the percentage of patients with a palliative care code used at either diagnosis or specialty level.

- Palliative care coding is a group of codes used by hospital level coding teams to reflect palliative care treatment of a patient during their hospital stay. To ensure these are not exploited for minimising an organisation's reported standardised mortality ratio, Trusts are required to meet strict rules that govern the use of such codes to only those patients appropriately seen and managed by a specialist palliative care team.

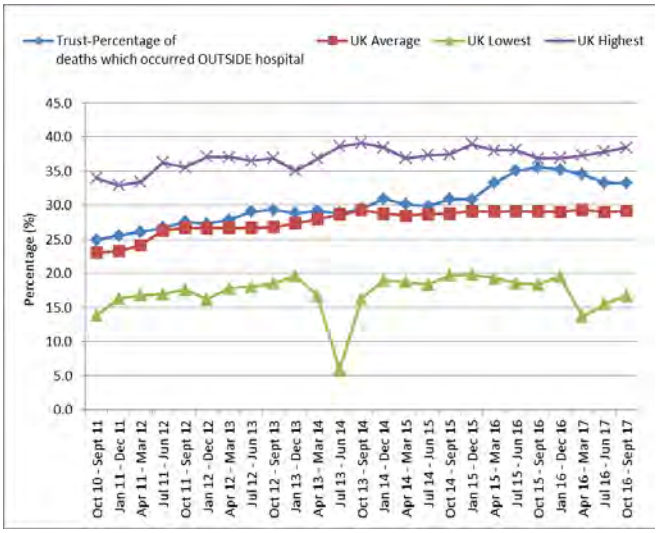
- The SHMI does **not** exclude this group of patients, rather they are included and the appropriate risk factor for each is statistically determined according to the model. As palliative care coding is a key mortality indicator, the SHMI on publication each quarter include the above breakdown of data for Trusts to see the proportion of palliative care codes being used versus the national average.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust Board, formally supported by the Mortality Assurance & Clinical Improvement Committee and more recently by a refocussed Mortality Improvement Group, has been focussing on understanding the key factors impacting on mortality. The SHMI indicator includes deaths within 30 days of a patient being discharged from the acute hospital. This detail enables a breakdown of the SHMI between hospital and out of hospital care, as illustrated below.



'Official' SHMI: Contextual Indicator: In-hospital SHMI



'Official' SHMI: Contextual Indicator: Out of hospital SHMI

Source: HED Information, CHKS

Key to abbreviations:
In-hospital SHMI – The percentage of in-hospital deaths
Out of hospital SHMI – The percentage of out of hospital (within 30 days following discharge) deaths
National Average – the UK average percentage for both in and out of hospital

- One of the improvement activities has been to use this greater understanding of mortality across the healthcare community to support greater collaborative working with general practice and other community partners. This remains underway with community partners being members of the Trust's Mortality Improvement Group.

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:

- Mortality has been included as a distinct project within the Improving Together quality improvement programme, led on by the Trust's Medical Director, supported by two clinical leads for mortality and the Trust's Improvement and Quality & Audit teams.
- The Trust are strengthening its arrangements with regards to case note review for mortality, being led on by the Trust's two clinical leads. The Trust is also recruiting for a dedicated analyst to support further understanding of themes and trends from mortality case review as well as the reported data available.
- The Mortality Improving Together Project includes dedicated work streams, each with an appointed lead. These work streams, and progress against the plan will be project managed by the Trust's Improvement Team and support will also be provided by the Quality & Audit Team. The work streams included are as follows:
    - Reinforce the use of safety huddles
    - Deteriorating patient and sepsis (to also include Acute Kidney Injury and Critical Care Outreach)
    - Hydration
    - Medical assessment (including board rounds, specialty in-reach)
    - Multi-disciplinary Team learning from mortality – Structured Judgement Reviews
    - Consultant of the week model
    - Ward based morbidity and mortality meetings with the mortality clinical leads working with clinical teams to establish and adopt effective arrangements,

- External learning events with CCGs/GPs, wider community forums.
- Specific inclusion in the work plan of 'coding and information quality':
  - Co-morbidities being carried forward from previous episodes & inclusion as part of the electronic patient record in WebV or SystmOne,
  - Mortality clinical leads and coding manager to visit local Trusts with effective clinician and coder relationships,
  - SystmOne access for front line clinicians.

2.3b Patient Reported Outcome Measures (PROMS)

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

a) Groin hernia surgery
b) Varicose vein surgery
c) Hip replacement surgery
d) Knee replacement surgery.

during the reporting period.

Type of surgery	Sample time frame	Trust adjusted average health gain	National average health gain	National highest	National lowest
Groin hernia	April 2010 – March 2011	0.121	0.085	0.156	-0.020
	April 2011 – March 2012	0.084	0.087	0.143	-0.002
	April 2012 – March 2013	0.083	0.085	0.157	0.015
	April 2013 – March 2014	0.051	0.085	0.139	0.008
	April 2014 – March 2015	0.085	0.084	0.154	-0.006
	April 2015 – March 2016	0.128	0.088	No data available	No data available
	April 2016 – March 2017	0.109	0.086	No data available	No data available
Varicose vein	April 2010 – March 2011	No data available	0.091	0.155	-0.007
	April 2011 – March 2012		0.094	0.167	0.047
	April 2012 – March 2013		0.093	0.175	0.023
	April 2013 – March 2014		0.093	0.150	0.023
	April 2014 – March 2015		0.095	0.154	-0.002
	April 2015 – March 2016		0.096	No data available	No data available
	April 2016 – March 2017		0.092	No data available	No data available
Type of surgery	**Sample time frame**	**Trust adjusted average health gain**	**National average health gain**	**National highest**	**National lowest**
Hip replacement (Primary)	April 2010 – March 2011	0.438	0.405	0.503	0.264
	April 2011 – March 2012	0.405	0.416	0.532	0.306
	April 2012 – March 2013	0.461	0.438	0.538	0.369
	April 2013 – March 2014	0.426	0.436	0.545	0.342

	April 2014 – March 2015	0.436	0.437	0.524	0.331
	April 2015 – March 2016	0.485	0.438	No data available	No data available
	April 2016 – March 2017	0.501	0.445	No data available	No data available
Knee replacement (Primary)	April 2010 – March 2011	0.316	0.299	0.407	0.176
	April 2011 – March 2012	0.317	0.302	0.385	0.180
	April 2012 – March 2013	0.357	0.319	0.409	0.195
	April 2013 – March 2014	0.332	0.323	0.416	0.215
	April 2014 – March 2015	0.339	0.315	0.204	0.418
	April 2015 – March 2016	0.349	0.320	No data available	No data available
	April 2016 – March 2017	0.361	0.324	No data available	No data available

Source: NHS Digital Quality Account Indicators Portal, Primary data used, EQ-5D Index used (http://content.digital.nhs.uk/qualityaccounts)

Comment:

- The Patient Reported Outcome Measure (PROMs) is a national initiative designed to enable NHS trusts to focus on patient experience and outcome measures. The 4 areas listed above are nationally selected procedures.
- Varicose vein surgery is not performed by the Trust, therefore no data is available.
- Reporting for Groin hernia will also phase off due to the NHS England decision in October 2017 to discontinue the mandatory groin-hernia surgery national PROM collections. The rationale for this decision is that Groin hernia surgery is offered mainly to reduce the risk of requiring emergency surgery, rather than to relieve symptoms, which are often relatively minimal. This, along with the fact that there is no condition-specific PROM for groin-hernia surgery, means that the existing PROM has limited value. The last available data will cease after May 2018
- From April 2015 – March 2017, no national data regarding highest and lowest scores across Trusts is available for reporting
- The above table shows the Trust's reported adjusted health gain against the EQ-5D index, which is a measure of the patient's own reported outcome following surgery within the Trust.
- EQ-5D™ - Index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/discomfort, and anxiety/depression) and combines them into a single value.
- The single value scores for the EQ-5D index range is from -0.594 (worse possible health) to 1.0 (full health). For the period of April 2016 – March 2017, the adjusted average health gain on the EQ-5D index for respondents following their operation was as follows:
    - Groin hernia score 0.109 (0.086 England average)
    - Hip replacement Primary score 0.501 (0.445 England average)
    - Knee replacement Primary score 0.361 (0.324 England average)

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

- The results for the latest available data release as at February 2018 demonstrates

that the Trust was not an outlier for any of the health gain outcomes for any of the procedures.

- Quarterly reports are received from NHS Digital that provide progress updates on both the participation rates both pre and post-surgery, and the overall health gain reported by patients.

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

- Presenting the patient level results at the surgery and critical care quality & safety days bi-annually as well discussing at clinical governance group and presenting to clinicians at the general surgery clinical audit meetings. The Trusts access to patient level data enables us to analyse in house and use findings to drive further improvements in patient reported outcomes.
- Continuing to review participation rates for each clinical procedure and making improvements in the internal monitoring of pre-operative questionnaire returns to ensure all eligible patients are given the opportunity to participate.

2.3c Readmissions to hospital

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

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

Readmitted to a hospital which forms part of the Trust within 28 days of being discharged from a hospital which forms part of the Trust during the reporting period.

