Northern Lincolnshire and Goole NHS Foundation Trust

AGENDA

A meeting of the Council of Governors
to be held on Thursday, 9 January 2025 at 14:00 to 17:00 hours
To be held via MS Teams - Join the meeting now

For the purpose of transacting the business set out below:

No.	Agenda item	Format	Purpose	Time
1. CORE BUSINESS ITEMS				
1.1	**Welcome and Apologies for absence** Sean Lyons, Group Chair	Verbal	Information	**14:00**
1.2	**Declarations of Interest** Sean Lyons, Group Chair	Verbal	Information	
1.3	**Minutes of the Previous Meetings held on 31 October 2024** Sean Lyons, Group Chair	Attached CoG(25)001	Approval	
1.4	**Urgent Matters Arising** Sean Lyons, Group Chair	Verbal	Information	
1.5	**Action Tracker – Public** Sean Lyons, Group Chair	CoG(25)002 Attached	Approval	
2. REPORTS AND UPDATES				
2.1	**Group Chair's Update** Sean Lyons, Group Chair	CoG(25)003 Attached	Information	**14:10**
2.2	**Group Chief Executive's Update** Jonathan Lofthouse, Group Chief Executive	CoG(25)004 Attached	Information	
2.3 2.3.1 2.3.2 2.3.3	**Lead Governor's Update** Ian Reekie, Lead Governor **To include:** • **Appointments and Remuneration Committee (ARC)** • **Membership and Public Engagement & Assurance Group Highlight Report (MPEAG)** • **Membership and Public Engagement & Assurance Group (MPEAG) Activity Report**	CoG(25)005 Attached No ARC meeting to report	Information / Assurance	
BREAK - 15:00 – 15:10				
3. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS				
3.1	**Audit, Risk & Governance Committees-in-Common (CiC) Highlight / Escalation Report** Simon Parkes, Non-Executive Director CiC Chair	No meeting since last CoG		
3.2	**Capital & Major Projects CiC Highlight / Escalation Report** Gill Ponder, Non-Executive Director CiC Chair	CoG(25)006 Attached	Assurance	**15:10**
3.3	**Performance, Estates and Finance CiC Highlight / Escalation Report** Gill Ponder, Non-Executive Director CiC Chair	CoG(25)007 Attached	Assurance	**15:20**
3.4	**Quality & Safety CiC Highlight Report / Escalation Report** Sue Liburd, Non-Executive Director CiC Chair	CoG(25)008 Attached	Assurance	**15:30**

3.5	**Workforce, Education & Culture CiC Highlight / Escalation Report** Julie Beilby, Non-Executive Director CiC Chair	CoG(25)009 Attached	Assurance	**15:40**
4.	**COG BUSINESS ITEMS**			
4.1	**Health Tree Foundation Update** Neil Gammon, Independent Chair Health Tree Foundation Trustees' Committee and Lucy Skipworth, Charity Manager	CoG(25)010 Attached	Information	**15:50**
4.2	**Finance Update** Philippa Russell, Deputy Group Chief Financial Officer	CoG(25)011 Attached	Information	**16:10**
5.	**OTHER**			
5.1	**Questions from Governors** Sean Lyons, Group Chair	Verbal	Information	**16:40**
5.2	**Questions from the Public** Sean Lyons, Group Chair	Verbal	Information	
5.3	**Items for Information / To Note (as per Appendix A)** Sean Lyons, Group Chair	Verbal	Information	
5.4	**Any Other Urgent Business** Sean Lyons, Group Chair	Verbal	Information	
5.5	**Matters to be escalated to the Trust Board** Sean Lyons, Group Chair	Verbal	Information	
5.6	**Council Performance, Meeting Reflection & Timings Review** Sean Lyons, Group Chair	CoG(25)012 Attached	Information	
6.	**DATE OF THE NEXT MEETING**			
6.1	The next meetings of the Council of Governors will be held on: Council of Governors Business Meeting Tuesday 25 February 2025 from 09:00 - 10:30 hours via MS Teams Council of Governors Business Meeting Wednesday 16 April 2025 from 14:00 - 17:00 hours Venue TBC			

APPENDIX A

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

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

5.3.	**Items for Information**		
5.3.1	Governors, Executive Directors, Non-Executive Directors and Other Directors Register of Interests	David Sharif, Group Director of Assurance	CoG(25)013 Attached
5.3.2	Board Assurance Framework (BAF)	David Sharif, Group Director of Assurance	CoG(25)014 Attached
5.3.3	Integrated Performance Report (IPR)	Adam Creeggan, Group Director of Planning & Performance	CoG(25)015 Attached
5.3.4	Acronyms & Glossary of Terms	Alison Hurley, Deputy Director of Assurance	CoG(25)016 Attached

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

- **Members should contact the Chair** as soon as an actual or potential conflict is identified. **Definition of interests -** A set of circumstances by which a reasonable person would consider that an individual's ability to apply judgement or act, in the context of delivering, commissioning, or assuring taxpayer funded health and care services is, or could be, impaired or influenced by another interest they hold. Source: NHSE - Managing Conflicts of Interest in the NHS
- In accordance with Standing Order 2.4.3 (at Annex 6 of the Trust Constitution), any Governor wishing to submit an agenda item must notify the Chair's Office in writing at least **10 clear days** prior **to the meeting at which it is to be considered.** Requests made less than 10 clear days before a meeting may be included on the agenda at the discretion of the Chair.
- Governors are asked to raise any questions on which they require information or clarification in advance of meetings. This will allow time for the information to be gathered and an appropriate response provided.

COUNCIL OF GOVERNORS BUSINESS MEETING

Minutes of the meeting held on Thursday, 31 October 2024
at 14:00 to 17:00 hours in the Main Boardroom at Diana, Princess of Wales Hospital and via MS Teams

For the purpose of transacting the business set out below:

Present:

<u>Core Members</u>:

Sean Lyons	Group Chair
Diana Barnes	Public Governor (virtual)
Mike Bateson	Public Governor
David Cuckson	Public Governor
Cllr Paul Henderson	Stakeholder Governor
David James	Public Governor (virtual)
Corrin Manaley	Staff Governor
Shiv Nand	Public Governor
Rob Pickersgill	Deputy Lead Governor (virtual)
Ian Reekie	Lead Governor
Caroline Ridgway	Public Governor
Dr Gorajala Vijay	Public Governor

<u>In Attendance</u>:

Julie Beilby	Non-Executive Director
Mark Brearley	Interim Group Chief Financial Officer
Stuart Hall	Associate Non-Executive Director
Alison Hurley	Deputy Director of Assurance
Linda Jackson	Trust Vice Chair
Sue Liburd	Non-Executive Director
Jonathan Lofthouse	Group Chief Executive
Ivan McConnell	Group Chief Strategy & Partnerships Officer
Simon Nearney	Group Chief People Officer
Gill Ponder	Non-Executive Director (virtual)
David Sharif	Group Director of Assurance
Dr Kate Wood	Group Chief Medical Officer
Suzanne Maclennan	Corporate Governance Officer (minutes)

Public Members:
Jenny Aspinwall

KEY
HUTH - Hull University Teaching Hospitals NHS Trust
NLaG – Northern Lincolnshire & Goole NHS Foundation Trust

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Group Chair, Sean Lyons, welcomed those present to the Council of Governors (CoG) Business Meeting which was held both in person and virtually via MS Teams. A particular welcome was extended to Mark Brearley, the new Interim Group Chief Financial Officer and Jenny Aspinwall who joined the meeting as a Trust member observer and would be a member of the CoG from 14 November 2024.

Alison Hurley provided details of apologies for absence for Public Governors' Kevin Allen, Paula Ashcroft and Jeremy Baskett, Staff Governor, Ahmed Aftab and Stakeholder Governor, Emma Mundey.

Apologies were also received for Amanda Stanford (Group Chief Nurse) and Simon Parkes, Non-Executive Director (NED).

1.2 Declarations of Interest

No declarations of interests were received in respect of any of the agenda items.

1.3 Minutes of the Previous Council of Governors Meetings:

1.3.1 Business Meeting 18 June 2024

The minutes of the Business Meeting held on the 18 June 2024 were received and accepted as a true and accurate record.

1.3.2 Annual Review Meeting 22 August 2024

The minutes of the Annual Review Meeting held on the 22 August 2024 were received and accepted as a true and accurate record.

1.3.3 Annual Members' Meeting 12 September 2024

The minutes of the Annual Members' Meeting held on the 12 September 2024 were received and accepted as a true and accurate record.

1.4 Urgent Matters Arising

Sean Lyons invited members to raise any matters requiring discussion not captured on the agenda. None were raised.

1.5 Action Tracker

The Council reviewed the Action Tracker and agreed the completed actions could be moved to the closed section following the meeting. The outstanding actions were discussed and it was agreed to update the Action Tracker as follows:

- A follow up e-mail be sent to Diane Lee requesting the Public Health data for Goole and Howdenshire and East and West Lindsey

- The CoG meetings 2025 review of timings and format was included in a report later on the agenda
- David Sharif reported the use of acronyms and jargon was an ongoing issue within meetings and was being addressed. Sean Lyons requested attendees raise a query if unfamiliar terminology was used
- Cllr Paul Henderson was scheduled to meet with Andy Haywood the following week to discuss patient feedback and what was already captured.

2. REPORTS AND UPDATES

2.1 Group Chair's Update

Sean Lyons provided a thorough overview of the report and advised that Jonathan Lofthouse would provide further details around the industrial relations. Questioned were then welcomed. None were received.

2.2 Group Chief Executive's Update

Jonathan Lofthouse took the report as read, provided a summary of the report and highlighted some key points.

It was reported the NHS Humber Healthcare Partnership, the Group for Northern Lincolnshire and Goole (NLaG) NHS Foundation Trust and Hull University Teaching Hospitals (HUTH) NHS Trust, was entering the Faster 20 programme having been identified to receive enhanced support to accelerate pathways of care for patients on general waiting lists with a focus on working adults. Further updates would be provided at future CoG meetings.

Jonathan Lofthouse was pleased to report the very complimentary and celebratory feedback from the Integrated Care Board (ICB) leadership team following extensive visits to the Emergency Departments (ED) at Diana, Princess of Wales Hospital (DPoW) and Scunthorpe General Hospital (SGH) in September.

Mark Brearley provided an update on the financial position and reported that month 6 was on plan, although there were risks in the second half of the year due to the cost improvement target. It was confirmed funding had been received for the industrial action and an allocation of cash to cover the in-year planned deficit aimed to achieve the break-even position by year-end.

Jonathan Lofthouse expressed appreciation to Simon Nearney and team along with the corporate nursing team for their long-term efforts in stabilising the nurse recruitment programme. These efforts had significantly reduced the previous high spend on bank and agency staff.

Jonathan Lofthouse highlighted that further industrial action was planned for NLaG with regards to 66 maternity support workers who had challenged their historic pay gradings. It was reported that financial reimbursement could be backdated to a certain point in time which was dictated by central guidance from NHS England (NHSE). A reasonable brokerage had been offered and disappointingly it remained unsettled at the time of reporting. It was anticipated further formal strike action from some of the maternity support workers would take place during November 2024. Dialogue remained open with both UNISON and the Advisory, Conciliation and Arbitration Service (ACAS) to reach a mediated settlement.

Jonathan Lofthouse then drew the Council's attention to the celebratory comments towards the end of the report for noting.

In response to questions raised by Ian Reekie it was reported by Jonathan Lofthouse that the options appraisal for the Goole and District Hospital (GDH) was being conducted internally by the Trust with the Integrated Care Board's (ICB's) knowledge. It was confirmed that GDH was built in 1984 with 176 bed spaces of which 31/32 were currently in use and over many years the infrastructure had deteriorated. Several options were available which were to do nothing, invest heavily, shrink the entity and/or allow for partner organisations to be based at GDH to maximise the facilities. Further discussions were due to take place at the Board Development session week commencing 4 November 2024 where a timeline and update on the diagnostic work would need to be agreed by the Board and shared with the ICB. It was anticipated the diagnostic element of work would be concluded by Christmas and by February/March 2025 a debate package would be available for statutory consultation. For the 291 staff currently working at GDH (of which many live in the locality), there will be two roadshows scheduled before Christmas to allow for discussions to take place. Ian Reekie requested engagement with local communities at the option development stage rather than presenting them with a consultation.