Age group	Time frame	Trust Emergency readmissions (%)	National re-admissions (%)	National highest (%)	National lowest (%)
0 to 15	2011/2012	8.56%	10.01%	14.94%	0.00%
	2010/2011	8.19%	10.15%	25.80%	0.00%
	2009/2010	7.93%	10.18%	31.40%	0.00%
	2008/2009	7.59%	10.09%	22.73%	0.00%
16 or over	2011/2012	9.47%	11.45%	17.15%	0.00%
	2010/2011	9.18%	11.42%	22.93%	0.00%
	2009/2010	8.92%	11.16%	22.09%	0.00%
	2008/2009	8.64%	10.90%	29.42%	0.00%

Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Comment:

- The above table does not contain any more recent data after the 2011/12 reporting period. There has been no updated information added to the NHS Digital Quality Account indicators site, therefore the Trust cannot provide any further update on this section.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

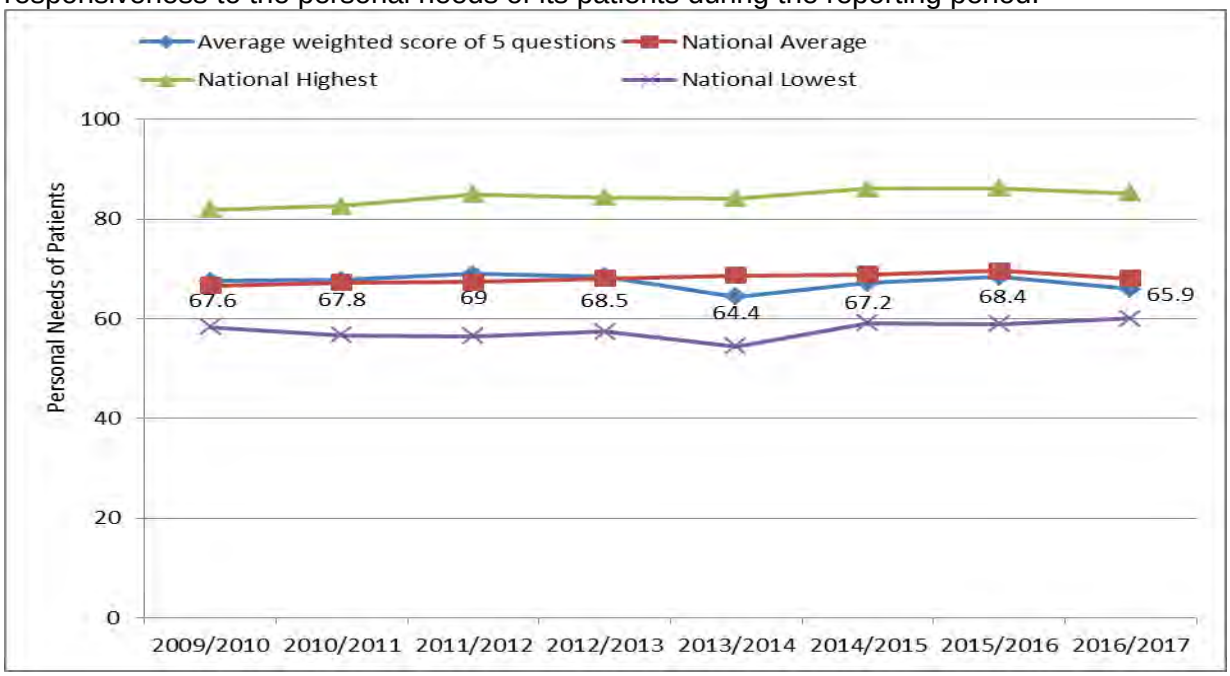
- The Trust has been consistently below the national rates for re-admissions.

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

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

2.3d Responsiveness to the Personal needs of patients

The data made available to the Trust by NHS Digital with regard to the Trust's responsiveness to the personal needs of its patients during the reporting period.



Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Key to abbreviations: Average weighted score of 5 questions – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average,
National highest – The Trust/hospital/unit reporting highest scores,
National lowest – The Trust/hospital/unit reporting lowest scores.

Comment:

- The table above highlights the average weighted score for five specific questions. This information is presented in a way that allows comparison to the national average and the highest and lowest performers within the NHS.

- The above figures are based on the adult inpatient survey, which is completed by a sample of patients aged 16 and over who have been discharged from an acute or specialist trust, with at least one overnight stay. The indicator is a composite, calculated as the average of five survey questions from the inpatient survey. Each question describes a different element of the overarching theme:

"*Responsiveness to patients' personal needs".*

1. Were you involved as much as you wanted to be in decisions about your care and treatment?
2. Did you find someone on the hospital staff to talk to about your worries and fears?
3. Were you given enough privacy when discussing your condition or treatment?

4. Did a member of staff tell you about medication side effects to watch for when you went home?
5. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left hospital?

- Individual questions are scored according to a pre-defined scoring regime that awards scores between 0-100. Therefore, this indicator will also take values between 0-100.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

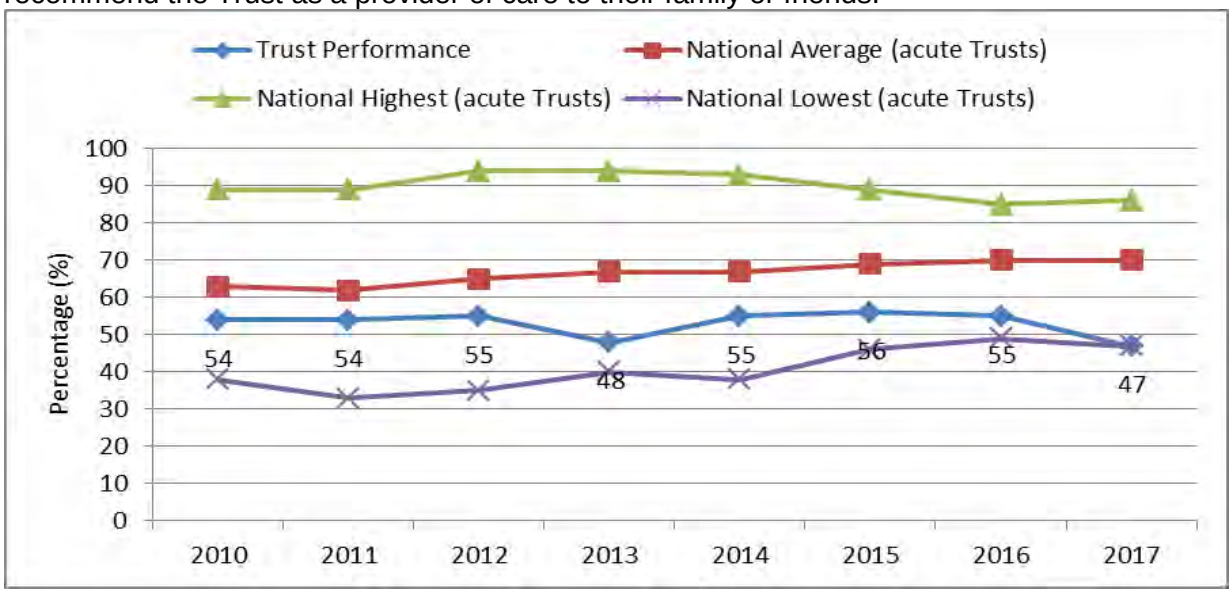
- The Trust response rates are in line with the other 81 Trusts surveyed by our survey provider. Whilst this position offers some assurance it is not where we aspire to be.
- We are continuing to work at improving our position and have some examples below of how this will be supported.

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

- Development of electronic care planning based on a person centred model which will support patient, carer and family involvement.
- As we work tirelessly to improve our staffing position we are also providing compassion based training to our newly qualified staff around listening to patients, carers and families. Part of this includes the value of #hellomynameis and the associated relationships, highlighting how they build trust and improve experience.
- Development of our quiet/relative rooms has provided areas away from the ward, and we continue this work as areas are refurbished. We encourage staff to use these where clinically able, but also to utilise consideration with any bedside conversations. Ensuring patients, carers and families have a choice is central to our continued improvement.
- Our pharmacy team have created an excellent reconciliation service where bedside education starts for patients. We hope to see this improved at final discharge point with review of our discharge and flow processes.
- Following patient led review of our Information for Patients Leaflets this is an area they have identified contact post discharge as a key part of the leaflet and this will be part of the template and education going forward. We hope this will help reinforce the value of this information.

2.3e Staff recommending Trust as a provider to friends and family

The data made available to the Trust by NHS Digital with regard to the percentage of staff employed by, or under contract to, the Trust during the reporting period who would recommend the Trust as a provider of care to their family or friends.



Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Trust performance – Northern Lincolnshire and Goole NHS Foundation Trust,

National average – The United Kingdom average,
National highest (acute Trusts) – The Trust/hospital/unit reporting highest scores,
National lowest (acute Trusts) – The Trust/hospital/unit reporting lowest scores.

Comment:

- The above table illustrates the percentage of staff answering that they "Agreed" or "strongly agreed" with the question: "If a friend or relative needed treatment, I would be happy with the standard of care provided by this Trust".
- 47% of staff surveyed would recommend the Trust.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust finds the feedback from this survey disappointing but not surprising as it recognises from this key themes such as staffing shortages and low morale.
- The Trust have identified these themes prior to the national staff survey being released and have been proactively working to address some of the themes underpinning these findings.

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

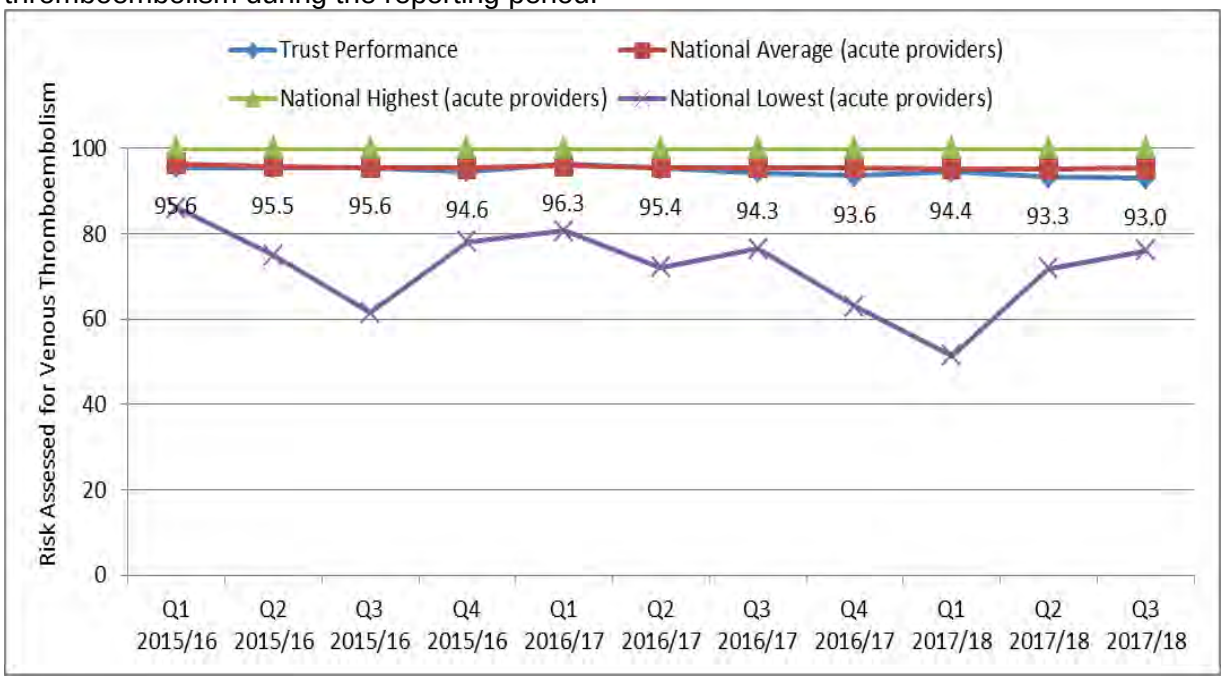
- Prior to release of the NHS staff survey, action had already commenced, with culture being included as a specific and distinct work stream as part of the Trust's Improving Together Programme. Actions already taken include:
    - Invested in the Listening into Action (LIA) programme, with dedicated project support to empower Trust staff to be able to make changes and bring their improvement ideas to life.
    - A new 'Pride and Respect (our anti-bullying campaign)' project has been launched to provide staff with access to an advice line to help them raise concerns where unacceptable behaviours or poor professional standards are demonstrated.
    - The Trust has also appointed a Freedom to Speak Up Guardian (FTSUG) to

again be on hand to provide staff with a confidential route to raise concerns about anything in the Trust.

- A key finding from the NHS Staff Survey was in connection with a lack of staff. The Trust have continued to use innovative ways to recruit to posts that are challenging to fill. This has included the creation of new roles. The Trust are also focussing on retention of staff also and this has led to the creation of a dedicated retention strategy. This is also a key part of the Trust's Improving Together Programme.

2.3f Risk assessed for venous thromboembolism

The data made available to the Trust by NHS Digital with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.



Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average for acute Trusts,
National highest – The Trust/hospital/unit reporting highest compliance rates,
National lowest – The Trust/hospital/unit reporting lowest compliance rates.

Comment:

- The above table illustrates the percentage of patients admitted to the Trust and other NHS acute healthcare providers who were risk assessed for venous thromboembolism (VTE) since quarter one, 2015/16. The Trust are not at present achieving the 95% target for this area.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

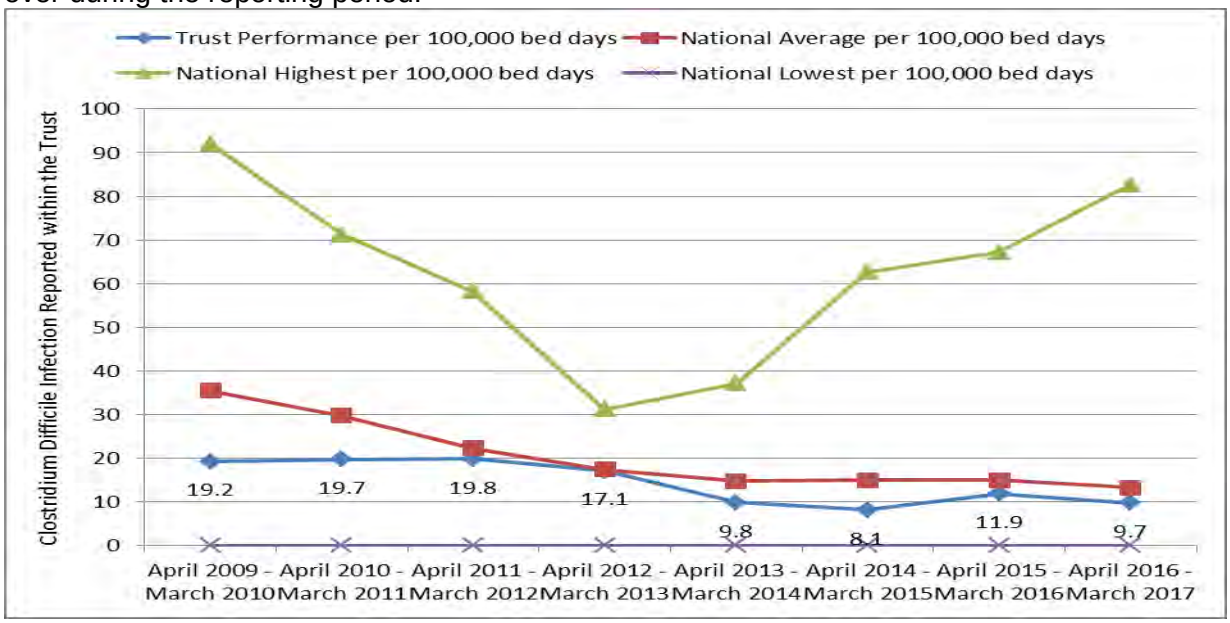
- The Trust is striving to oversee compliance with VTE risk assessments and prophylaxis prescribed. This is accomplished through monthly reporting through the Trust's performance framework. Where possible this overall compliance is broken down to ward and department level to aid continued understanding and improvement.

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

- A specific project is underway to understand the root causes behind why performance reported here is not yet achieving the target, and work to address this will be undertaken overseen by the Trust's Medical Director.

2.3g Clostridium Difficile infection reported within the Trust

The data made available to the Trust by NHS Digital with regard to the rate per 100,000 bed days of cases of C. difficile infection reported within the Trust amongst patients aged 2 or over during the reporting period.



Source: NHS Digital Quality Account Indicators Portal, Trust apportioned cases (http://content.digital.nhs.uk/qualityaccounts)

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust,
National average – The United Kingdom average,
National highest – The Trust/hospital/unit reporting highest rates per 100,000 bed days,
National lowest – The Trust/hospital/unit reporting lowest rates per 100,000 bed days.

Comment:

- The above table illustrates the rate of C. difficile per 100,000 bed days, for the Trust (Trust apportioned cases), for specimens taken from patients aged two years and over.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The trust ended the financial year on 37 cases of C.difficile toxin positive. The rise in number of cases may be partially attributed to the high level of influenza with many patients developing a secondary bacterial infection. The majority of cases were detected on the DPOW site as per the previous year.

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

- The Trust has an evidence based C. difficile policy and patient care pathway.
- Multi-disciplinary team meetings are held for inpatient cases to identify any lessons to be learnt and root cause analysis is conducted for every hospital acquired case and a director of infection prevention and control (DIPC) review is held where there has been a breach in practice or the patient has died.
- For each case admitted to hospital, practice is audited by the infection prevention and control team using the Department of Health Saving Lives' audit tools.
- A Post Infection Review process to review hospital attributed cases of CDI has been introduced to enable focused work on learning lessons and sharing best practice.
- Themes learnt from PIR process will be monitored by the Infection Prevention &

Control Committee and shared with relevant bodies.

- The formation of a HCAI working group to explore all matters pertaining to IPC where relevant lessons and infection cases will be discussed with multidisciplinary teams.
- The development of a bespoke IPC WebV module that will alert IPC team to previous cases of CDI readmitted into the trust. The system also should allow the interface with future electronic prescribing software to help identify prescribing habits.
- GPs will be sent a letter to inform them of a patients C.difficile/GDH status again to help reduce the amount of antimicrobial use and prevent future CDI cases.
- Development and implementation of a rolling programme of antibiotic prescribing audits reviewed by the steering group and the HCAI working group.
- The introduction of Ultraviolet non touch decontamination on the DPOW site to enhance deep cleaning process.
- A move towards using disposable antibacterial coated disposable curtains across the trust.

2.3h Patient safety incidents

The data made available to the Trust by NHS Digital with regard to:

a) The number and, where available, rate of patient safety incidents per 1,000 bed days reported within the Trust during the reporting period,

Time frame	Trust number of patient safety incidents reported	Trust rate of patient safety incidents reported per 1,000 bed days	Acute – Non-specialist average rate of patient safety incidents per 1,000 bed days	Acute – Non-specialist highest rate per 1,000 bed days	Acute – Non-specialist lowest rate per 1,000 bed days
April 2014 – September 2014	5,124	41.5	35.9	75.0	0.2
October 2014 – March 2015	5,483	43.2	37.1	82.2	3.6
April 2015 – September 2015	5,570	44.7	39.3	74.7	18.1
October 2015 – March 2016	5,395	42.8	39.6	75.9	14.8
April 2016 – September 2016	5,953	49.5	40.8	71.8	21.1
October 2016 – March 2017	6,536	52.3	41.1	69.0	23.1

Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

Comment:

- The above table demonstrates the total number of patient safety incidents and the rate per 1,000 bed days reported.

- Northern Lincolnshire and Goole NHS Foundation Trust average rate of patient safety incidents reported is above the average of other acute non-specialist NHS

organisations. The Trust actively promotes and encourages staff to report all incidents as part of an open and transparent culture designed to support learning and improvement.

b) And the number and rate of such patient safety incidents that resulted in severe harm or death.

Time frame	Trust number of patient safety incidents reported involving severe harm or death	Trust rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national average rate of patient safety incidents reported involving severe harm or death per 1,000 bed days	Acute – Non-specialist national highest rate involving severe harm or death per 1,000 bed days	Acute – Non-specialist national lowest rate involving severe harm or death per 1,000 bed days
April 2014 – September 2014	12	0.10	0.2	1.09	0.00
October 2014 – March 2015	6	0.09	0.2	1.53	0.02
April 2015 – September 2015	6	0.05	0.17	1.12	0.03
October 2015 – March 2016	9	0.07	0.16	0.97	0.00
April 2016 – September 2016	7	0.06	0.16	0.60	0.01
October 2016 – March 2017	21	0.17	0.16	0.53	0.01

Source: NHS Digital Quality Account Indicators Portal (http://content.digital.nhs.uk/qualityaccounts)

NB: Please note the denominator changed in April 2014 to benchmark Trusts safety incidents reported against 1,000 bed days, instead of the previously used comparison rate 'per 100 admissions'. The classification of Trusts also changed from 'large acute', 'medium acute', 'small acute' and 'acute teaching' to simply 'Acute non-specialist' and 'Acute specialist'. As a result of these changes, the previous historic data is not comparable and is therefore not included within this quality account.

Comment:

- The above table demonstrates the total number and rate per 1,000 bed days of patient safety incidents involving severe harm or death.

Northern Lincolnshire and Goole NHS Foundation Trust considers that this data is as described for the following reasons:

- The Trust has reported a higher number of incidents involving severe harm or death during October 2016 – March 2017. During this timeframe, there has been a corresponding increase in the number of serious incident investigations (SIs) initiated by the Trust, in response to any incident having the potential for or resulting in serious morbidity or death, that could have been linked to problems in care. It should be stressed that this approach ensures escalation via a thorough investigation, and on completion of such, the harm or death was unrelated to the care provided by the Trust. Where improvement issues are identified the Trust includes this within its approach to learning lessons.
- The number of reported SIs remains high since March 2017, this illustrates the Trust's sensitivity to ensuring it reviews any incident with the potential for or that did result in severe harm or death that could have been linked to a problem in care. This approach is designed to ensure we are capturing any resulting lessons that provide improvement opportunities.