Rob Pickersgill queried whether the budget announcement from the Government would change the emphasis of the GDH issue. In response Jonathan Lofthouse thought it would not as the issue was not solely regarding facilities but also involved staffing and skill investment. It was reported that to ensure GDH met current safe standards it would require several millions of investment, a sufficient volume of patients and the correct number of staff to care for them. It was reported that the Goole conurbation had approximately 19,000 residents, and patients across the Group's geographical area were offered free transport to GDH to receive their treatment. Despite this the two theatres at GDH functioned at around 50-70% capacity most weeks. Jonathan Lofthouse reported that the Group would have an increase of £12.6 million as a result of the National Insurance announced in the budget.

Mike Bateson queried whether patients had been asked why they did not wish to attend GDH for their treatment. In response Jonathan Lofthouse confirmed the feedback had been that GDH was not viewed as an attractive proposition as it was simply too far for some patients and their relatives / visitors to travel even when a taxi was offered for patients. In addition, patients felt vulnerable in a hospital with few services available particularly if they became unwell out of hours. Dr Kate Wood reminded the Council that the number of beds at GDH was reduced due to the unacceptable mortality rates prior to 2017, which at it's peak was 156.

David Cuckson referred to two recent visits to GDH where it was identified that two patients were from Hull and it was queried whether the patient flow from Hull could be increased. Jonathan Lofthouse confirmed this could only be offered if the patients were clinically stable and advised that with the imminent opening of day case theatres at the Castle Hill Hospital (CHH), Hull patients were unlikely to select GDH.

Mark Brearley confirmed that GDH was offered as an option where feasible. Ivan McConnell reported that from the Goole area DN14 postcodes the inpatient attendance was 1,768 in a year, with 5,000 attending SGH, 262 DPoW, 2,000 to Hull Royal Infirmary (HRI) and 2,100 to CHH. Outpatient activity was reported as

very different with the majority of Goole residents attending GDH for ophthalmology, urology, trauma and orthopaedics. Ivan McConnell highlighted that the backlog maintenance at GDH was approximately £14.5-15 million and the improvements to meet healthcare fire standards would require £3.5 million. Ivan McConnell outlined further constraints which included the lack of high voltage power on the GDH site and the medical gas and medical air were out of commission and the contracts were out of date.

Shiv Nand requested reassurance regarding the demographic that may suffer from the Faster 20 programme and asked what funding was available. In response Jonathan Lofthouse advised as this was new further information and the context was not available yet although the Council would be updated once more information was available.

Sean Lyons reminded the Council that it was only a couple of years ago that the coal fired boilers at GDH were decommissioned which were possibly the last in the United Kingdom. Sean Lyons reassured the Council that discussions regarding GDH were highly sensitive and would be considered carefully, taking into account the constituencies interests, patients, staff and the public purse.

In response to a query regarding the ICB Maternity Services review Jonathan Lofthouse outlined the work had commenced three to four months ago and had progressed slowly to date. The review covered our entire ICB area which included Harrogate and District NHS Foundation Trust, York and Scarborough Teaching Hospitals NHS Foundation Trust, ourselves and the remote community services. It was confirmed that detailed statistics regarding staffing and population growth had been provided for Hull, Scunthorpe and Grimsby. Jonathan Lofthouse reported there was at least £10-12 million funding shortfall for maternity services across the ICB, further discussions were expected in January/February 2025.

In response to a query from Cllr Paul Henderson about the financial position of GDH, Jonathan Lofthouse confirmed the landmass and hospitalisation facility had a land value of £3.4 million, it was losing approximately £4 million per year and had a estates backlog calculated at £20 million. Sean Lyons reminded the Council that these figures should not be taken out of context as finances were only one aspect of considerations and there were several conversations required before any decisions would be made regarding the future of GDH.

Cllr Paul Henderson commended the work which had enabled the Trust to meet financial targets for the first half of the year (H1) and queried what was required to achieve the activity and revenue targets for H2. Jonathan Lofthouse confirmed that maximising the utilisation and performance of existing assets, such as equipment and infrastructure, in order to increase efficiency, productivity, and profitability was the key. Examples would be operating 5-6 days a week and long days where possible which would require 178 additional staff for new facilities. The focus was to reduce the long wait times to 52 weeks which was the new prescribed standard. The output of all the facilities across the Group were not currently maximised and could be improved by creativity and effectiveness. It was reported that £119 million worth of activity was outsourced to the private sector and largely undertaken by the Group's own staff. Patient pathways could be described in simple terms although they contained complex financial nuances within them.

2.3 **Lead Governor's Update**

Ian Reekie provided a summary of the report which was taken as read. The key points to note were:

- Willingness of local HealthWatch organisations to collaborate with Governors on Governor Drop-In engagement sessions was welcomed
- Ian Reekie urged Governor colleagues to be diligent in submitting intelligence regarding their individual engagement
- The CoG welcomed the re-appointment of Sean Lyons as the Group Chair from February 2025 for three years
- CoG virtual ratification for the appointment of Jule Beilby into the full NED role
- Request for Governor colleagues to express their interest in the Lead/Deputy Lead Governor roles along with vacancies within the Appointments and Remuneration Committee (ARC) and Membership and Public Engagement & Assurance Group (MPEAG)

A break took place at 15:10 hours and the meeting resumed at 15:20 hours.

3. BOARD COMMITTEES-IN-COMMON HIGHLIGHT / ESCALATION REPORTS

3.1 **Audit, Risk and Governance Committees-in-Common Highlight Report**

Sean Lyons reported that due to Simon Parkes' absence there would not be a summary of the report although welcomed any questions relating to the paper. None were received.

3.2 **Capital and Major Projects Committees-in-Common Highlight Report**

Gill Ponder highlighted three key points from the report beginning with the referral to the Secretary of State regrading the Humber Acute Services review (HASR) processes. The Committees were assured that planning for implementation could continue unless the Secretary of State called it in. The Committees had requested further information on the electronic patient record (EPR) project, specifically on the planned benefits realisation and the mandatory Windows 11 upgrade noting that many pieces of equipment across the Trust were not capable of supporting Windows 11.

Ian Reekie queried why there was no system in place for direct referrals from GP's to the Community Diagnostic Centres (CDC). Ivan McConnell confirmed that the Trust was the lead provider for the system and that referrals would go through to the CDC via one of the Trust's systems. The GP's were required to use a system called ICE which they had so far refused to use due to GP collective action. It was reported that the ICE system was interoperable with Trust systems which sits on a CDC waiting list and not an acute patient tracking list (PTL).

3.3 **Performance, Estates and Finance Committees-in-Common Highlight Report**

Gill Ponder reported on the limited assurance received for the financial plan and cost improvement plan (CIP) due to increased challenges in H2. There was optimism that mitigations would lead to improved performance with focus on increased elective recovery income and improved productivity. Performance initiatives were reported as underway although the Committee received limited

assurance due to the lack of evidence of sustained improvement. The Emergency Department (ED) performance continued to cause concern, although some improvements had been evident. Gill Ponder reported the Committee conducted a deep dive into waiting lists, noting a significant increase in GP referrals, particularly for urgent suspected cancer. It was noted these referrals were not leading to an increase in cases which required treatment. The trajectory and target had been missed for cancer performance overall and performance had dipped over the summer against the 28-day faster diagnosis standard which had been, particularly in breast and skin cancer diagnoses due to workforce issues. The Committees received assurance these issues were being addressed.

Mike Bateson queried how the unidentified gap in the CIP would be addressed and resolved and whether this was linked to the GDH review. Gill Ponder confirmed the unidentified gap was a recurring theme and had been since the beginning of the year. It was reported the gap had been closed and further work was in progress to identify what income or cost cutting exercises could further close the gap. Additionally, work with PA Consulting was underway to identify opportunities to ensure the plan was met by the end of the year.

3.4 **Quality and Safety Committees-in-Common Highlight Report**

Sue Liburd provided a summary of the report which was taken as read. It was reported that the Committee continued to monitor the dispute over pay for the Maternity Support workers at DPoW which had been discussed earlier in the meeting. It was noted that the NLaG Summary Hospital Level Mortality Indicator (SHMI) was the lowest it had been on record. Dr Kate Wood reminded the Council that in 2017 the Trust was in the bottom ten Trusts in the country for SHMI levels and had for the last three years sustained the ‘as expected’ range. It was reported this was due to a number of structures and cultural changes which had been implemented. The final point highlighted by Sue Liburd was the increase in C-Difficile rates with ongoing work in terms of infection control, hygiene practices and re-educating staff.

Shiv Nand requested further information on the lower infection rates noted in established outpatients departments such as at GDH. Dr Kate Wood reported that in pure elective settings infection rates would be lower due to the lower length of stay. Patients who remained in hospital for longer periods or who had chronic illnesses were more susceptible to pressure ulcers, chest infections and deep vein thrombosis for example.

David Cuckson questioned whether face masks should be readily available at the hospital entrances. Dr Kate Wood confirmed that national guidance did not require facemasks to be available although if they were requested then the Trust would be very happy to provide them.

3.5 **Workforce, Education and Culture Committees-in-Common Highlight Report**

Sue Liburd provided the key points from the report which included CDC staffing, raised at the CoG Annual Review Meeting, learning and organisational development work and the aforementioned Maternity Support workers industrial action. The Committee were not assured on the progress of the Group culture and transformation work which had been discussed by the Trust Boards in September.

Cllr Paul Henderson queried the level of staff morale and whether there had been a noticeable rise in staff retention and absences. Simon Nearney reported that staff sickness was 6.5% 12 months ago and was now just over 5.1% and similarly staff turnover had reduced from 13% to 10%. It was highlighted that for around ten years NLaG had suffered challenges with staff feeling engaged and motivated, which has been further affected by the move to the Group. Simon Nearney highlighted the upcoming work within the next six months to address culture and engagement along with the new leadership programme.

Cllr Paul Henderson wondered what the external perception of the Trust was and whether this was affecting the ability to recruit. Simon Nearney reported that the overall vacancies for NLaG had reduced and as of November nursing would be fully established. There were difficulties in recruiting consultants and medics from overseas which required them to undertake a four-year programme.

Linda Jackson reflected on the last ten years at NLaG which had included challenges with the Care Quality Commission (CQC) interventions and the Trust having been in special measures. It was felt that over time this had benefited and united the staff and created a level of pride although with the introduction of the Group it meant working arrangements had changed and caused some grieving in the cultural change process. Sean Lyons summarised that the two Trusts had very different starting points and histories and the challenge was to unite all the staff through a cultural change.

Stuart Hall joined the meeting at 15:50 hours

David Cuckson queried whether any agency staff had joined the Trust as employees. It was confirmed by Simon Nearney that following a change in reporting mechanisms, agency staff were unable to easily work for the Trust and consequently joined the Trust in substantive posts.

4. COG UPDATES

4.1 Integrated Care System (ICS) Working – including Place, the Collaborative of Acute Providers and Integrated Care Board (ICB)

Jonathan Lofthouse advised this was not a routine paper and was in response to a request to reflect on collegiate activities across the ICS and Collaborative of Acute Providers. The report was taken as read and Jonathan Lofthouse highlighted two programmes where the CoG and members of the public could engage:

- The ICB led ‘We Need to Talk’
- The national conversation called ‘Change NHS’.

Sean Lyons re-iterated the opportunity for Governors to participate.

Ian Reekie requested some indication of the scale of high intensity usage of NLaG services and any specific initiatives being considered to mitigate this following a debate at the August 2024 ICB meeting regarding management and support of vulnerable patients. Jonathan Lofthouse provided a broad Group perspective and reported that any patient who visited the Emergency Department (ED) five times a year was classified as a frequent attender. Across the ICS this had identified around 300-325 patients as frequent attenders and a collective piece of work was

ongoing to establish the reasons for frequent attendance. It had provided a greater understanding for a collective approach to resources and monies.

4.2 **Culture and Leadership Transformation**

Simon Nearney provided an overview of the presentation which covered the following:

- Darzi Report
- Culture dashboard figures
- Healthcare Assistants (HCA) - taster days available for this demanding physical and emotional role
- Administration staff – Buddy system in place and tailored induction programme
- Mandatory training currently at 90%
- Staff survey – NLaG below the national average
- Staff Charter
- Culture objectives and seven key actions agreed by the Trust Board

Caroline Ridgway requested further information on staff who had left the Trust within 12 months. Simon Nearney explained there was an exit interview process which was discussed regularly at the Workforce Transformation meetings although the main focus remained on the turnover of HCA's and administration staff.

Sean Lyons encouraged Governors to hold NEDs to account for the seven agreed culture objectives and actions, and to question where the Trust is over the coming months as needed.

Rob Pickersgill queried the cause of staff being disengaged and Simon Nearney reported that some of the Trusts services had grown by 10-20% in the last two years and staff were overwhelmed by the pressure and demand on these services coupled with a lack of resources. The aftermath of Covid-19 and joining together as Humber Health Partnership were also considered factors.

Corrin Manaley was pleased to hear there was a leadership programme and queried whether change management would be highlighted in the programme. Simon Nearney confirmed change management would be central to the programme which would require meaningful consultation.

Cllr Paul Henderson noted that half of the staff stated they would not recommend the facilities to friends and families and queried what was causing staff to have this perception of the services they provided and how this would be identified and monitored. Simon Nearney confirmed there would be three questions posed to staff every quarter with a target of 60% of staff answering them to create some staff metrics.

Sean Lyons highlighted slide nine in the presentation which provided the data for current culture values and desired culture values, confirming the need for the Trust to monitor whether staff feel rewarded, recognised and cared for to ensure they feel empowered. Alison Hurley reminded the Council that Governor drop-in sessions were a way of collecting vital feedback from staff with questions set in co-ordination with the People directorate.

Sean Lyons expressed sincere gratitude to Stuart Hall at his last CoG meeting before retirement from the Associate NED role. Stuart Hall noted the last ten years had been extremely beneficial and rewarding, thanked the Council for their kind thoughts and wished everyone well for the future.

Sean Lyons asked the Council to note that Karen Green had retired from the CoG due to personal reasons. Appreciation was extended to David Cuckson for three and half years as an NLaG Governor. In response David Cuckson expressed thorough enjoyment in the role and extended particular thanks to Alison Hurley and the Corporate Assurance team for their support of himself and the Governors. Similarly, appreciation was extended to Shiv Nand who had decided not to re-stand in the Governor election due to the in-person and daytime commitments required.

4.3 **Governor Elections and Extension to Governor Terms of Office**

Alison Hurley highlighted the results of the uncontested elections noted in the report and advised the Staff Governor ballot was ongoing and would be concluded on 13 November 2024.

Following approval by the Group Chair and Group Director of Assurance the Council were asked to approve the extension of Jeremy Baskett's term of office from May to November 2025 to coincide with the annual elections. The Council approved the extension.

Rob Pickersgill left the meeting at 16:28

Alison Hurley highlighted one vacant seat for Goole & Howdenshire due to Rob Pickersgill being at the maximum term of office of nine years. It was therefore recommended that the term of office for Rob Pickersgill be extended by 12 months. The Council were asked to approve this recommendation with a majority vote. The Council approved the extension.

Action:
- **Extend the term of office for Jeremy Baskett from May 2025 to November 2025**
- **Extend the term of office for Rob Pickersgill by 12 months to November 2025**

4.4 **Proposed Governor Induction and Mandatory Training Plans**

Alison Hurley highlighted that following feedback from new Governors in November 2023 it was reported the Trust induction was not fully relevant to Governors and a new Governor specific induction had been created. Sean Lyons and the MPEAG agreed to this approach and recommended approval by the CoG. The Council approved the Governor Induction programme.

Additionally, it was proposed that Governors completed the mandatory training in-line with Trust Volunteers via the e-Learning for Healthcare website. The Council approved the mandatory training via e-learning for Healthcare.

Action: The new Governor induction and mandatory training would commence from November 2024

4.5 **Lead/Deputy Lead Governor Plans**

Alison Hurley provided a summary of the report and the Council were asked to note the planned approach to appoint/elect the Lead and Deputy Lead Governors with interested Governors to provide a personal expression of interest for these roles if appropriate by Thursday, 7 November 2024.

Ian Reekie requested that the deadline for expressions of interest was delayed allowing new Governors to commence their term of office which would enable them to vote if necessary. The Council approved that expressions of interest would be sought from 14 November 2024.

Action: Request expressions of interest for the Lead/Deputy Lead Governor roles on 14 November 2024

5. OTHER

5.1 **Questions from Governors**

Sean Lyons welcomed any questions from Governors. None were received.

5.2 **Questions from the Public**

Sean Lyons welcomed any questions. None were received.

5.3 **Items for Information / To Note**

Sean Lyons drew the Councils attention to the items for information noted in Appendix A.

5.4 **Any other Urgent Business**

No items were raised.

5.5 **Matters to be escalated to the Trust Board**

Ian Reekie requested that Governors concerns regarding the future of GDH were included at the Trust Board Development session. Sean Lyons confirmed they would be included in discussions.

5.6 **Council Performance, Meeting Reflection & Timings Review**

Alison Hurley provided a summary of the report which had arisen following an action raised at the CoG Annual Review Meeting in August 2024.

Shiv Nand reported that it had been difficult to attend meetings during the day whilst maintaining full time employment and hoped that there was consideration for holding meetings outside of working hours.

Sean Lyons confirmed a further survey would be emailed to Governors, Executives and NEDs who had yet to respond.

6. DATE AND TIME OF THE NEXT MEETING

6.1 Date and Time of the next Council of Governors meeting:

The next Council of Governors Business Meeting will be held on Thursday, 9 January 2025, at 14:00 – 17:00 hours in the Main Boardroom, Diana, Princess of Wales Hospital, Grimsby - TBC

The Group Chair thanked those present for their attendance and contributions and closed the meeting at 16:38 hours.

Cumulative Record of Governor’s / Executive’s and NED Attendance 2024/2025 - Public

Name	Possible	Actual	Name	Possible	Actual
Ahmed Aftab	5	3	Raquel Jakins	2	1
Kevin Allen	5	4	David James	5	3
Paula Ashcroft	5	2	Corrin Manaley	5	3
Diana Barnes	5	5	Emma Mundey	5	2
Jeremy Baskett	5	3	Shiv Nand	5	2
Mike Bateson	5	4	Anthonia Nwafor	5	0
Tony Burndred	1	0	Rob Pickersgill	5	4
David Cuckson	5	5	Ian Reekie	5	4
Karen Green	4	1	Caroline Ridgway	5	4
Paul Henderson	4	3	Dr Gorajala Vijay	5	2
David Howard	5	2			

Name	Possible	Actual	Name	Possible	Actual
Lee Bond	2	0	Simon Nearney	4	2
Mark Brearley	2	1	David Sharif	5	5
Paul Bytheway	3	1	Shaun Stacey	1	1
Jonathan Lofthouse	4	4	Amanda Stanford	3	2
Ivan McConnell	4	3	Dr Kate Wood	4	3

Name	Possible	Actual	Name	Possible	Actual
Julie Beilby	5	5	Sean Lyons	5	4
Stuart Hall	5	3	Simon Parkes	5	4
Linda Jackson	5	3	Gill Ponder	5	4
Sue Liburd	5	4	Kate Truscott	3	1

Hull University
Teaching Hospitals
NHS Trust

Northern Lincolnshire
and Goole
NHS Foundation Trust

COUNCIL OF GOVERNORS
ACTION TRACKER

2024/25

ACTION TRACKER - CURRENT ACTIONS - 9 JANUARY 2025

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

COUNCIL OF GOVERNORS

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
COG(24)025	31/10/24	Lead/Deputy Lead Governor Plans	4.5	Request expresions of interest for the Lead/Deputy Lead Governor roles	Alison Hurley	Nov-24	Expressions of interest sought via email 14.11.24 and results announced 21.11.24	Complete	Emails
COG(24)024	31/10/24	Proposed Governor Induction and Mandatory Training Plans	4.4	New Governor induction and mandatory training would commence from November 2024	Alison Hurley/ Corporate Assurance Team	Nov-24	First Governor Induction sessions booked for 04.12.24 and 15.01.25 Mandatory training instructions and details emailed to Governors on 06.12.24	Complete	Emails and Induction sessions
COG(24)023	31/10/24	Governor Elections and Extension to Governor Terms of Office	4.3	Extend the term of office for: Jeremy Baskett from May 2025 to November 2025 Rob Pickersgill by 12 months to November 2025	Corporate Governance Officer	Nov-24	Confirmation emails sent to Jeremy Baskett and Rob Pickersgill on 06.11.24	Complete	Emails
COG(24)022	12/09/24	CoG AMM - Questions from the Public	4.1	Request for Public Health data for Goole & Howdenshire and East & West Lindsey	Diane Lee		Diane Lee provided the data which was emailed to Governors & NEDs on 06.11.24	Complete	Emails and links
COG(24)019	22/08/24	CoG ARM - Overarching themes from the CoG ARM Framework		Request preferences from EDs, NEDs and Governors on timings and format of 2025 CoG meetings	Corporate Governance Officer	Sep-24	Provide an overview of responses at the October CoG meeting. Follow up response requested 25.11.24 with outcome to be discussed with Sean Lyons and presented to CoG on 09.01.25		Email & MS Forms
COG(24)017	22/08/24	CoG ARM - Accountability	2.3	Highlight the overuse of acronyms and jargon to the Executive team	David Sharif	Aug-24	David Sharif to provide update at October 2024 CoG meeting - Ongoing reminders	Complete	
COG(24)015	22/08/24	CoG ARM - Engagement with Members and Stakeholders	2.1	Electronic surveys for feedback	Corporate Governance Officer	Sep-24	Cllr Paul Henderson met Andy Haywood to discuss requirements and options using existing tools. Andy Haywood to consult internally and meet Cllr Paul Henderson again in early 2025		Emails

Key:

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

ACTION TRACKER - CLOSED ACTIONS

Council of Governors

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
COG(24)021	22/08/24	CoG ARM - Any Other Urgent Business	4.2	Confirmed date of next CoG ARM for 2026 meeting schedule	Corporate Governance Officer	Aug-24	Advised Sarah Meggitt the next CoG ARM will be February 2026 for inclusion on meeting schedule	Complete	Email
COG(24)020	22/08/24	CoG ARM - Workforce, Education and Culture Committees-in-Common Highlight Report	3.5	Group culture update at the October CoG meeting		Oct-24	Added to the October agenda	Complete	Agenda
COG(24)018	22/08/24	CoG ARM - Conduct of Meetings	2.4	Clarify essential meeting attendance and requirements for Governors via email	Corporate Governance Officer	Sep-24	Governors emailed on 23.09.24 with an overview of Governor meetings and required attendance	Complete	Email
COG(24)016	22/08/24	CoG ARM - Accountability	2.3	Review and update the Aconyms and Glossary of Terms	Corporate Governance Officer	Sep-24	Reviewed and updated August 2024 v.8.8	Complete	Acronyms and Glossary of Terms
COG(24)014	22/08/24	CoG ARM - Engagement with Members and Stakeholders	2.1	Review Governor entries on the Castle database - Liaise with Comms regarding distribution of Members Newsletter	Corporate Governance Officer	Aug-24	All Governors remain members on the Castle database. Comms confirmed the distribution list was exported from the Castle database.	Complete	Castle database
COG(24)013	22/08/24	CoG ARM - Minutes of the Previous Meeting	1.3	Add Apologies for Jeremy Baskett to within the CoG ARM 2023 minutes	Corporate Governance Officer	Aug-24	Jeremy Baskett was already noted within the Apologies for the CoG ARM 2023 meeting.	Complete	Minutes
COG(24)012	18/06/24	Appointments and Remuneration Committee (ARC) Terms of Reference (ToR)	5.1	Further updates required followiong June CoG meeting	David Sharif	Jul-24	ARC ToR circulated virtually to ARC and CoG members for approval - Approved incoporating minor changes from comments received Added to October ARC agenda for information.	Complete	Emails
COG(24)011	18/06/24	Group Digital Developments	4.2	Andy Haywood to arrange Governor session following initial meeting with Karen Green	Andy Haywood	Oct-24	Digital Strategy Development session for Governors scheduled 9 October 2024	Complete	Emails & Diary invite
COG(24)010	18/06/24	Operational and Financial Plan 2024-25	4.1	Include Integrated Performance Report (IPR) as an item for information at CoG business meetings	Corporate Governance Officer	Oct-24	Added to the October agenda	Complete	Agenda