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

- The Trust undertakes an in-depth review of the themes emerging from concluded Serious Incident investigations. This is reported and overseen by the Trust's Quality & Safety Committee, who seeks further assurance from relevant Trust leads regarding action being taken to improve.
- The Trust are also in the process of strengthening its quality governance framework with the introduction of an executive led Quality Governance Group. A sub-group will oversee in greater operational detail the learning themes from SIs.
- The Trust have included within its improvement plan (Improving Together) a work stream focussed on safety culture, including within this is specific work regarding improving learning lessons.

Part 3: Other information

An overview of the quality of care based on performance in 2017/18 against indicators

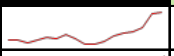
3.1 Overview of the quality of care offered 2017/18

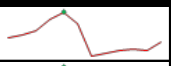
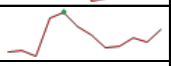
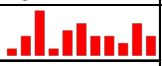
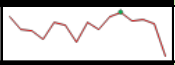
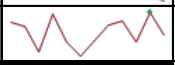
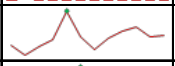
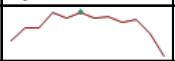
Parts 2.1a, 2.1b and 2.1c of this report outlined progress during 2017/18 towards achieving the priorities for this financial year just ended which the Trust set out in its previous Annual Quality Account for 2016/17.

For these indicators selected by the Trust, the full report, contained within parts 2.1a, 2.1b and 2.1c refer to benchmarked data, where available, to enable performance compared to other providers. References to the data sources used are also stated within these earlier parts of this report and where relevant this includes whether the data is governed by standard national definitions. This information, presented in part two of this report also illustrates historical data for comparison and trending purposes. If the basis for calculating data has changed from that of historical data, this is explained in full detail within section two of this report.

During 2017/18 the quality priorities were monitored within the Improving Together reported KPIs or the Integrated Performance Report for the most part. A summary of the Trust's performance against these key indicators (outlined within part 2 in full) are summarised as follows:

QUALITY PRIORITIES AT A GLANCE: 2017/18

Indicator			Time period / RAG	Comparator	Trending	Target
Clinical Effectiveness: THEME 1: Reducing Mortality			**Most recent data**	**Previous data**	**Trending**	**Target**
1	Summary Hospital-Level Mortality Indicator (SHMI) (Oct 16-Sep 17)		119.1 R	118.5		100
	HED 'Provisional' SHMI data (Jan 17 - Dec 17)		117 R	115		100
	Position vs peers		Higher than expected R	Within expected range		Within expected range
Patient Safety: THEME 2: Increase Harm Free Care			**Mar-18**	**Feb-18**	**Target achieved**	**Target**
1	Safety Thermometer	Acute	90.4% R	92.20%		95.0%
		Community	96.2% G	97.60%		95.0%
2	Care of the deteriorating patient	Vital signs (NEWS) recorded in accordance with planned	No data: Data collection method being designed			95.0%
		Appropriate clinical response been actioned	No data: Data collection method being designed			95.0%
			Sep-17	**Aug-17**	**Target achieved**	
3	Nutrition and Hydration	Fluid management chart completed accurately/fully in line with plan	85.7% R	87.9%		100.0%
		Food record chart completed accurately/fully in line with plan	100.0% G	93.3%		100.0%

			Mar-18		Feb-18	Target achieved	
4	Safe Nurse Staffing	% Substantive nursing posts vacant	9.8%	R	9.2%		6.0%
		Nursing agency spend £000s	588		503		No target
5	Infection Prevention and Control	C Diff (Monthly) (YTD: 37)	3		5		No target
		C Diff (Lapse in care) (YTD: 6)	0	G	1		21
		MRSA (YTD: 1)	0	G	0		0
Patient & Staff Experience: THEME 3: Providing Care Resulting in a Positive Experience			**Mar-18**		**Feb-18**	**Target achieved**	**Target**
1	Patient experience	Emergency Care	72.5%	R	78.0%		98%
		Community	99.6%	G	99.1%		
		Day Case	99.1%	G	99.3%		
		Inpatient	99.0%	G	97.8%		
		Maternity	97.1%	A	100.0%		
			2017 Survey		**2016 Survey**	**Target achieved**	**Target**
2	Staff experience	NHS National Staff Survey: "Recommend Trust to work in"	43.0%	R	50.0%		63%
Patient Experience: THEME 4: Outpatient Services			**Mar-18**		**Feb-18**	**Target achieved**	**Target**
1	Patient experience	Feedback from the Out-Patient FFT is 'Extremely likely' or 'Likely'	66.6%	R	88.0%		98%
Clinical Effectiveness: THEME 5: Discharge and Transfer			**Mar-18**		**Feb-18**	**Target achieved**	**Target**
1	Patient Flow	% of patients waiting less than 4 hours in A&E	79.50%	R	83.42%		90%
		Non Elective length of stay	4.8	A	4.9		4.7
2	Timely access	% patients on incomplete RTT pathways waiting <18 wks from referral	66.20%	R	68.10%		92%
		% receiving treatment for cancer following referral within 62 days (Post)	65.90%	R	78.80%		85%
Patient Safety: THEME 6: Medical Quality Indicators			**Mar-18**		**Feb-18**	**Target achieved**	**Target**
1	Venous Thromboembolism (VTE)	% of patients screened for VTE on admission	90.3%	R	93.4%		95%
2	Safe Medical Staffing	% Substantive medical posts vacant	23.59%	R	23.45%		14.17%
		Medical agency spend £000s	1,508		1,952		None

3.2 Performance against relevant indicators and performance thresholds

Performance against those indicators that form part of appendices 1 and 3 of the Single Oversight Framework (SOF) is presented as follows.

Indicator	Quarter 1 17/18			Quarter 2 17/18			Quarter 3 17/18			Quarter 4 17/18			17/18 Performance
	Apr-17	May-17	Jun-17	Jul-17	Aug-17	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18	Mar-18	
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway Ⓐ	77.1%	77.4%	77.4%	75.9%	74.0%	72.8%	73.7%	73.2%	70.5%	69.1%	68.1%	66.2%	Average: 72.9%
A&E: Maximum waiting time of four hours from arrival to admission/transfer/discharge Ⓐ	78.8%	85.2%	82.8%	83.8%	89.2%	87.4%	91.6%	92.4%	87.9%	86.2%	83.4%	79.5%	Average: 85.7%
All cancers: 62-day wait for first treatment from referral/screening	76.0%	77.0%	66.6%	84.3%	74.3%	61.4%	72.0%	74.6%	78.7%	69.2%	81.8%	*72.6%*	Average: 74.0%
C.difficile: variance from plan [lapses in care] (target 21)	0	0	0	2	0	1	0	1	1	0	1	0	6
Maximum 6-week wait for diagnostic procedures	98.0%	98.2%	96.3%	95.8%	93.1%	93.4%	92.6%	94.6%	92.6%	90.5%	93.3%	91.5%	Average: 94.2%
Venous Thromboembolism (VTE) risk assessment	94.4%			93.3%			93.0%			92.5%			Average: 93.3%
Summary Hospital-level Mortality Indicator	June 2017 Release (Covering Jan 16 - Dec 16 data period): 1.12			September 2017 Release (Covering Apr 16 - Mar 17): 1.14			December 2017 Release (Covering Jul 16 - Jun 17): 1.19			March 2018 Release (Covering Oct 16 - Sept 17): 1.19			Average SHMI for Jan 16 - Sept 17 period: 1.16

3.3 Information on staff survey report

Summary of performance – NHS staff survey

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

In 2017, 33.6 per cent of our staff completed a survey (a decrease from 41.1 per cent the previous year).

The survey was open from September to December 2017, and all staff were encouraged to participate. Prizes were offered for the 500th, 1,000th, 1,500th and so on staff who completed their survey and the survey features in various internal communications across the organisation, including the staff bi-monthly magazine, weekly team brief, the Hub (intranet), all staff emails and at the chief executive's monthly cascade meeting.

Detailed performance – NHS staff survey

The Trust undertook a census sample survey during 2017, offering 6,156 eligible staff the opportunity to participate. From this 2,066 surveys were completed and returned.

	2016		2017		Trust improvement/ deterioration
Response rate	Trust	National average	**Trust**	**National average**	
	41.1%	39.9%	**33.6%**	**45.5%**	7.5% reduction

Source: NHS Staff Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Staff Survey 2017 findings

Highest five ranking scores:

	2016		2017		Trust improvement/ deterioration
Highest five ranking scores	Trust	National average	**Trust**	**National average**	
KF16 % of staff working extra hours	70%	72%	**71%**	**72%**	Increase
KF20 % of staff experiencing discrimination at work	11%	11%	**12%**	**12%**	Increase
KF27 % of staff reporting most recent experience of harassment, bullying or abuse	47%	45%	**45%**	**45%**	Reduction
KF29 % of staff reporting errors, near misses or incidents witnessed in the last month	92%	90%	**90%**	**90%**	Reduction
KF11 % staff appraised in the last 12months	88%	87%	**86%**	**86%**	Reduction

Source: NHS Staff Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Lowest five ranking scores:

	2016		2017		Trust improvement/ deterioration
Lowest five ranking scores	Trust	National Average	**Trust**	**National Average**	
KF13 Quality of non-mandatory training, learning or development	4.02	4.05	**3.90**	**4.05**	Reduction
KF7 % staff able to contribute towards improvements at work	65%	70%	**59%**	**70%**	Reduction
KF15 % staff satisfied with the opportunities for flexible working	44%	51%	**40%**	**51%**	Reduction
KF5 recognition and value of staff by managers and the organisation	3.30	3.45	**3.21**	**3.45**	Reduction
KF32 Effective us of patient /service user feedback	3.51	3.72	**3.41**	**3.71**	Reduction

Source: NHS Staff Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Regarding staff feeling of experiencing harassment, bullying or abuse from staff:

	2016		2017		Trust improvement/ deterioration
KF26	Trust	National Average	**Trust**	**National Average**	
The percentage of staff experiencing harassment, bullying or abuse from staff in the last 12 months	25%	25%	**28%**	**25%**	Increase

Source: NHS Staff Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

Future priorities and targets

The Trust recognises that its greatest asset are its staff. As such the Trust's Improving Together plan contains numerous staff focused work streams, including (but not limited to):

- Continuing the highly successful LiA Crowdfixing events,
- Improving medical engagement, including the review of Divisional structures and ensuring that effective clinical leadership is evidenced in the Trust and its decision making processes,
- To further development of its nationally recognised apprenticeship programme,
- To continued review of workshop establishments to enable the introduction of new roles such as Advanced Clinical Practitioners to support services and the medical rotas,
- An extensive and targeted recruitment programme supported by a tailored Staff Retention Strategy and a wide range of retention deliverables,

The above work streams performance and outputs are monitored through the Trusts Improving Together Oversight Committees and Improving Together Board. These work streams will positively contribute to overcoming staffs concerns within the 2017 staff survey.

Importantly though the Trust recognised that as well as these initiatives transformational change is required if it is to see improvements in, amongst other things, staff survey results and staffs perception of working in the NLG NHS Trust.

Consequently the Trust rather than embarking on a multi-stranded transactional action plan to address all the concerns within the findings report is instead investing in a two work stream, staff engagement orientated, transformation approach to address staffs concerns:

- **Staff Survey Work stream 1:** Significant and sustained corporate investment in staff engagement, including investing heavily in increasing staff voice to improve clinical/non-clinical services.
- **Staff Survey Work stream 2:** Invest in Divisional Staff Survey Action Teams. Each Divisional leadership team, working in partnership with their own staff, to jointly agree between themselves a maximum of three areas from within the survey that they want to improve within their area of work.

The above two work streams will be monitored through the 'Culture and OD' Improving Together work stream. Additionally progress reports will be presented at the Trust Management Board and Trust Board itself. The staff survey transformational work streams commence April 2018. The measure of success will be taken from quarterly pulse check surveys aligned to staff survey key finding KPIs and ultimately by the findings within the 2018 staff survey report.

3.4 Information on patient survey report

Introduction

The National Inpatient Survey for 2017 was sent out to 1250 of patients who stayed in our Trust, 41.1% choose to respond. This extensive questionnaire helps provide a more detailed insight into their care received and provides a mechanism by which we can focus our improvement priorities in a patient led way.

Response rate compared with previous year:

	2016		2017	
Response rate	Trust	National average	**Trust**	**National Average**
	44%	41%	**41.1%**	**38.3%**

Source: NHS Patient Survey

Key to abbreviations: Trust – Northern Lincolnshire and Goole NHS Foundation Trust, National average – The United Kingdom average

These are the areas where we performed higher than the 81 Trusts we were benchmarked against:

	Trust	National average	Trust improvement/ deterioration
Planned admission: specialist not given all the necessary information	1%	2%	-1%
Hospital: food was fair or poor	32%	39%	-7%
Hospital: not always offered a choice of food	13%	20%	-7%
Overall: not always well looked after by non-clinical hospital staff	11%	15%	-4%

The Trust acknowledges with the areas where our patients responses were lower than the other Trusts surveyed that our work to improve these will continue.

	Trust	National average	Trust improvement/ deterioration	Site comparison
Admission: had to wait long time to get to bed on ward	48%	34%	+14%	DPOW: 55% SGH: 41%
Hospital: shared sleeping area with opposite sex	11%	8%	+3%	DPOW: 8% SGH: 14%
Doctors: did not always get clear answers to questions	37%	30%	+7%	DPOW: 41% SGH: 32%
Doctors: talked in front of patients as if they were not there	27%	22%	+5%	DPOW: 29% SGH: 26%
Nurses: sometimes, rarely or never enough on duty	45%	40%	+5%	DPOW: 47% SGH: 45%
Nurses: did not always know which nurse was in charge of care	54%	49%	+5%	DPOW: 54% SGH: 55%
Care: not enough or too much information given on condition or treatment	22%	19%	+3%	DPOW: 26% SGH: 19%

Discharge: did not definitely know what would happen next with care after leaving hospital	52%	47%	+5%	DPOW: 52% SGH: 53%
Discharge: not given any written/printed information about what they should or should not do after leaving hospital	43%	36%	+7%	DPOW: 42% SGH: 47%
Discharge: not fully told of danger signals to look for	63%	56%	+7%	DPOW: 62% SGH: 62%
Overall: not always treated with respect or dignity	21%	16%	+5%	DPOW: 23% SGH: 19%

Actions to be taken as a result:

Areas will be fed into existing Trust Groups who are supporting our Improving Together programme. The Trust is undertaking a large piece of work to change staff culture which will have definite impact on several of the areas highlighted.

Annex 1: Statements from commissioners, local Healthwatch organisations and overview and scrutiny committees

Annex 1.1: Statements from Commissioners

Feedback from:
This statement has been prepared in collaboration with the following Clinical Commissioning Groups:

- **North East Lincolnshire CCG,**
- **North Lincolnshire CCG,**
- **East Riding of Yorkshire CCG.**

We welcome the opportunity to provide feedback to the Northern Lincolnshire & Goole NHS Foundation Trust (NLaG) on their Annual Quality Account. The Quality Account provides a useful overview of Trust performance and the work streams of the Improving Together Programme. We are disappointed that the account does not provide clear clinical quality indicators for the 2017/18 reporting period.

Throughout 2017, the content of the Trusts monthly Integrated Performance report has been challenged by commissioners at contract meetings with a view to supporting the Trust to improve the focus, monitoring, assessment and response to clinical quality in the organisation. We would expect to see the content of the monthly reports improve and become more quality related during 2018/2019 and we would also expect to see improvement of accurate data collection and analysis.

The Trusts efforts in relation to staff recruitment and retention have been recognised as extremely positive and we acknowledge the significance of the work stream and commend the Trust in being recognised nationally for the new approach at apprenticeships, enabling staff to study to master's level.

The Trust's work around improving the culture of 'speaking up' is encouraging and we look forward to seeing the impact of this in the coming year.

It has been positive to see the learning from never events included in the Annual Report and the introduction of 'live drills' in the Trust to support 'grass root' learning. The improvement in openness and engagement in relation to learning lessons is positive; we also anticipate seeing an improvement in the embedding of lessons learnt and assurance processes adopted by the Trust in the coming year.

The Trust has reported on data from the Friends and Family Test and the Patient Survey regarding the experience of people using the service, and commissioners would also like to see other ways of hearing the patient voice and experience of the quality of services during 2018/19.

It is recognised that NLaG's quality position remains significantly challenging, and we await the outcome of the forthcoming comprehensive CQC inspection. We recognise the ongoing programme of work being undertaken to address all of the challenges they face and as commissioners, we will continue to support the Trust to achieve high quality care.

We have welcomed involvement in the Trust's work streams and system improvement work being undertaken with stakeholders and look forward to working closely together this coming year.

Feedback from:

- **Lincolnshire East CCG,**

NHS Lincolnshire East Clinical Commissioning Group (the commissioners) welcomes the opportunity to review and comment on the Northern Lincolnshire & Goole NHS Foundation Trust (the trust) Draft Annual Quality Account 2017 – 18.

The Quality Account provides a comprehensive picture of the quality priorities the trust has focussed on during the year, including the work undertaken to reduce mortality and increase harm free care within the organisation. However, it is not clear from the description within the account how the organisation has ensured that the programme of work in relation to quality priorities is reflective of the needs of the local population, or is underpinned by robust patient and public involvement in setting these priorities. The commissioner also would like the trust to be more ambition in ensuring that the levels of mortality and harm free care achieve the expected levels for a large acute provider.

The Quality Account has examples of some good work undertaken by the trust over the past year, the commissioner believes the work undertaken by the trust in relation to clinical audit including the opportunities for improvement and action plans are of particular note.

Looking forward to the 2018 – 19 and the Quality Priorities whilst the commissioner supports the six overarching themes and the supporting detailed activities, the CCG would have appreciated the opportunity to be more involved in setting these priorities. It is acknowledged that there are a wide range of activities which should ensure that these activities reach into all areas of the trust, this is necessary to enable the trust to exit the Care Quality Commission Special Measures process that the trust has entered for the second time in recent years.

The commissioner can confirm the level of CQUIN (Commissioning for Quality & Innovation) payments for 2017 – 18. Moving into the 2018 – 19 contract year the commissioner expects a greater level of supporting information from the trust to enable a robust critical evaluation of the CQUIN Schemes which are designed to improve the quality & safety of patient care.

The commissioner confirms that to the best of our knowledge the accuracy of the information presented within the working draft of the Quality Account submitted is a true reflection of the quality delivered by Northern Lincolnshire & Goole NHS Foundation Trust based upon the information submitted to the commissioner and trusts Quality Contract Meetings.

The commissioner can confirm that this Quality Report has been critically appraised against the 2010 Quality Account Regulations and subsequent additions to the regulations in 2017 and 2018. The results of this appraisal have been issued to the trust.

NHS Lincolnshire East Clinical Commissioning Group looks forward to working with the Trust over the coming year to further improve the quality of services available for our population in order to deliver better outcomes and the best possible patient experience.

Annex 1.2: Statement from Healthwatch organisations

Feedback from:
Healthwatch North Lincolnshire
Healthwatch North East Lincolnshire
Healthwatch East Riding of Yorkshire

Healthwatch North Lincolnshire, North East Lincolnshire & East Riding of Yorkshire accept the Quality Accounts for the forthcoming year and acknowledge the key priorities that the North Lincolnshire and Goole Trust have identified to focus on.

In addition to this Healthwatch jointly applaud the efforts of the Trust to improve identified concerns within the organisation that as a result have been improved over the last twelve months.

The Trust appear to be open to improvement and have made it a priority to listen to the views

of the public and their staff in a bid to improve.

Healthwatch Lincolnshire

Healthwatch Lincolnshire would like to thank you for sharing your Trust Quality Account for our representative's consideration and comment. We support the response you have already received from our Healthwatch colleagues in North Lincolnshire, North East Lincolnshire and East Riding of Yorkshire.

Healthwatch Lincolnshire share all relevant patient experiences we receive with NLAG and thank you for your responses to these which are generally returned to us within our 20 day working day requirement. Your responses are shared in turn with the patient or carer who raised the issue, in many cases this provides them with a level of closure they may not otherwise receive. We believe learning through patient feedback and experiences is an essential part of any service improvement and acknowledge your Trusts work to better assess what has occurred using case records, investigations and patient and carer feedback from many sources. We consider it important to include actions that are being implemented to demonstrate how this learning is being used.

Going forward Healthwatch Lincolnshire would welcome better communications with your Trust to enable us to adequately respond and represent the West and East Lincolnshire patients accessing your services.