COG(23)18	13/07/23	Chief Executive Update	2.2	Arrange a Electronic Patient Records briefing session for Governors	Corporate Governance Office	TBC	* Report requested for distribution at 27th November 2023 briefing session. * Update deferred due to Integrated Care Board (ICB) investigation into awarded investment and outstanding decision on purchase and implementation. * Andy Haywood to present a Digital update at the June CoG to include EPR	Complete	Jan, April & June 2024 CoG minutes and June agenda
COG(24)09	18/04/24	Annual Governors Register of Interest	5.2	Forward Annual Governors Register of Interest to Communications for publication on the Trust website	Corporate Governance Office	May-24	Emailed to Communications on 22nd April and published on the Trust website	Complete	Email and website
COG(24)08	18/04/24	Performance, Estates and Finance Highlight Report	3.3	Provide Governors an update on signage within 7 days	Jonathan Lofthouse	May-24	Email update sent to all Governors on 5th June 2024	Complete	Emails
COG(24)07	11/01/24	Any Other Urgent Business	5.4	Provide an update on the Safekeeping of Patient's Cash, Valuables and Property Policy and associated staff training	Shaun Stacey	Apr-24	Emailed Shaun Stacey on 20.03.24 for a response. Shaun Stacey provided an update during the April CoG meeting and post meeting note in the minutes	Complete	Email and April Minutes
COG(24)06	11/01/24	Annual Governors' Register of Interest	4.3	Add updated Annual Governors' Register of Interest to April CoG agenda	Corporate Governance Office	Apr-24	Governor declarations approved by Corporate Governance within ROI system	Closed	ROI System & Emails
COG(24)05	11/01/24	Future Role of the Council of Governors and Governor Assurance Group	4.1	Add Membership and Public Engagement & Assurance Group (MPEAG) terms of reference to the first agenda of the group for approval and return to CoG for ratification	Corporate Governance Office	May-24	Added to the MPEAG draft agenda for the first meeting on 21st May 2024	Closed	MPEAG draft agenda
COG(24)04	11/01/24	Future Role of the Council of Governors and Governor Assurance Group	4.1	Seek expressions of interest for the Membership and Public Engagement & Assurance Group (MPEAG)	Corporate Governance Office	Feb-24	Invitations for expressions of interest requested from Governors on 23rd January 2024. Governors informed of the group members via email on 7th March 2024	Closed	Emails
COG(24)03	11/01/24	Chief Executive Update	2.2	Circulate Executive structure and Operational structure	Corporate Governance Office	Jan-24	Operational structure emailed to Governors on 16th January 2024 and Executive Structure emailed to Governors on 17th January 2024	Closed	Email
COG(24)02	11/01/24	Chief Executive Update	2.2	Humber Acute Services (HAS) proposal concerns and outcome of HAS consultation work	Linda Jackson	Jan-24	Response requested from Ivan McConnell and circulated to Governors following the meeting on 11th January 2024	Closed	Emails
COG(24)01	11/01/24	Chief Executive Update	2.2	Confirmation on the qualification required for the Group Chief Nurse vacancy	Shaun Stacey	Jan-24	Update provided by Shaun Stacey and emailed to Governors on 22.02.24	Closed	Emails

Key:

Grey	Completed - can be closed/archived following meeting

Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)003

Name of the Meeting	**Council of Governors**
Date of the Meeting	9 January 2025
Director Lead	Sean Lyons, Group Chair
Contact Officer/Author	Sean Lyons, Group Chair
Title of the Report	**Group Chair's Update**
Executive Summary	Briefing for the Council of Governors on the key highlights from the recent Trust Board and current issues
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Chair's Update

Chair's Report for Northern Lincolnshire & Goole (NLaG) NHS Foundation Trust Council of Governors meeting 9 January 2025

May I start with wishing Governors and Board Colleagues a very happy and healthy 2025.

I am pleased to present my report to Governors which provides an update on matters since my last report on 31 October 2024.

The Trust is feeling the expected Winter operational pressures, and at the time of writing the sense is that we are coping well, although the front door access measures are not where we would want them. However, these do largely represent the wider system challenges, which in turn are reflected nationally.

Our staff continue to work hard to respond to the challenges and I think we owe it to them to continue to say thank you whenever we can this makes such a difference.

The Industrial relations climate in NLaG has much improved with the dispute involving Maternity Support Workers (MSWs) being largely resolved now and with no further action planned. The Group Chief Executive (CEO) will provide an update on the latest position during the meeting.

Organisation and Governance

May I extend a warm welcome to Governors who may be attending the Council of Governors for the first time. I look forward to completing face to face conversations in the usual way.

I am pleased to report that Murray Macdonald has been appointed as Vice Chair at Hull University Teaching Hospital (HUTH) and Associate Non-Executive Director (NED) at Northern Lincolnshire & Goole NHS Foundation Trust (NLaG). Murray's details have already been circulated to Governors and he brings a wealth of Executive and NED experience to us. I am sure Governors will give Murray a warm welcome. As mentioned in previous reports Murray succeeds Stuart Hall, who leaves us with our best wishes after 10 years' service as a NED in the NHS.

The group CEO will comment on Executive matters, but I would like to draw Governor's attention to the recent appointment of Amanda Stanford as Group Chief Nurse following a competitive process. Amanda has been acting in this role on an interim basis for several months and I am sure we all would wish to congratulate her and wish her well in this appointment.

Other Items

Governors will be aware that discussions regarding the options for service provision on the Goole District Hospital (GDH) site are underway.

The CEO will update us on where we are with this matter in his report, but I would stress that at this stage all options are open for discussion, and it is vitally important that the voices of all stakeholders are understood and considered as we move forward. I am sure that Governors will take a keen interest in this matter and remain objective.

It has been quite a busy couple of months, and I have been pleased to attend several events:

- Group Top 100 Leadership Event - 8 November 2024
- Care Transition Conference - 11 November 2024
- Visit with Governors to Scunthorpe CDC - 12 November 2024
- NHS 10 Year Plan Engagement Event - 21 November 2024
- Group Nursing Midwifery and Healthcare Professionals Conference - 25 November 2024
- Speak up Champions Recognition Event - 28 November 2024
- First Group BAME Network Event - 13 December 2024

Alongside this Board members have had the pleasure of presenting colleagues with 'Shining Lights' awards in recognition of doing a great job – this is a great idea which is going down well with staff.

Sean Lyons
Group Chair

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)004

Name of the Meeting	**Council of Governors Business Meeting**	
Date of the Meeting	9 January 2025	
Director Lead	Jonathan Lofthouse, Group Chief Executive	
Contact Officer/Author	Jonathan Lofthouse, Group Chief Executive	
Title of the Report	**Group Chief Executive's Update**	
Executive Summary	This report updates the Council of Governors on: • Changes in the Executive team, welcoming three colleagues and giving thanks to three interim colleagues. • An update on discussions for the options appraisal for Goole & District Hospital. • Key outputs from the latest system-level GIRFT review by Professor Tim Briggs, which highlighted examples of best practice in our patch as well as some opportunities to go further. • Our current Group performance on patient safety, access targets and finance. • The current position on the two devolution deals covering our footprint and the networking opportunities these offer. • Our highly successful Hackathon event on 27 November 2024. • Positive progress with the Paediatric Day Surgery development at Castle Hill Hospital. • Good news stories, including our new Shining Lights programme, which has seen 118 nominations since launch, about the great work of our staff.	
Background Information and/or Supporting Document(s) (if applicable)		
Prior Approval Process		
Financial implication(s) (if applicable)		
Implications for equality, diversity and inclusion, including health inequalities (if applicable)		
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

Group Chief Executive Officer

Briefing to the Council of Governors
Thursday 9 January 2025

1. Introduction

1.1 I would like to start my briefing by sending my best wishes to the Governors for the New Year.

1.2 We welcome Emma Sayner as our substantive Group Chief Finance Officer. Emma joined us on Monday 2 December 2024 from her role as Acting Executive Director of Finance and Investment at Humber and North Yorkshire ICB. I would also like to offer my sincere thanks to Mark Brearley for filling the role of interim Group Chief Finance Officer so well over the past few months. Mark continues to work within the ICB system, providing valuable support and advice.

1.3 As briefed previously to the Council of Governors, we have taken our next steps around the operational structure at Executive level. Paul Bytheway completed his interim role as Group Chief Delivery Officer on 31 October 2024 and we send our sincere thanks for his hard work as part of the Humber Acute Services programme as well as in the interim Group Chief Delivery Officer role. We welcomed Clive Walsh as Interim Group Chief Delivery Officer on 4 November 2024. On Monday 2 December 2024, the Site Chief Executive roles started on an interim basis. Clive Walsh moved over to the Interim Site Chief Executive role on the north bank as of this date. I am very pleased to welcome Sarah Tedford, who also started with us on 2 December 2024, as Interim Site Chief Executive for the south bank. These roles will be pivotal in bringing operational delivery of our patient services closer to the Cabinet and enable a direct line of accountability to the Care Group leadership teams.

1.3 My sincere thanks also go to Rob Chidlow, who completed his tenure as interim Group Director of Quality Governance on 30 November 2024. Rob has been instrumental in responding to regulatory requirements as well as starting the processes for Group quality governance systems and teams during his time with the Group. The post of Group Director of Patient Safety and Quality Governance is currently open to national advertisement.

1.5 Governors will be aware of the discussions that have commenced around Goole & District Hospital. I am very grateful for those Governors who have already given their time to be part of the workshop sessions that have taken place over the last two months, and for their future contributions. It is important to note that we have been asked by our ICB to put together an options appraisal to better to meet the acute hospital healthcare needs of the population of Goole and the surrounding area, with an assessment of the status of the Goole campus as part of this.

1.6 I would like to assure our Governors that no decisions have yet been taken and we are only part-way into a cross-organisation co-creation of the options. I have personally met with staff twice through my scheduled Ask the Chief Executive roadshow sessions and will be returning this month for a follow-up session. Ivan McConnell as Group Chief Strategy and Partnerships Officer, as well as his deputy, Dr Linsay Cunningham, are continuing the workshop sessions with staff and stakeholders over the coming weeks.

1.7 We have also started the process to engage with community stakeholders. On Thursday 19 December 2024, I met with the local MP, Sir David Davis, as well as elected members and senior officers for East Riding of Yorkshire Council. We have all committed to meet regularly in Goole in the early part of this new year for follow-up discussions.

2. Patient Safety, Quality Governance and Patient Experience

2.1 I was honoured to welcome Dr Prem Premachandran MBE to our November 2024 Top 100 Leaders' event. Dr Prem is the Medical Director at the Care Quality Commission and an

ED Consultant at Frimley Health NHS Foundation Trust. Dr Prem shared his valuable insights, both as a clinical leader who has made significant improvements in patient safety, as well as from a CQC leadership perspective. I was particularly struck by his encouragement to all of our leaders to have professional curiosity and courage. It is part of our new Group staff charter to *do the right thing, even if it hard to do* and Dr Prem's words of wisdom on active listening and leading with compassion really resonated throughout the room.

2.2 I am also very grateful for Dr Prem's presentation regarding the Care Quality Commission's re-positioning of the hospital inspection framework. I am very keen to continue to work in partnership with the Care Quality Commission as we deliver on our strategic objectives to improve health outcomes and narrow health inequalities for our patients. For our Group to be managed as an early adopter of the re-based CQC hospital inspection framework, I will be meeting with the CQC Executive over the coming weeks.

2.3 A big thank you to Dr Kate Wood and Amanda Stanford for inviting me to speak at the Group Consultants' and the Group Nursing, Midwifery and Health Professionals' Conferences that have both taken place in the last two months. Having an opportunity to link our strategic objectives to the operational delivery of our services, and to share our passion with our clinicians to be ambitious for our patients' health and well-being has been a privilege and the feedback has been positive.

2.4 On Monday 2 December 2024, I chaired a meeting with colleagues from across our ICB for our system-level GIRFT review with Professor Tim Briggs. This was a follow-up session to a review visit last year and has given a real sense of the progress we have made across our system to adopt best national practice on productivity and clinical outcomes.

2.5 Professor Briggs highlighted in particular that our system is in line with the requirement to return to full compliance with the 18-week elective standard by the end of this Parliamentary term.

2.6 In addition, with our system focus on paediatric waiting times, our new ICB trajectory is to be under 40-weeks by July 2025, with the majority of patients already seen within 18 weeks. Our excellent collective work has enabled our use of independent sector capacity to be reduced by £1.7m in the last 12 months. We have much to be proud of as a system and we are well positioned to embrace the Further Faster 20 support from the centre as part of the Secretary of State for Health and Social Care's focused programme for heathcare's role in national economic recovery.

2.7 We continue to work closely with the CQC and colleagues in the ICB and NHS England on our position on patient safety and quality. I am very grateful to our clinical teams for continuing to make progress in key areas and to our quality governance teams in supporting the collation and submissions of evidence to external bodies.

2.8 We are making good progress on the upgrade works to the Daisy Day Surgery Centre at Castle Hill Hospital. This is on track to open as a dedicated paediatric day surgery unit this month. I am delighted that we will be meeting the needs of our young patients in a bespoke facility, which is enabling us to have positive discussions with Sheffield Children's Hospital NHS Foundation Trust around the potential for a centre of excellence relationship for our patients north and south of the river.

3. Urgent and Emergency Care and Planned Care

3.1 As Governors will recall, the four-hour standard is measured on a 'footprint' basis against the 78% standard set nationally, accounting for all Type 1 and Type 3 activity.

3.2 The south bank 'footprint' performance in October 2024 for all Type 1 and Type 3 activity, including the UTC in Goole, was 76.3% against a plan position of 73%, which is an improvement in the last two months.

3.3 We have seen an upturn in the number of Type 3 attendances on both banks of the river. We are seeing a number of patients needing urgent review, particularly within specific clinical specialties, which we believe is partly linked to the national GP collective action, as well as our expanded IAAU and SDEC services.

3.4 Nationally, October 2024 was the busiest month this year for Urgent and Emergency Care activity, which was mirrored in our geography. While both of our sovereign organisations are in Tier 2 for Urgent and Emergency Care with NHS England, we were called to a system meeting on Tuesday 3 December 2024 to discuss our fluctuations in performance in recent weeks, in particular ambulance handover times as well as ED performance.

3.5 The ambulance handover position for the south bank in October 2024 saw a small deterioration however remains within normal operating range. Improvement actions continue on flow, particularly ensuring assessment space is available in a timely manner to enable ambulance off-loads, with a standard of zero tolerance to over 45-minute handovers being the aim.

3.6 In respect of elective care, the 65-week position remains under significant scrutiny. Our Group continues to perform well in this regard, with specialty-specific action plans being put in place where there are volumes of patients at risk of breaching 65-weeks each month. The main work for patients on the South Bank is reducing the number of patients waiting over 52-weeks for treatment month on month.

4. Strategy and partnership developments

4.1 As briefed previously, two devolution deals in our footprint were authorised by HM Government in September 2024. We have been updated as to the current progress and next steps of these deals by our partners in North East Lincolnshire Council.

4.2 In respect of the Greater Lincolnshire County Combined Authority (GLCCA), which covers North Lincolnshire, North East Lincolnshire and Lincolnshire, each of these Local Authorities are working towards the necessary enabling processes for the first Mayoral elections in May 2025. A working group is established, focused on governance. This will be the work necessary to establish, operate and govern the GLCCA. This includes the development of the GLCCAs constitution, its structure, financial procedures and assurance framework.

4.3 A number of working groups with cross-constituent council membership are focusing on the work necessary to implement the devolution deal – for example, Transport, Employment and Skills, Housing, and Business and Trade. We will network with these groups as would be helpful to maximise the impact of the devolution deal. The immediate priorities that have been earmarked are housing in North Lincolnshire, low carbon brownfield and industrial sites in Lincolnshire and transport in North East Lincolnshire. There is a stated priority for economic development and skilled jobs through the region from the devolution investment funds.

4.4 The work and the delivery of statutory responsibilities of the three individual Local Authorities continues; the devolution deal brings long-term investment that is locally prioritised through the GLCCA. When the GLCCA is formed, two councillors (including the Leader) from the Cabinet of each constituent council will have a place on the Board, chaired by the elected Mayor. The District Councils within Lincolnshire will have 4 seats on the Board. They will be joined by the Police and Crime Commissioner and a business representative. The GLCCA will meet to discuss and make key decisions on where best to invest the money and exercise the range of powers that will be devolved by the Government and develop the necessary enabling strategies.

4.5 The Mayor will be elected by the people of Greater Lincolnshire and will hold office for four years. The GLCCA Mayor does not replace any of the civil mayors or council chairs in any of the Local Authorities, rather is the locally elected figurehead locally and nationally for the investment and devolved powers that the GLCCA will be granted in the new year.

4.6 The devolution deal for the north bank, which covers Hull City Council and East Riding of Yorkshire Council, is undertaking similar steps. The Hull and East Riding Mayoral Combined Authority is a separate devolution deal to the GLCCA. The links to the industrial development taking place on both sides of the estuary and particularly the energy transition to low and zero carbon technologies means that job creation and potential economic growth arising from this is likely to be large scale.

4.7 There is an existing Humber Leadership Board (HLB), which has been in place for around 10 years. This is a Joint Committee of the four councils around the Humber estuary. The aim is that the HLB will transition into a Joint Committee of both combined authorities, bringing the two elected Mayors and all constituent councils together to focus on matters of mutual strategic and economic interest. I will keep the Trust Boards in Committee updated on progress and our involvement in particular in the enabling strategies for the devolution deals.

5. Digital

5.1 On Thursday 28 November 2024, we ran a highly successful Digital Hackathon event in partnership with NHS England and Microsoft. 181 staff participated in this digital event, identifying a number of business problems needing digital solutions. Nine solutions using Microsoft products were created on the day, a number of which will be taken forward to use as business as usual, which will all seek to make our processes much more straightforward to complete, saving staff and patients time.

6. Financial Performance and Estates and Facilities updates

6.1 In respect of the Group financial position, the Month 7 position is that the Group's in-month deficit was £3.8m, circa £1.5m adverse to plan. Group Capital spend was £20.6m, which was £16.5m behind plan, largely due to some slippage on the Community Diagnostic Centres. Capital spending plans have been reviewed in detail to ensure the full capital budget is utilised this year.

6.2 The Group reported delivery of £41.3m in cost improvements against a year-to-date target of £35.7m, which was £5.6m better than plan. Our cash balance was rated green at £71.8m and will continue to be monitored closely. The Group spent £7m less on agency, bank and overtime costs than the same period in 2023/24. This is now below the NHS England 3.2% target of total pay expenditure, at 2.9%

6.3 We are slightly behind on activity levels to ensure Elective Recovery Performance income, however, with activity projections as currently profiled, this should still recover by year-end.

6.4 Work continues at pace on our capital developments, particularly those at Castle Hill Hospital and the Community Diagnostic Centres. As noted above, there has been some slippage on these capital schemes, however clinical activity has started to be provided and planned in other community settings. I will provide further information about this at the Trust Boards in Common meeting.

7. Workforce Update

7.1 We have fully refreshed our induction programme and will be launching our new Group induction this month with all new starters. This is a full day programme to onboard our new colleagues with our Group vision, values and staff charter, provide staff with their mandatory training in one set and get them mission ready with NHS Humber Health Partnership. I am grateful to colleagues across the Group, particularly the Organisational Development and Education teams, for coordinating this effort and taking a fresh approach to induction.

8. Equality, Diversity and Inclusion (EDI)

8.1 I was humbled to share the story of one of our neurodiverse colleagues at this year's Group Staff Disability network conference. Our colleague had really struggled in her apprenticeship programme placement, despite being really open and clear about her support needs and having successfully been a volunteer in one of our wards before this. Hearing our disabled staff's experiences at this year's conference as well as having time to put forward ideas for real improvements made for an excellent conference session.

8.2 I was really pleased to be asked to speak the Group's Black, Minority and Minority Ethnic (BAME) Staff Leadership conference, which was on the theme of 'Challenging and Overcoming Racial Discrimination in Healthcare'. We have recently launched our Group-wide Zero Tolerance to Racism reporting tool and I am grateful to our colleagues across the Group who undertake the Circle groups and support systems whenever a colleague reports unacceptable behaviour from staff or from a patient.

9. Good News Stories and Communications Updates

9.1 Liver health project has potential to save lives

Funding of £500,000 over two years from NHS England and the Humber and North Yorkshire Cancer Alliance has been secured to pilot Liver Health Checks in a number of community locations across Hull, East Yorkshire, North and North East Lincolnshire.

9.2 Initially starting in Hull and East Yorkshire in April 2023, the project was extended after 12 months to encompass Scunthorpe, Grimsby and surrounding areas, and parts of Scarborough too. The region is one of just 18 sites across the country conducting the liver health checks project and this is based on high levels of deprivation and poor health outcomes from liver disease.

9.3 By working with healthcare and service providers, local authorities, local employers, community groups and taking scans out to those who might benefit most, the team is seeking to identify liver disease and begin treatment at a much earlier stage.

9.4 **Hundreds of patients benefiting from new hospital project**

A team of 16 MSK physios, supported by hospital admin staff, have seen, treated and supported almost 300 patients with bad backs, shoulder injuries or leg, knee or ankle pain and other MSK issues at three special Community Appointment Days (CAD) since June.

9.5 Waiting times for appointments have fallen from the longest wait of 26 weeks to just over 10 weeks in four months, non-attendance rates have almost halved, almost a quarter of patients receive pain management support on the day and almost 20 per cent are joining initiatives to support healthier lifestyles.

9.6 **Community staff receive prestigious title**

Three of our community staff have received a top honour, recognising their commitment to our patients.

9.7 Claire Clarke, Garry Cowling and Claire Hebden have been awarded the title of Queen's Nurse (QN). This is a formal recognition by the Queen's Nursing Institute (QNI) that they're part of a professional network of nurses committed to delivering and leading outstanding care in the community.

9.8 **Shining Lights**

The Shining Lights recognition scheme allows staff and patients to nominate our workforce for recognition, celebrating those who go the extra mile to brighten the days of patients, staff, and visitors. Whether it is a kind word, a thoughtful gesture, or simply easing someone's anxiety, these small acts make a huge difference.

9.9 In October and November 2024 we received 118 nominations. Board members have each committed to visiting one nominee every month to say thank you and well done and pass on a Shining Lights card and badge. In the past two months, these have included Sean Lyons, who dropped in on Sallie Longman, Radiotherapy and Chemotherapy Booking Coordinator and Julie Beilby who visited ED consultant Dr Sergio Sawh at Diana, Princess of Wales Hospital. I met and chatted with Nursing Auxiliary, Emma Tymon, on Ward 90 at Hull Royal Infirmary, who was really pleased to receive her card and badge. I also visited Becky Dent, who works on our admin bank as a Progress and Discharge Assistant. Becky mostly works on IAAU and SDEC at DPoWH and was nominated by her colleagues, as she always goes the extra mile. Well done to everyone who has received a Shining Light nomination.

Jonathan Lofthouse
Group Chief Executive
27 December 2024

Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)005

Name of the Meeting	**Council of Governors**
Date of the Meeting	09 January 2025
Director Lead	
Contact Officer/Author	Ian Reekie
Title of the Report	**Lead Governor's Update**
Executive Summary	The purpose of this report is to update governors on highlights from the Membership and Public Engagement & Assurance Group (MPEAG) meeting held on 18 December 2024. The Appointments & Remuneration (ARC) has not met since the last Council of Governors meeting. It is **recommended** to Council of Governors: • that highlights from the MPEAG meeting held on 18 December be noted • that Jackie Weavill be appointed to fill the staff governor MPEAG vacancy.
Background Information and/or Supporting Document(s) (if applicable)	None
Prior Approval Process	None
Financial implication(s) (if applicable)	None
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	None
Recommended action(s) required	✓ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

COUNCIL OF GOVERNORS

9 January 2025

Lead Governor's Update

MEMBERSHIP AND PUBLIC ENGAGEMENT & ASSURANCE GROUP (MPEAG) HIGHLIGHTS

A meeting of MPEAG was held on Wednesday 18 December when the following issues were discussed:

- **Committee Membership** – Wendy Lawtey was welcomed to her first meeting as a new member of MPEAG and it was reported that Jeremy Baskett was standing down due to a clash of dates with his Louth Town Council commitments. Subsequently Jackie Weavill has expressed interest in joining the committee which means that if she is appointed there will be staff governor representation as required by the terms of reference.
- **Quality Priorities 2025/26** – Richard Dickinson and Kelly Northcott-Orr reported progress with the delivery of the 2024/25 quality priorities and reported on the proposed retention for 2025/26 of the same five priorities – Deteriorating Patients, Sepsis, End of Life Care, Medication Safety and Mental Capacity. Committee members expressed some concern at the pace in implementing current year improvement initiatives but agreed to support carrying them forward as the 2025/26 priorities.
- **A Commitment to Excellence** – Amanda Stanford, who attended the meeting on the day her permanent appointment as Group Chief Nurse was confirmed, revealed that the groupwide replacement for NLaG's '15 Steps' ward quality improvement programme is to be known as 'A Commitment to Excellence' or 'ACE'. Training for governors on the new approach will be available early in 2025.
- **Integrated Performance Report (IPR)** – Ashy Shanker assisted MPEAG with its bi-annual review of the IPR. In particular she highlighted:
    - the progress that had been made in minimising 65 week elective waits but the challenge involved in moving on to the elimination of 52 week waits while the volume of referrals is still increasing
    - the diagnostic modalities that are particularly problematic in seeking to achieve the six week diagnostic standard
    - the challenge in converting relatively good performance in meeting the two week referral standard for cancer patients into achieving the 62 day referral to treatment standard performance which is currently only around 50%
    - actions that are being taken to mitigate the impact of a significant increase in urgent and emergency care demand which during December has been driven by the number of flu patients.
- **Member and Public Engagement Strategy** – Ade Beddow updated the meeting on progress in preparing a Group Engagement Strategy and promised to share a draft of the section relating to member engagement before the end of January at which time he agreed to convene a briefing session to enable governor input to the final version which he hopes will be available by the end of March.
- **MPEAG Review of Effectiveness** – It was reported that a full response to a survey of MPEAG members had revealed general satisfaction with the work of the committee although some concern was expressed as to whether it is possible to adequately discharge all the committee's responsibilities in four 90 minute meetings per annum.
- **Governor Engagement Feedback** – A detailed report was considered on outcomes from the first round of governor drop-in engagement sessions held in conjunction with the local HealthWatch organisations in North and North East Lincolnshire. A feedback report from these drop-in sessions is attached as Appendix 1. It was agreed that at future sessions efforts should be made to adopt a more integrated approach by including questions generated by HealthWatch even if they do not relate specifically to

hospital services. MPEAG members hoped that future drop-in sessions in the new year would receive support from more governors.