Annex 1.3: Statement from local council overview and scrutiny committees (OSC)

Feedback from:
North Lincolnshire Council – Health Scrutiny Panel's Quality Accounts comments for Northern Lincolnshire and Goole NHS Foundation Trust

North Lincolnshire Council's Health Scrutiny Panel welcomes the opportunity to comment as part of Northern Lincolnshire and Goole NHS Foundation Trust's (NLG) Quality Account. NLG are a key partner and provider of local services, and members have built a valuable working relationship with Trust personnel over many years. Our day-to-day contact with the Trust is always handled in a timely, professional manner, and NLG representatives have always expressed a willingness to provide information and assist with specific issues. The panel would wish to pass on our sincere appreciation for this.

As stated in the comments submitted for several years now, the panel remains deeply concerned about the Trust's overall performance in many areas. This view is supported by the findings of the April 2017 CQC reports, the subsequent move back into special measures, and the worrying performance across many key indicators. For example, performance on most waiting time indicators are acknowledged by the Trust to be wholly unacceptable, and many have been deteriorating further in recent months. Whilst we understand that there are elements to this that are beyond the Trust's control, we remain concerned on behalf of our local community. Examples, such as the large number of patients waiting more than a year for treatment, are worrying to all. Despite this, the panel does note that there have been some successes across the Trust. We would wish to pass on our appreciation for the hard work of the urgent and emergency care teams in meeting the 90& 4-hour target in Quarter 3, and the oncology team in reducing the number of patients waiting longer than 104 days from referral to treatment.

In general terms, the panel has been concerned for a number of years about the Trust's seeming inability to improve in any meaningful, strategic manner. We have clear evidence of many actions being led by the Trust to improve; however, in general terms, it is not always clear to the panel that these actions result in genuine or measurable improvements. When this, coupled with the vacancy rate (particularly medical staffing), deteriorating staff morale,

and the Trust's sizeable financial deficit (including the accompanying requirement for significant savings throughout 2018/19 and beyond), the panel is concerned that the situation may deteriorate further, and whilst we are naturally aware of ongoing, large-scale work to review the acute sector across Humberside, we have yet to see any meaningful evidence that this will address the serious concerns about the Trust's performance and sustainability.

As described during each of the panel's submissions since 2014/15, and prior to this, set out in the panel's June 2013 scrutiny report on this subject, members remain concerned regarding the lack of progress on reducing the SHMI rate. Indeed, in recent months the SHMI rate has deteriorated back into the 'higher than expected' banding. The SHMI has been reported quarterly since October 2011, and mortality has been measured by the Trust using alternate models (HSMR/RAMI) for many years prior to this. However, there has been little evident improvement throughout this time. Measures planned and described to the panel to reduce the SHMI rate have been echoed since at least summer 2012, when the Trust agreed an action plan in response to an independent review of local mortality outcome performance. As such, we remain cautious about the likelihood of improvement, and reiterate that only a genuine whole-system approach to reducing mortality will overcome operational and organisational boundaries. Despite this, the panel welcomes the drive and enthusiasm shown by the Clinical Leads and the Acting Medical Director to reinvigorate work on this crucial issue, and we look forward to monitoring progress closely, beginning with the June 2018 data release.

The panel generally welcomes the quality priorities agreed by the Trust and set out within the Quality Account. In particular, the panel fully supports the prioritisation given to ensuring safe emergency care and maternity care. It is clear to us that ensuring the safe, sustainable and continued delivery of these crucial services within North Lincolnshire should be a priority to the Trust and the local health economy more widely.

For several years now, the panel has noted with concern the findings from the Annual Staff Survey. We stated in our comments from 2016/17 that

> *"As in previous years, we note with serious concern the feedback on the number of staff who would recommend the organisation as a place to work or receive treatment. It is deeply troubling that nearly half the staff working in the Trust would not recommend it as a provider of care to their family and friends. We believe that the lack of progress in this key area is again indicative of an organisation that struggles to improve".*

We therefore note with serious unease that the 2017 survey shows a continued and statistically significant deterioration in many areas, and particularly on this measure. Trust representatives have reiterated statements to the panel for several years that the organisation has 'invested heavily' in work to engage with staff. However, this appears not to be having any meaningful impact. Indeed, the staff engagement indictors (KF1) have significantly worsened, from an already low base, and remain in the bottom quintile. Most worrying to the panel though is the result of Q21.d, with a *minority* (47%) of staff willing to state that 'if a friend or relative required treatment, they'd be happy with the standard of care provided by the Trust'. Given the national median is 71%, and local performance has deteriorated by 8%, we are deeply concerned. Naturally, when a majority of staff, including front-line staff who understand the real-life situation better than anyone, would not recommend the Trust then this is deeply concerning. Nevertheless, we do note the frank admission by the Chief Executive that urgent improvements are necessary and understand the actions that are underway to address this. We look forward to receiving updates and indicate that the panel intends to monitor this issue closely, given the correlation between staff morale and the long-standing issues of retention and recruitment. Clearly, significant improvements are required in the coming months. The panel has passed on our concerns to commissioners, and would expect that a co-ordinated approach to addressing these damning results be agreed urgently.

Despite the above concerns, we do note that several key figures in the Trust's senior leadership team are relatively new in post and will require a period of time to steer the Trust out of special measures and towards delivering improved services. However, we believe that the local residents who help to fund these senior roles should now be seeing these genuine and substantial improvements.

We also note that many issues that have concerned the panel throughout 2017/18 (such as the 'missed referrals') were identified because of reviews of historic working practices. We further believe that Trust representatives are earnest in their desire to improve the services delivered to local residents. However, we firmly believe that 2018/19 is a pivotal year for the Trust to begin to deliver on long-standing promises to improve. We look forward to seeing evidence of this much-needed progress in the coming year.

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 2017/18.

The Sub-Committee welcomes the quality priorities set for 2018/19 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.

While the Sub-Committee welcomes the Trust's plans for improvement, it remains deeply concerned for the Trust's patients in the context of the Trust's continued rating by the CQC and the Trust's ability to deliver sustainable improvements during the previous few years.

Comments:

- The Sub-Committee was pleased to read in the introduction an open and honest acknowledgement of the Trust's ongoing issues and commitment to improvement from the Chief Executive.
- At the meeting of the Health, Care and Wellbeing OSC held on 17 April 2018, the Sub-Committee was pleased to hear that the Trust is engaged in a programme of reviewing cases of mortality (in-hospital and within 30 days of discharge) to identify how the quality of care can be improved and was encouraged to note that these reviews had shown that care, on the whole, was of a high quality in each case. The Sub-Committee remains concerned, however, that SMHI is 'higher than expected'.
- The Sub-Committee welcomes the Trust's intentions to address staffing issues and applauds its efforts to improve recruitment and retention of registered nurses. Councillors are keen to see the Trust address the decline in staff morale as staff members are the most important resource for any NHS trust; these are the people who will affect the changes the Trust desperately needs to make.
- A&E wait times are decreasing following a difficult winter but the Sub-Committee remains concerned that the target of treating 90% of patients within four hours was only met in Quarter 3. The Sub-Committee is keen to see the Trust address this and would encourage more ambitious targets in future (95%).
- The Sub-Committee is pleased to see that the percentage of patients with incomplete RTT pathways waiting less than 18 weeks from referral has been identified as an area for improvement. This had dropped to 68.06% (under a target of 92%) in February 2018 following a steady decline throughout the year. Similarly, the peaks and troughs for the percentage of cancer patients receiving treatment within 62 days throughout the year is a cause for concern which must be addressed.
- The Sub-Committee is also please to read that patient safety will be prioritised as the number of patient safety incidents has risen in recent years from 41.5 per 1000 in

2014 to 52.3 in 2017.

North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel

The Trust has shared the draft quality account with the North East Lincolnshire Council – Health, Housing and Wellbeing scrutiny panel, but due to local election commitments and the period of purdah, no formal meeting was possible to discuss the contents and no comments have been made on the content of the report by the committee for inclusion in the Trust's quality account.

Lincolnshire – Health Scrutiny Committee for Lincolnshire

The quality account was shared with the Health Scrutiny Committee for Lincolnshire. For 2017/18 quality accounts, the committee has concentrated on the draft quality accounts of Lincolnshire-based providers, so were unable to make a statement on the draft quality account of Northern Lincolnshire and Goole NHS Foundation Trust.

Annex 1.4: Statement from the Trust governors'

Feedback from:
The Governors Quality Review Group, from the chair of the group

The Council recognises that the Trust Board has, in the face of extraordinarily difficulties, enhanced the focus on quality throughout the Trust during the year through the introduction of innovative quality improvement initiatives including the "Improving Together" and "Listening into Action" programmes.

The Council is also clear that the introduction of such initiatives and work streams, together with the implementation of procedural improvements stemming from them, would not have been possible without the outstanding commitment and support of Trust's staff, and the Council is deeply grateful to all members of staff for this.

It is encouraging to note that the Trusts quality priorities for 2018/19 are related to patient safety and also to ensuring that patients' experience of care within the Trust is positive. In turn, these priorities are clearly linked to CQC inspection criteria, helping to ensure that there is a systematic framework for addressing CQC quality improvement targets for the Trust. The continuance of detailed root cause analysis around mortality and RTT waiting times and the improvement in A&E waiting time performance are all welcomed.

The Council notes that there have also been changes to the Trust board Committee structure and the clear alignment of non-executive Directors' responsibilities with the new committees' terms of reference. The Quality and Safety Committee now oversees all aspects of quality reporting within the Trust, and helps to provide comprehensive assurance to the Governor Quality Review Group and to the Council of Governors that the focus on quality and safety continues to strengthen.

Annex 1.5: Response from Trust to stakeholder comments

The Trust have received stakeholder comments and have welcomed the opportunity to discuss the contents of this report. No changes to the structure or content of the report have been made following consultation. Any constructive feedback will be reviewed for inclusion in the Trust's approach to strengthened quality governance arrangements, as outlined within this report and underpinned by the Trust's Quality Improvement Priorities for 2018/19.

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 Improvement has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support the data quality for the preparation of the quality report.

In preparing the Quality Report, directors are required to take steps to satisfy themselves that:

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2017/18 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 2017 to the 17 May 2018
    - Papers relating to quality reported to the board over the period April 2017 to 17 May 2018
    - Feedback from commissioners dated 08 May 2018 and 14 May 2018
    - Feedback from governors dated 01 May 2018
    - Feedback from Local Healthwatch organisations dated 02 May 2018 and 09 May 2018
    - Feedback from Overview and Scrutiny Committees dated 30 April 2018 and 03 May 2018
    - The trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 29 May 2018
    - Latest national patient survey 2018
    - Latest national staff survey 2018
    - The head of internal audit's annual opinion of the trust's control environment dated 15 May 2018
    - CQC inspection report dated 6 April 2017.
- The Quality Report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate; except in the case of waiting list information, where the Trust's internal scrutiny and review has identified that reported waiting list data did not provide a true picture of performance;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The majority of data underpinning the measures of performance reported in the Quality Report are robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review. From these internal controls and scrutiny and review of data during 2017/18, the Trust determined that the waiting list data did not provide a true picture of the Trust's waiting list position. The directors are confident that the extent of the data quality issues are being understood and a robust and reliable plan of action is in place to ensure the required data quality standards and prescribed definitions for waiting list data are adhered to and are assured that progress in this area will be reported to directors of the board; and

- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Report.