- **Membership Report** – Consideration was given to the latest version of the membership report which for the first time incorporated a complete breakdown of public members by age band. MPEAG members were surprised and encouraged by the fact that the young working age population is so well represented which is the result of recruitment initiatives undertaken in colleges a decade or more ago. It was felt that other targeted recruitment drives should now be considered.

Governor Drop- In Session Feedback

1. Background

Governor Drop-In sessions were organised in collaboration with HealthWatch representatives as discussed at the previous meeting of the MPEAG in September. These were organised to enable our Governors to discharge their statutory duty to engage with members, public, staff and patients and the opportunity to also collaborate with HealthWatch representatives was welcomed. These sessions were subsequently held on 22 October at Scunthorpe General Hospital and 7 November 2024 at Diana, Princess of Wales Hospital at Grimsby.

The Drop-Ins provided an opportunity for Governors to engage and gather soft intelligence to help highlight areas of good practice or any concerns which could lead to service improvements.

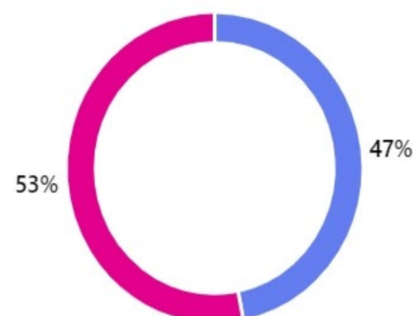
Feedback from these Drop-In engagement sessions was captured electronically utilising the IT Tablets and electronic MS form via responses to the set questions together with any other general comments. This was then reported to the Patient Experience leads for consideration which may be captured in Assurance Reports or addressed at Nursing Metrics Meetings.

2. Results Summary

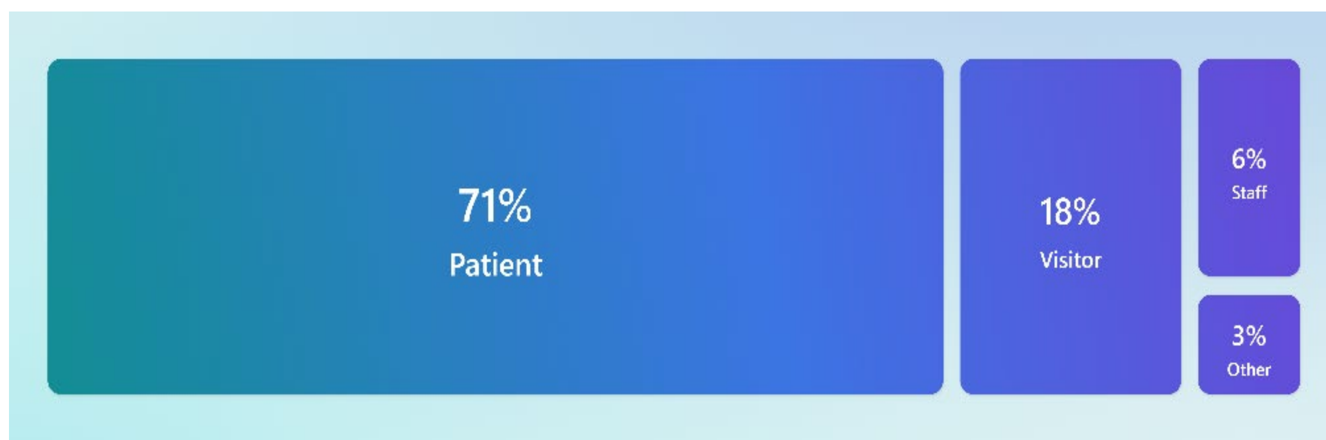
32 responses were received in total from both sites which were covered by four Governors. The feedback form took an average of seven minutes to complete and below are summaries of the feedback collected:

a) Responses per Site

SGH	15
DPOW	17



b) Cohorts Represented

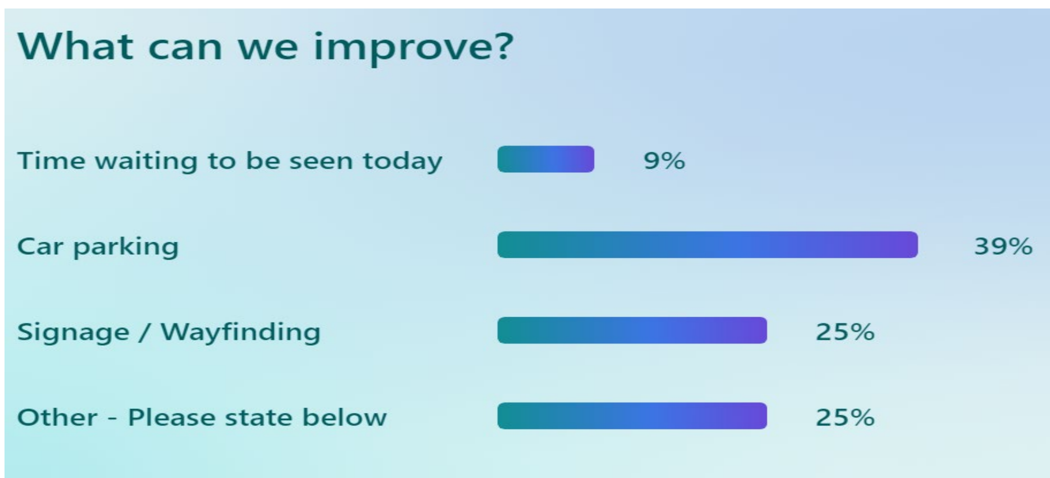


c) Feedback about experiences

When asked how their experience had been so far, 25% of respondents replied ‘Good’. Details of other comments received in answer to this question are captured below:

d) Improvements

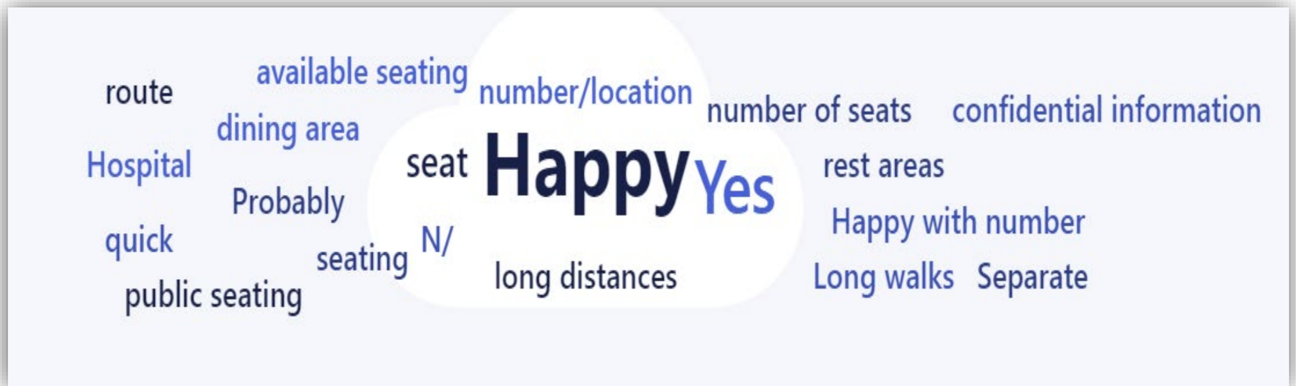
In response to the question about what we could on improve on, car parking had the majority of responses as noted below:



e) Other improvement comments

When asked for further comment on what we could improve, of the 10 people who had responded ‘other’, one mentioned an issue with smoking outside the main entrance. Please see further comments below:

f) The Patient Experience team particularly requested feedback on two subjects, the availability of rest areas around the hospital site and the quality of Outpatient letters. Please see below some of the comments in response to these questions:



30

Responses

Latest Responses

"Friend's appointment letter contained all necessary detail"

"Accesses portal via NHS App to read appointment letters which are accurate... "

"Attends regular twice weekly Cardio rehab programme so does not receive i... "

...

3. Governor's Feedback

Governors were asked for feedback regarding the sessions and how we could work more collaboratively with the HealthWatch representatives on these sessions. Please see the comments below:

Governor name(s)	Eng't activity / opp'y / event	Date	Summary of feedback/suggestions/learning for consideration by MPEAG and possible escalation to CoG
David James	DPoW Session	7 Nov 2024	A very enjoyable session. One suggestion I have is that the form we complete needs to ask which department has been visited. If positive or negative feedback is given, there is little that can be done if we are unaware of which department is being spoken about
Ian Reekie	DPoW Session	7 Nov 2024	I think in future we should ask the respective local HealthWatch organisations in advance of sessions if there is a specific question they would like to have added to our tablet script. Depending on the focus of their workplan at the time their question may not be strictly hospital related, for example the primary care experience prior to referral, but I don't see this as a problem

4. Conclusion

The Governor Drop-Ins were found to be a successful means of engagement by Governors, although further improvements to the feedback form and collaborative working with HealthWatch are to be considered.

The feedback from these sessions was welcomed by the Patient Experience leads and Chief Nurse Directorate for their consideration / further action as was the support of Governors in gathering this soft intelligence.

5. Recommendation

- To note the feedback given and review the Governor’s comments regarding future collaboration with HealthWatch representatives.

Governor Feedback Form

Drop-in Sessions

In Collaboration with HealthWatch

1. Which Drop-in session?
   - ○ SGH
   - ○ DPOW

2. Date?

3. What is the purpose of your visit today?
   - ○ Patient
   - ○ Visitor
   - ○ Staff
   - ○ Other – please state

4. How was your experience today?

5. What can we improve?

   - ○ Time waiting to be seen today
   - ○ Carparking
   - ○ Signage / Wayfinding
   - ○ Other – please state below

6. Other / comments on the above

7. Would you like to see more rest areas around the hospitals to stop on the way to appointments / wards and car parks?

   - ○ Yes
   - ○ No

   Comments on the above

8. How did you find the quality and accuracy of the Outpatient letters (if applicable)

9. Name of the Governor completing the form?

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)006

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	Gill Ponder, Non-Executive Director and Chair of Capital and Major Projects Committees-in-Common
Contact Officer/Author	Gill Ponder, Non-Executive Director and Chair of Capital and Major Projects Committees-in-Common
Title of the Report	**Capital and Major Projects Committees-in-Common (CiC) Highlight Report**
Executive Summary	The attached report details the matters considered at the Capital and Major Projects CiC on 29 October and 26 November 2024.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	The report has been received by the Boards-in-Common
Financial implication(s) (if applicable)	Financial implications are detailed in the Report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	12 December 2024
Report from:	Capital and Major Projects Committees in Common
Report from meeting(s) held on:	29 October 2024 and 26 November 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Capital and Major Projects Committees-in-Common at their meeting(s) held on 29 October 2024 and 26 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- *Board Assurance Framework and Risk Register Report*
- *Group Capital Plan Funding and Delivery*
- *Review and evaluation of new Business Cases, Investments and Dis-Investments within Delegated Limits and/or endorsement for Trust Board Approval – Allam Building Internal Fit Phase 2*
- *Post Project Evaluation*
- *Capital Contract Approvals*
- *Humber Acute Services Review – including Key Risks*
- *Goole Hospital Options Appraisal (not included below as already discussed at Board Development)*
- *Community Diagnostic Centre Programme – including Key Risks*
- *Digital Plan Delivery – Including Key Risks*
- *Group Capital Committee Meeting Minutes*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

a) Slippage of £16.5m on the Group Capital Programme was presented, mostly due to slippage on the CDC programme for reasons outside the Group's control, such as planning issues, unforeseen building complications and Procurement delays. Cabinet had reviewed capital schemes to be brought forward from the 2025/26 draft plan to offset the slippage from the 2024/25 plan, to create the headroom in funding in 2025/26 to complete the delayed works. The revised Capital Plan for 2024/25 and the draft 2025/26 Capital Plan were due to be received at the November 2024 Committee meeting; amendments to the 2024/25 plan were presented and it was confirmed that around £12m of the slippage would still be spent by the end of the year. Further details were requested on the remaining £4.5m and on the items being brought forward from the draft 2025/26 capital plan and those papers werecirculated to Committee members after the meeting for further assurance. The CIC noted the underspend on the capital programme but were reasonably assured that plans were in place to ensure that the Group would not be underspent on Capital by year-end and that bringing items forward from the 2025/26 plan would result in there being sufficient headroom in the 2025/26 capital budget to complete all slipped schemes from 2023/24.

b) Business Case Endorsement – The Committees endorsed the Allam Building Internal Fit Phase 2 contract extension proposal for Board approval. There remains ongoing review to ensure activity within the building can be optmised, however the project requires completion. The 1st and 2nd floors in relation to Phase II have a clear purpose for accommodation and education.

c) The Committees received the first 2 Post Capital Project Evaluations, using the standard NHSE templates. The Committees felt that this was a significant step in the right direction to ensure that benefits projected in business cases were actually delivered and that lessons were learned to improve future programmes, but felt that there would be further benefits from the inclusion of more data and evidence to underpin the responses in each section in future evaluations. One of the key lessons learned was to be more realistic on timelines. The projects reviewed were in line with financial evaluation, however delays were noted. There is often pressures to meet specific completion deadlines that may not be realistic. It was agreed that these difficult conversations need to be held up front. Revenue plans are adversely impacted through continual delays.

d) Group HASR – Concerns raised about the programme by system partners were being dealt with by the local resolution process or direct referral to the Secretary of State. Planning for implementation could continue in parallel with these processes, but there might be a need to pause if the Secretary of State called in a programme due to any referrals. In the meantime, efforts were continuing with Local Authorities to find solutions to items raised including transport issues, which were one of the main concerns. A package of mitigations had been prepared for Cabinet and submission to a full North Lincolnshire Council meeting due to be held on 5 December. Nothing would be implemented until after that meeting had taken place.

e) Group Digital Plan – The Digital Strategy engagement programme is now complete and a report detailing feedback would be presented to Group Cabinet in December. The team had engaged with 600 members of staff regarding the digital service and how it could be improved and the main themes that had emerged were around the basic functionality of equipment, Lorenzo and WebV, plus the benefits of an EPR. The EPR outline business case is still with NHSE and the Treasury for approval. There is

still a £14.5m gap to close to enable the Group to obtain tender responses from suppliers in the mid financial range of the market.

Badgernet had been successfully implemented and the feedback had been positive. Work is ongoing to align patient led booking initiatives, contracts and processes across the Group by rolling out Dr Doctor across HUTH, followed by NLAG. This would improve patients' ability to manage their own appointments, whilst retaining the existing benefits from the current Patients Know Best system. The Uninterrupted Power Supply (UPS) had been installed for the Scunthorpe Data Centre and the EPRR team are revising Business Continuity plans and planning to test those plans with a table-top Group-wide Cyber Security exercise. The Windows 11 draft business case is complete and requires £2.5m capital and £500k in supporting costs, which could be covered by the existing capital budget and EPR funding. The business case would be presented to Group Cabinet in 2024/25.

In view of the level of grip and control over programmes, the CIC gave significant assurance and praised the longer-term vision and view of expenditure.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

a) Group CDC – There were a number of key risks presented which included unforeseen build requirements, planning permission delays and delays to high voltage power and water connections. All of the CDCs are experiencing slippage and the revised expected dates for go live were now:

- Hull and East Riding would be 14/04/25
- Scunthorpe would be 02/12/24 (with MRI and CT still March 2025 as planned)
- Grimsby would be early January 2025 in a phased approach
- ERCH Phase 2 Ophthalmology end of March or beginning of April 2025

These delays had an impact on activity and would create a potential loss of income in 2024/25, but steps were being taken to mitigate this risk by carrying out additional work in alternative locations. The aim is to achieve the H2 revenue targets despite the delays.

There were further financial risks from a potential total CDC income loss to the ICB of £2.3m and the deficit from the mobile scanners which had been transferred to the HUTH Balance Sheet, but could not carry out the volume of work planned due to lost time setting up each time a scanner was moved to a new location. The CFO is pushing to ensure efforts are being undertaken to minimise this loss within the York & Scarborough trust.

As there were detailed mitigation plans for all risks, the Committees were assured. An assurance rating of Significant was considered, but the Committees agreed that the level would be Reasonable in view of the number of risks that were outside the Group's control. The Committees also requested a paper on the financial impact of the various risks and mitigations in place.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

5.1 The new Board Assurance Framework was presented and the strategic risks relating to Digital and Strategic Capital Investment were discussed. The risk ratings agreed at the Board Development session in October 2024 were presented and there had been no changes since. The risk descriptions had been updated and the controls and gaps in controls were easier to view. Actions in place to address the gaps were also shown. The Committees liked the new format of the BAF, but would like to see the journey to get to a tolerable score for each strategic risk.
The high-level risk report was presented alongside the BAF. The Committees requested that this was tailored to each CiC, that mitigations for each risk were clearly included and that the impact of mitigations was clear by having a pre and post mitigation score for each high-level risk.

Both the BAF and the high level risk register were to be presented together on a quarterly basis in the future. The CIC workplan would be updated accordingly.

6.0 Trust Board Action Required

6.1 The Trust Boards are asked to:

- Note the matters for escalation in item 3.1 above.
- Approve the Allam Building Internal Fit Phase 2 contract extension

Helen Wright, Non-Executive Director/CIC Chair, HUTH

Gill Ponder, Non-Executive Director/CIC Chair, NLAG

26 November 2024

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)007

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	Gill Ponder, Non-Executive Director and Chair of Performance, Estates and Finance Committees-in-Common
Contact Officer/Author	Gill Ponder, Non-Executive Director and Chair of Performance, Estates and Finance Committees-in-Common
Title of the Report	**Performance, Estates and Finance Committees-in-Common (CiC) Highlight Report**
Executive Summary	The attached report details the matters considered at the Performance, Estates and Finance CIC on 30th October and 27th November 2024.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	The report has been received by the Boards-in-Common
Financial implication(s) (if applicable)	Financial implications are detailed in the Report
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	12 December 2024
Report from:	Performance, Estates and Finance Committees in Common
Report from meeting(s) held on:	30 October 2024 and 27 November 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Performance Estates and Finance Committees-in-Common at their meeting(s) held on 30 October 2024 and 27 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

- *Board Assurance Frameworks including Risk Register Report*
- *CQC Actions Report – Group*
- *Business Planning Timetable and Progress Update*
- *Group Finance Report Months 6/7*
- *Costing and Benchmarking*
- *Review of Effectiveness*
- *Procurement Improvement Plan*
- *Group Integrated Performance Report (including Cancer Deep Dive)*
- *Winter Plan*
- *Estates and Facilities – General Update and Fire Action Plan*
- *Contract approval – Sleep Therapy Services, Equipment and Consumables*

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

a) Limited assurance was given regarding the ability to deliver the Financial Plan given the current best case anticipated gap to plan of circa £13.4m. The CIP targets significantly increase in H2 and there remains a risk of £8m in relation to assumed income that has not been confirmed. The year to date performance reflects a shortfall

against plan of £1.5m, largely due to a pay award funding gap, but HUTH received £1.4m of non-recurrent ERF income in Month 7 and £2m of non-recurrent balance sheet flexibility was also released. It is critical that the Care Groups manage within their budgets.
There is a risk to the cash position if the CIP is not delivered, which is of particular concern for HUTH. The plan is more challenging in this half year and the current forecast is that the plan will deliver £11.8m less than the £84.6m target, although this is an improvement on the Month 6 position of a £14.2m shortfall.
The ICB are aware of the current gap to plan and the steer is that this will be declared to NHS England at month 9 once all gap closing activities have been explored. The work being undertaken by PA Consulting highlights significant opportunities to improve performance, however the execution of the plan will take time and limited benefits will be realised this year. An updated forecast and recommendation on the most likely financial outturn after all attempts have been made to close the gap will be brought to the December meeting. Despite limited assurance that the plan will be delivered, the Committees received reasonable assurance that the plan is well understood and that there is significant collective focus on minimizing the deficit.

b) Urgent Care – Performance had deteriorated at HUTH on the 3 key enablers of time to first clinical assessment, time in department and improved frailty assessment times, due to an anomalous increase of 7% in patients presenting at ED in October.. This had resulted in ED congestion and longer ambulance handover times. NLAG had been less affected, but had also seen a slight deterioration in performance in October, although there had been an overall sustained improvement at NLAG of 10% compared to last year. The difference across the Group was mainly due to the grip and control achieved with more resources allocated to managing ED risks and performance at NLAG. The shortage of this resource at HUTH resulted in poor bed management and key risk areas included Boarding, ambulance handovers and SDEC. Best practice would be shared. Improvement activities continued to focus on improving flow through the hospitals and a MADE event was planned with system partners to improve discharge rates of patients that no longer needed to be in an acute hospital. Limited assurance was agreed by the CICs for HUTH, due to unsustained performance improvements, increased demand resulting in shortage of assessment space and the impact of the local GP collective action, but the CICs were reasonably assured by improvements in performance at NLAG.

c) Elective Care - The Group had not achieved the plan to eliminate 65 week waits by the end of September with HUTH reporting 15 patients and NLAG reporting 11. By the end of October, this number had reduced to 19 across the Group. The main causes of the continued long waits for those 19 patients were workforce shortages for plastic surgery and some patients being given insufficient notice of admission dates which they had then declined. The Group were on track to achieve the new target of having no more than 8 patients waiting more than 65 weeks by the end of December. There remain concerns about the level of demand which had not reduced in line with operational plans, growing waiting lists due to a 7% increase in referrals which presented a risk to sustaining the 65 week wait position and non-delivery of RTT. A range of improvement plans were in place, including seeing patients by 40 weeks, improving theatre utilisation rates and work with PA Consulting to improve outpatient transformation initiatives. Whilst the Group was amongst the best in the country for delivery of 65 week wait reductions, which the CICs commended, non-delivery of the RTT performance standard, demand continuing to exceed planned reductions and concerns about the overall waiting list growth resulted in limited assurance being agreed by the CiCs.

Diagnostics – Whilst the number of people waiting over 6 weeks for diagnostic tests increased over the summer leave period, mutual aid focused on those modalities where the Group benchmarked worst such as DEXA scanning had resulted in a 20% reduction in the number of patients on the waiting list and a 50% reduction in those waiting over 6 weeks for their tests. This performance had moved the Group into the top 50% in the country. Additional activity was planned to improve performance further and additional capacity from the CDC's will also improve waiting times when that becomes available. Reasonable assurance was agreed due to the significant improvements being seen, although the CICs were also alerted to the discovery of a potential data quality issue at HUTH which was under investigation. A report on that would be brought back to the Committees once investigations had been completed.