By order of the Board

23/5/2018 Date ..... Chair

22/5/2018 Date ..... Chief Executive

Annex 3: Independent auditor's report to the Board of Governors on the Annual Quality Report

Independent Auditors' Limited Assurance Report to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust to perform an independent assurance engagement in respect of Northern Lincolnshire and Goole NHS Foundation Trust's Quality Report for the year ended 31 March 2018 (the 'Quality Report') and specified performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2018 subject to limited assurance (the "specified indicators") marked with the symbol Ⓐ in the Quality Report, consist of the following national priority indicators as mandated by NHSI:

Specified Indicators	***Specified indicators criteria*** (exact page number where criteria can be found)
Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period.	Criteria can be found on page 92 of the Quality Report
Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.	Criteria can be found on page 92 of the Quality Report

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the specified indicators criteria referred to on pages of the Quality Report as listed above (the "Criteria"). The Directors are also responsible for the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") and the "Detailed requirements for quality reports for foundation trusts 2017/18" issued by Monitor (operating as NHS Improvement) ("NHSI").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- The Quality Report is not consistent in all material respects with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria set out in the FT ARM and the "Detailed requirements for external assurance for quality reports for foundation trusts 2017/18".

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with the following documents:

- Board minutes for the period April 2017 to the date of signing the limited assurance report (the period);
- Papers relating to quality reported to the Board over the period April 2017 to the date of signing the limited assurance report;
- Feedback from the Commissioners (North East Lincolnshire, North Lincolnshire, East Riding of Yorkshire and Lincolnshire East CCGs) dated 08/05/2018;

- Feedback from Governors dated 20/04/2018;
- Feedback from local Healthwatch organisations (East Riding of Yorkshire Healthwatch, Healthwatch Lincolnshire, North Lincolnshire Healthwatch and North East Lincolnshire Healthwatch) dated 02/05/2018;
- Feedback from the Overview and Scrutiny Committee (North Lincolnshire Council – Health Scrutiny Panel, North East Lincolnshire Council – Health, Housing and Wellbeing Scrutiny Panel, East Riding of Yorkshire Council – Health, Care and Wellbeing Overview and Scrutiny Sub-Committee and Health Scrutiny Committee for Lincolnshire) dated 03/05/2018, 01/05/2018, 27/04/2018, 23/04/2018;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 06/05/2018;
- The latest national patient survey dated January 2018;
- The latest national staff survey dated 27/03/2018;
- Care Quality Commission inspection report, publish date 15/06/2017; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated 16/05/2018.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information.

Our Independence and Quality Control

We applied the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics, which includes independence and other requirements founded on fundamental principles of integrity, objectivity, professional competence and due care, confidentiality and professional behaviour].
We apply International Standard on Quality Control (UK & Ireland) 1 and accordingly maintain a comprehensive system of quality control including documented policies and procedures regarding compliance with ethical requirements, professional standards and applicable legal and regulatory requirements.

Use and distribution of the report

This report, including the conclusion, has been prepared solely for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust as a body, to assist the Council of Governors in reporting Northern Lincolnshire and Goole NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2018, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Northern Lincolnshire and Goole NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board ('ISAE 3000 (Revised)'). Our limited assurance procedures included:

- reviewing the content of the Quality Report against the requirements of the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18";
- reviewing the Quality Report for consistency against the documents specified above;
- obtaining an understanding of the design and operation of the controls in place in relation to the collation and reporting of the specified indicators, including controls over third party information (if applicable) and performing walkthroughs to confirm our understanding;

- based on our understanding, assessing the risks that the performance against the specified indicators may be materially misstated and determining the nature, timing and extent of further procedures;
- making enquiries of relevant management, personnel and, where relevant, third parties;
- considering significant judgements made by the NHS Foundation Trust in preparation of the specified indicators;
- performing limited testing, on a selective basis of evidence supporting the reported performance indicators, and assessing the related disclosures; and
- reading the documents.

A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different but acceptable measurement techniques which can result in materially different measurements and can impact comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and "Detailed requirements for quality reports for foundation trusts 2017/18"and the Criteria referred to above.

The nature, form and content required of Quality Reports are determined by NHSI. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different NHS Foundation Trusts.

In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Northern Lincolnshire and Goole NHS Foundation Trust.

Basis for Disclaimer of Conclusion – incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period

The 18 week indicator is calculated each month based on a snapshot of incomplete pathways and reported through the Unify2 portal. On detailed analysis of the dataset data integrity issues have been identified.

Open pathways have been omitted from snapshots and illogical workflows have been identified that lead to exclusion of the patient pathway from the dataset. This leads to significant data integrity and completeness issues and therefore no assurance can be given that the dataset is a complete representation of all patient pathways within the reporting period.

As a result of the matter described above, we were not able to obtain sufficient appropriate evidence to provide a basis for a limited assurance conclusion on this indicator.

Basis for Disclaimer of Conclusion – patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

No supporting clinical documentation was available for patients to support the time of admission, transfer or discharge (clock stop) within the tested sample. As a result, the Trust's performance against the indicator cannot be determined as appropriate.

In addition from our testing of amendments to clock stop dates we noted that for the majority of the sample validators have amended patients from breach to non-breach without appropriate clinical documentation to support or verify the new A&E wait time. For the two sampled items where supporting documentation was available it was noted that both should have been in breach but had had the clock stop date incorrectly amended from a breach to a non-breach position. This is not in line with the NHS England Guidance: 'A&E Attendances and Emergency Admissions Monthly Return Definitions November 2015' >> www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2015/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf

As a result of the matter described above we were not able to obtain sufficient appropriate audit evidence to provide a basis for a limited assurance opinion on this indicator.

Conclusion including Disclaimer of Conclusion on 'incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator' and 'patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge'.

Because of the significance of the matter described in the 'Basis for Disclaimer of Conclusion - incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period' we have not been able to form a conclusion on the incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period indicator.

Because of the significance of the matter described in the 'Basis for Disclaimer of Conclusion - patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge' we have not been able to form a conclusion on patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge.

Nothing has come to our attention that causes us to believe that, for the year ended 31 March 2018:

- The Quality Report does not incorporate the matters required to be reported on as specified in the FT ARM and the "Detailed requirements for quality reports for foundation trusts 2017/18"; and
- The Quality Report is not consistent in all material respects with the documents specified above.

PricewaterhouseCoopers LLP
Chartered Accountants
Central Square
29 Wellington Street
Leeds
LS1 4DL

24th May 2018

The maintenance and integrity of the Northern Lincolnshire and Goole NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

Annex 4: Glossary

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".

Standardised Mortality Ratios (SMRs) – which ones are used by the Trust?

There are a number of different standardised mortality ratios (SMR) in use throughout the United Kingdom. Historically, this has made understanding and benchmarking an NHS Trust's performance against mortality indicators very difficult. As a result the NHS commissioned an 'official' standardised mortality ratio called the Summary Hospital Mortality Indicator or SHMI.

As this is the 'official' NHS mortality indicator of choice, it is calculated using a strict methodology then ensures all NHS organisations are measured in the same way using the same indicators. Interestingly, in the calculation of 'expected mortality' the SHMI does not adjust for regional deprivation levels.

Unlike other SMRs, the SHMI includes deaths in the community up to 30 days following a person's discharge from hospital. So whilst SHMI contains the word 'hospital' in the title, this signifies that the patient admission to the hospital is the index date on which the SHMI operates covering that in-hospital episode and the 30 days immediately following discharge. Mortality outside of hospital is not covered by SHMI if no hospital contact is made. SHMI is only calculated for those patients having hospital contact.

SHMI should therefore be viewed as a wider healthcare community mortality indicator, not solely a reflection of the hospital Trust.

Another key note of importance is that SHMI (or any other SMR) should not be misunderstood to be a measure of quality of a healthcare system or be interpreted to mean that a SHMI indicator above 100 means that there is evidence of 'avoidable' deaths. National guidance stresses that a raised (or lowered SHMI) should be used as a smoke alarm, to investigate and understand in greater detail.

As a result of the SHMI including community mortality within the indicator, it is based not only on in-hospital recorded data but on information from the Office for National Statistics (ONS). This introduces a significant delay in publishing information on the healthcare community. As a result, when SHMI information is published each quarter, the time frame included within the report is between six and 18 months out of date. To illustrate this, in January 2016, the SHMI was published focusing on the time frame of July 2014 – June 2015. Therefore while the SHMI is a useful tool to aid the Trust's understanding of this important area, it has struggled to use this effectively in order to monitor ongoing performance due to the significant time lag in reporting.

What is Healthcare Evaluation Data (HED)

As a result of the time lag in reporting of SHMI, the Trust has purchased an additional information toolkit from the University of Birmingham Hospitals NHS Foundation Trust, called Healthcare Evaluation Data (HED).

HED uses the same methodology as the official SHMI, but enables a much more recent timeframe to be reported. The official SHMI publication in January 2016 reported data up to June 2015, the HED information reports data to the end of October 2015. As it is not the official SHMI indicator, it is treated by the Trust as a 'provisional' SHMI indication, but from rigorous reconciliation work, it has proved to be an accurate data source that reflects the official SHMI on publication.

As a result of this, the Trust uses both the official SHMI and the HED provisional SHMI indication as markers of performance.

Acuity: Defined as the severity of a patient's condition (physical or psychological) and the intensity and complexity of care and corresponding workload required by a patient/group of patients) on the Trust's healthcare professionals.

Commissioning for Quality & Innovation Framework (CQUIN): The CQUIN payment framework enables commissioners to reward excellence, by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals. Since the first year of the CQUIN framework (2009/10), many CQUIN schemes have been developed and agreed. This is a developmental process for everyone and you are encouraged to share your schemes (and any supporting information on the process you used) to meet the requirement for transparency and support improvement in schemes over time.

Friends and Family Test – Methodology: The Trust introduced the new friends and family test in April 2014, when it was launched across the country. Within 48 hours of receiving care or treatment as an inpatient or visitor to A&E, patients are given the opportunity to answer the following question:

"How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?"

Service users are then asked to answer how likely or unlikely along a six-point scale they would answer the above question. There is also an opportunity to elaborate on the reasons for their answer and all feedback will be encouraged whether positive or negative.

'Positive feedback' defined as the percentage of patients/service users answering 'extremely likely' and 'likely'

Patient Experience: This Trust has set the goal of being the hospital of choice for our local patients. Being the hospital of choice is a far different thing than being the hospital of convenience, proximity or default. We measure patient experience using methodologies employed by the NHS National Patient Experience Survey against two key indicators to help us determine that

our hospitals are the ones our patients would choose if the practical factors were removed.

The Trust uses *The Menu Card Survey* which asks five questions relating to patient experience and is attached to inpatients' menu cards. It measures the patients' experience in real time. The questions asked are all derived from questions that feature in all National Patient Surveys.

The scores depicted in the graphs reflect an absolute figure generated by this methodology (in short – high score is good, 100% would be the maximum achievable score).

Rate per 1000 bed days: So we can know if we are improving even if the number of patients we are caring for goes up or down, we also calculate an average called 'rate per 1,000 occupied bed days'. This allows us to compare our improvement over time, but cannot be used to compare us with other hospitals, as their staff may report in different ways, and their patients may be more or less vulnerable than our patients.

Readmission Rate (RA): This measure shows the percentage of patients who were readmitted to hospital as an emergency within one month of being discharged. It can serve as an indicator of the quality of care provided and post-discharge follow up. A low readmission rate is an indicator of the quality of care in that it reflects a healthy care balance. Where rates are low, patients do not have to come back to the Trust for care of the same complaint. Conversely, a high readmission rate potentially signals that an organisation is releasing patients home too soon or otherwise not addressing all elements of their clinical condition.

Safety Thermometer methodology for Acute Services:

The NHS Safety Thermometer provides the ability for 'a temperature check' of harm to be recorded. It did this by auditing on a point prevalence basis the care provided to patients on a given date each month. This point prevalence audit provided a 'snapshot' view of harm on that given day each month. It focusses on harm in four key areas:

- Pressure ulcers grades 2,3 & 4
- Falls – all falls reported, even if no harm occurred
- Catheter associated UTIs – those treated with antibiotics
- VTE – risk assessment, prophylaxis and treatment of DVT or PE

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.

Harm Free Care:

- Safety Thermometer enables the calculation of the proportion of patients who received harm free care. This is calculated by dividing the number of patients receiving harm free care (as the numerator) by the total number of patients surveyed (the denominator).
- Patients with more than one of the harms listed, will not be classified as harm free care and are thus not counted in the numerator. Patients recorded as having multiple harms are removed from the numerator in the same way as those with only one harm.

Proportion of patients with 'harm free' care:

- Those patients **without** any documented evidence of a pressure ulcer (any origin, category 2-4), harm from a fall in care in the last 72 hours, a urinary infection (in patients with a urinary catheter) or a new VTE (treatment started after admission).

Proportion of patients with 'harm free' care – new harms only:

- Those patients **without** any documented evidence of a **new** pressure ulcer (developed at least 72 hours after admission to this care setting, category 2-4), harm from a fall in care in the last 72 hours, a **new** urinary infection in patients with a urinary catheter which has developed since admission to this care setting, or a new VTE (treatment started after admission).

Venous Thromboembolism (VTE): VTE is a condition in which a blood clot (thrombus) forms in a vein. It most commonly occurs in the deep veins of the legs; this is called deep vein thrombosis. The thrombus may dislodge from its site of origin to travel in the blood – a phenomenon called embolism.

VTE encompasses a range of clinical presentations. Venous thrombosis is often asymptomatic; less frequently it causes pain and swelling in the leg. Part or all of the thrombus can come free and travel to the lung as a potentially fatal pulmonary embolism. Symptomatic venous thrombosis carries a considerable burden of morbidity, including long-term morbidity because of chronic venous insufficiency. This in turn can cause venous ulceration and development of a post-thrombotic limb (characterised by chronic pain, swelling and skin changes).

Annex 5: Mandatory Performance Indicator Definitions

The following indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the reporting period,
- Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer and discharge,
- Venous Thromboembolism (VTE) risk assessment.

Have been subject to external audit in line with the following criteria:

Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways:

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.

Detailed rules and guidance for measuring referral to treatment (RTT) standards can be found at http://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/rtt-guidance/

Detailed descriptor

E.B.3: The percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of the period

Numerator

The number of patients on an incomplete pathway at the end of the reporting period who have been waiting no more than 18 weeks

Denominator

The total number of patients on an incomplete pathway at the end of the reporting period

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (see Annex B: *NHS Constitution Measures)*.

Indicator format

Reported as a percentage

Percentage of patients with a total time in A&E of four hours or less from arrival to admission, transfer or discharge

Source of indicator definition and detailed guidance

The indicator is defined within the technical definitions that accompany *Everyone counts: planning for patients 2014/15 - 2018/19* and can be found at www.england.nhs.uk/wp-content/uploads/2014/01/ec-tech-def-1415-1819.pdf.

Detailed rules and guidance for measuring A&E attendances and emergency admissions can be found at https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/03/AE-Attendances-Emergency-Definitions-v2.0-Final.pdf.

Additional information

Paragraph 6.8 of the NHS England guidance referred to above gives further guidance on inclusion of a type 3 unit in reported performance:

- *We are an acute trust. Can we record attendances at a nearby type 3 unit in our return?*

- *Such attendances can be recorded by the trust in the following circumstances.*

    a) *The trust is clinically responsible for the service. This will typically mean that the service is operated and managed by the trust, with the majority of staff being employees of the trust. A trust should not assume responsibility for reporting activity for an operation if the trust's involvement is limited to clinical governance.*

    b) *The service is run by an IS provider on the same site as a type 1 unit run by the trust. This would need to be agreed by the parties involved, and only one organisation should report the activity.*

Where an NHS foundation trust has applied criterion (b) and is including type 3 activity run by another provider on the trust site as part of its reported performance, this will therefore be part of the population of data subject to assurance work.

In rare circumstances there may be challenges in arranging for the auditor to have access to the third party data in these cases. In this scenario the NHS foundation trust may present an additional indicator in the quality report which only relates to its own activity and have this reported indicator be subject to the limited assurance opinion.

Numerator

The total number of patients who have a total time in A&E of four hours or less from arrival to admission, transfer or discharge. Calculated as:

(Total number of unplanned A&E attendances) – (Total number of patients who have a total time in A&E over 4 hours from arrival to admission, transfer or discharge)

Denominator

The total number of unplanned A&E attendances

Accountability

Performance is to be sustained at or above the published operational standard. Details of current operational standards are available at: www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf (See Annex B: NHS Constitution Measures).

Indicator format

Reported as a percentage

Venous Thromboembolism (VTE) Risk Assessment
(https://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/05/NHS-England-VTE-Guidance-September-2016.pdf)

Data collection asks for the following items of information:

1. Number of adults admitted as inpatients in the month who have been risk assessed for VTE on admission to hospital using the criteria in the National VTE Risk Assessment Tool
2. Total number of adult inpatients admitted in the month

The percentage of adult inpatients, admitted within the month assessed for risk of VTE on admission is automatically calculated from items (1) and (2) and cannot be overwritten.

The mandatory data collection commenced in June 2010 and is ongoing until further notice. From April 2015 there will be a change to publication frequency from monthly to quarterly; providers will still be required to collect data monthly however they will only need to submit at the end of each quarter.

Data collection specifics:

- Completion: The "VTE Risk Assessment – Data Collection" must be completed and signed off by providers. A return is expected for each quarter covering each month of the quarter separately starting from April 2015.

- Submission: Data on VTE risk assessment for a particular month (running from 00:00 on the first day of the month to 23:59 on the last day of the month) should be collected for all three months in each quarter and uploaded onto UNIFY2 and signed off no later than 20 working days after the quarter end. The timetable covering the submission and publication dates are

available on UNIFY2.

- Sign off policy: Data collection should be signed off at provider level by the Chief Operating Officer/Director or their directly delegated officer. Commissioners are not required to sign off this collection.

- Revisions Policy: Revisions before the cut-off date for submission of data will be allowed, and can be made as many times as necessary. These revisions can be submitted in the normal way through UNIFY2. As stated above, this cut-off date will be 20 working days after the month end.
- Revisions after the cut-off date can also be made, but these must be done in liaison with Analytical Services in NHS England, by sending a revision request to england.vte@nhs.net, with details of the changes requested.

- Scope of this data collection: Adults admitted to hospital as inpatients need to be risk assessed according to the criteria set out in the 'National VTE Risk Assessment Tool'. Although NICE guidelines may differ for particular groups of patients (for example, medical vs surgery), all patients should be protected from avoidable illness or death from VTE.

- The risk factors for VTE identified in the National VTE Risk Assessment Tool link seamlessly to the risk factors and risk categories in NICE clinical guideline (CG92).This NICE guidance can be found at the following link: http://pathways.nice.org.uk/pathways/venous-thromboembolism

- The scope of this data collection is, therefore aligned with the current NICE guidance on VTE prevention and applies to both the numerator and denominator. This will be reviewed should NICE guidelines be updated in future.

- Within scope are adults (aged 18 and over at the time of admission) who are admitted to hospital as inpatients including:
    - surgical inpatients
    - inpatients with acute medical illness (for example, myocardial infarction, stroke, spinal cord injury, severe infection or exacerbation of chronic obstructive pulmonary disease)
    - trauma inpatients
    - patients admitted to intensive care units
    - cancer inpatients
    - people undergoing long-term rehabilitation in hospital
    - patients admitted to a hospital bed for day-case medical or surgical procedures
    - private patients attending an NHS hospital

- The Frequently Asked Question (FAQ) section gives more detail on handling the inclusion of patients in the data collection for two specific groups of patients:
    - the repeated risk assessment of regular day case attendees (FAQ 6)
    - permitted approaches to risk assessment for particular cohorts of patients (FAQ 7)

- Out of scope: The following specific groups of patients are not covered by NICE CG92 and are therefore outside the scope of this data collection:

    - people under the age of 18 at admission
    - people attending hospital as outpatients
    - people attending hospital emergency departments who are not admitted as inpatients
    - people who are admitted to hospital because they have a diagnosis or signs and symptoms of DVT or pulmonary embolism.