Cancer – The CiC carried out a deep dive into Cancer performance and concluded that there was Limited Assurance for the reasons outlined below, including increased referral rates without a corresponding increase in activity levels, leading to an increased backlog. The Group remains in Tier 1 support for Cancer. Non-recurrent funding allocations had not led to sustained improvements in performance. The 62-day performance against target had been affected by results deteriorating in large services that had historically met the required standards. Risks included workforce recruitment and retention and early recognition of benign pathology to enable patients to be removed from the Cancer pathway if Cancer had been ruled out. Improvement plans were in place, including sweating diagnostic assets at weekends and focusing on improving the enablers to achieving the 62-day performance standard.. There were signs of significant improvements in these enablers, with HUTH achieving 76.7% and NLAG achieving 73.3% against the faster diagnosis standard of 75% and early indications that both Trusts would achieve around 80% when October's results are published. Improvements had also been made in decision to treat by day 38. The CiCs recognised the hard work that had led to these improvements, which had not yet been sustained or resulted in an improvement in the 62-day performance.

d) Winter Plan – The Winter Plan first presented to the CiC in October required further work on the bed bridge to ensure that at least the same number of beds available last Winter would be available this year and to identify essential additional spending, based on risk assessments.

e) The updated Winter Plan was not received at the November 2024 meeting but a verbal update was given and the plan approved by Cabinet was circulated after the meeting. An increase in demand of 6% had been assumed in the Winter Plan and flow improvement activity was underway, including a 2-week MADE event due to start on 2 December 2024, support from PA Consulting, expansion of virtual wards and investments in Community capacity, paediatrics, pharmacy in-reach and additional site management resources on the North Bank. The focus was on patient safety, care and experience and the QI team were working with teams to improve board and ward rounds to identify discharges early. The CIC noted that the financial planning element had been supported by the PA Consulting review. Staff health and wellbeing were noted as critical to delivery. The CiCs were reasonably assured by the plans which would be presented for approval at the Boards-in-Common on 12 December 2024.

f) Contract Approvals - The CIC approved the Sleep Therapy Service equipment and consumables contract.

The CIC received updates on the business and financial planning processes for 2025/26, which would cover a 2-year period and would be based on assumptions until the central planning guidance was received. The plans were well thought out and communications were ongoing with regular updates on progress. They will come to the Committees in February for review, prior to submission for approval at the April Boards in Common.

g) Following a verbal update in November, a more detailed PA Consulting update will be received at the December 2024 meeting, highlighting the benefits of the work carried out and the actions in place to close the unidentified CIP gap.

h) The review includes theatres, outpatients, diagnostics and flow. Workplans are in place to underpin the proposals and no major risks had been flagged. The lack of PMO capability was highlighted and needs to be addressed in order to deliver the significant benefits that have been identified.

i) Estates and Facilities – The CiCs noted actions in place to mitigate risks and progress made on the lift upgrade programme at HRI and the positive impact of the PSDS work at Scunthorpe Hospital addressing a number of longstanding backlog maintenance risks on that site. The lack of decant facilities at both Trusts had been added to the Risk Register, because it restricted access for deep cleans and routine maintenance, especially over the Winter period. The new Public Sector Decarbonisation Schemes had opened and bids have been submitted based on carbon saving opportunities as bids were no longer approved on a first come, first served basis. Bid values would be confirmed within the next reporting period. It must be noted that there is now an expectation that the Trust will match any funding received.
The CICs received the comprehensive Group fire action plan and noted that the NLAG Fire Authorised Engineer had also been appointed to cover HUTH. The CICs agreed that they had received reasonable assurance on Estates and Facilities items.

j) The CIC received a Procurement update which highlighted the savings programme and how it was progressing well, despite the 15% vacancy rate and 221 expired contracts which the team lacked capacity to work on. All of the issues had comprehensive plans and actions in place. The CIC wondered if we should be investing more to make additional savings from Procurement and Contract Management activities. Reasonable assurance was agreed.

4.0 Matters on which the committees have requested additional assurance:

There were no items to add at this time.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

4.1 The new revised BAF strategic risks were presented to the CIC.

The scores for finance (25) and performance (20) were approved by the CIC.

The Committees liked the new format of the BAF, but would like to see the journey to get to a tolerable score for each strategic risk.

The high-level risk report was presented alongside the BAF. The Committees requested that this was tailored to each CiC, that mitigations for each risk were clearly included and that the

impact of mitigations was clear by having a pre and post mitigation score for each high-level risk.

Both the BAF and the high-level risk register were to be presented together on a quarterly basis in the future. The CIC workplan would be updated accordingly.

Further evidence has been continually requested to understand mitigations and risk scores post mitigation. The CIC wish to understand what actions will be instigated to move from current score to tolerable score for the 2 BAF risks and in what timeframe. These debates have been ongoing and it is requested that the Board discuss timings for responding to the CIC requests.

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

- Note the items for escalation in section 3.1
- Note the items where the CIC have requested additional assurance in section 4.1

Gill Ponder, Non-Executive Director and CIC Chair, NLAG

Helen Wright, Non-Executive Director and CIC Chair, HUTH

27/11/2024

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)008

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	09 January 2025
Director Lead	Sue Liburd, Non-Executive Director and Chair of the Quality and Safety Committees in Common (CIC)
Contact Officer/Author	Sue Liburd, Non-Executive Director and Chair of the Quality and Safety Committees in Common (CIC)
Title of the Report	**Quality and Safety Committees-in-Common Highlight and Escalation Reports**
Executive Summary	The attached report for the Council of Governors, provides an update on the work of the Quality and Safety Committees-in-Common at both its 24 October 2024 and 28 November 2024 meetings. The following matters are highlighted: a) Maternity Support Workers at DPoW are in dispute over their pay and some working conditions. Negotiations remain ongoing. b) C.Difficile bacteria rates are static in comparison with previous reporting to Council of Governors. c) CQC action plan items highlighted as red, show persistence and limited progress. Renewed action is being taken to progress. d) There is an increase in respiratory incidents among staff, notably sickness absence due to flu and RSV. e) Children and Young People Electronic Prescribing Medicine Administration (EPMA) report highlighted 146 prescribing incidents had been reported. There were no cases of harm noted.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Discussion ✓ Assurance ✓ Information ☐ Review ☐ Other – Detail below:

Committees-in-Common Highlight Report to the Council of Governors

Report for meeting of the Council of Governors:	09 January 2025
Report from:	Quality and Safety Committees in Common
Report from meeting(s) held on:	24 October 2024 28 November 2024
Quoracy requirements met:	Yes on both occasions

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on 24 October 2024 and 28 November 2024.

2.0 NLaG Matters considered by the committees

2.1 24 October 2024

The committees considered the following items of business:

- Operational pressures.
- Board Assurance Framework (BAF).
- Integrated Performance Report (IPR).
- Care Quality Commission (CQC) update report.
- Maternity and Neonatal Services.
- Patient Safety Incident Response (PSIRF).
- Mortality including Learning from deaths.

2.2 28 November 2024

The committees considered the following items of business:

- Operational pressures.
- Board Assurance Framework (BAF).
- Integrated Performance Report (IPR).
- CQC update report.
- Maternity and Neonatal Services.
- Patient Safety Incident Response (PSIRF).
- Children and Young People Assurance Report.
- Mortality including Learning from deaths report.
- Terms of Reference.

3.0 Matters for reporting / escalation to the Council of Governors

3.1 The committees agreed the following matters for reporting to the Council of Governors:

24 October 2024:

a) Maternity Support Workers at DPoW remain in dispute over their pay and some working conditions. Negotiations remain ongoing.
b) The maternity stop smoking incentive scheme and roll out of Respiratory Syncytial Virus (RSV) vaccine to birthing parents across NLaG was commended.
c) C.Difficile rates are static in comparison with previous reporting to the Council of Governors. Training, education, infection control and hygiene basics continue to be carried out.
d) CQC quarterly review of actions was conducted. Actions highlighted as red, show persistence and limited progress. Executive action agreed with Chief Executive oversight.
e) Domestic Abuse Coordinator role is fixed term funded. The service being delivered is impactful. The role is scheduled to end in February 2025. This item was referred to the Workforce and Education Committee in Common (WEC).

28 November 2024:

a) The health and wellbeing of staff during winter was discussed as a matter of priority. Committee noted the increase in respiratory incidents among staff – Flu and RSV. There is also a low uptake by staff of winter vaccinations. Further consideration was referred to Workforce Education Committees in Common (WEC).
b) Maternity Support Workers at DPoW remain in dispute over their pay and some working conditions. Negotiations remain on going. It was hoped an agreement would be reached soon. An increase in sickness absence also noted across in-patient maternity services.
c) Children and Young People Electronic Prescribing Medicine Administration (EPMA) report highlighted 146 prescribing incidents had been reported. There were no cases of harm noted. Medication management for neonates training and development actions are in place, and the shortage of Pharmacists was referred to WEC.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following item of business:

24 October 2024

a) Limited Assurance: Maternity Support Workers dispute resolution.
b) Limited Assurance: CQC persistent outstanding actions rated as non-compliant (red).

28 November 2024

a) Limited Assurance: Neonatal EPMA.

5.0 Council of Governors Actions Required

5.1 The Council of Governors is asked to:

- Note the issues for reporting in item 3.
- Note the items listed for further assurance and their assurance ratings.

Sue Liburd
Non-Executive Director
27 December 2024

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)009

Name of the Meeting	**Council of Governors Business Meeting**	
Date of the Meeting	9 January 2025	
Director Lead	Julie Beilby, Non-Executive Director Member of Workforce, Education and Culture Committees-in-Common	
Contact Officer/Author	Julie Beilby, Non-Executive Director Member of Workforce, Education and Culture Committees-in-Common	
Title of the Report	**Workforce, Education & Culture Committees-in-Common (CiC) Highlight / Escalation Report**	
Executive Summary	This report sets out the items of business considered by the Workforce, Education and Culture Committees-in-Common at their meeting(s) held on Thursday 24 October 2024 and Thursday 28 November. The following matters are highlighted: a) Group Board Assurance Framework b) Group CQC Actions Update c) Group Freedom to Speak Up Reports d) Group Integrated Performance Report e) Group Job Planning Report f) Medical Education Annual Report g) HUTH Guardian of Safe Working Annual Report h) Wellbeing Progress Report i) Bank Temporary Staffing and Spend j) Employee Relations Report k) Medical Workforce Strategy l) E-Rostering Progress Report m) Registered Nursing and Midwifery Staffing (HUTH/NLAG) n) Apprenticeship Levy Annual Report o) Undergraduate Medical Education Annual Report (HUTH/NLAG) p) Guardian of Safe Working Hours Quarterly Report (HUTH/NLAG) q) Retention of Staff (NLAG) Deep Dive	
Background Information and/or Supporting Document(s) (if applicable)	N/A	
Prior Approval Process	The report has been received by the Boards-in-Common	
Financial implication(s) (if applicable)	Financial implications are detailed in the Report	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A	
Recommended action(s) required	☐ Approval ☐ Discussion ✓ Assurance	✓ Information ☐ Review ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Committees-in-Common Highlight / Escalation Report to the Trust Boards

Report for meeting of the Trust Boards to be held on:	Thursday 12 December 2024
Report from:	Workforce, Education and Culture Committees in Common
Report from meeting(s) held on:	24 October 2024 and 28 November 2024
Quoracy requirements met:	Yes

1.0 Purpose of the report

1.1 This report sets out the items of business considered by the Quality and Safety Committees-in-Common at their meeting(s) held on 24 October 2024 and 28 November 2024 including those matters which the committees specifically wish to escalate to either or both Trust Boards.

2.0 Matters considered by the committees

2.1 The committees considered the following items of business:

24 October 2024

a) Group Board Assurance Framework
b) Group CQC Actions Update
c) Group Freedom to Speak Up Reports
d) Group Integrated Performance Report
e) Group Job Planning Report
f) Medical Education Annual Report
g) HUTH Guardian of Safe Working Annual Report
h) Wellbeing Progress Report
i) Bank Temporary Staffing and Spend
j) Employee Relations Report
k) Medical Workforce Strategy
l) E-Rostering Progress Report

28 November 2024

a) Group Board Assurance Framework
b) Registered Nursing and Midwifery Staffing (HUTH/NLAG)
c) Apprenticeship Levy Annual Report
d) Undergraduate Medical Education Annual Report (HUTH/NLAG)
e) Guardian of Safe Working Hours Quarterly Report (HUTH/NLAG)
f) Retention of Staff (NLAG) Deep Dive

g) WRES and WDES Action Plans
h) Group Leadership Programme
i) Appeal Panel – NED decision

3.0 Matters for reporting / escalation to the Trust Boards

3.1 The committees agreed the following matters for reporting / escalation to the Trust Boards:

24 October 2024

a) HR update – Negotiations were ongoing regarding the NLAG maternity support workers, a further increased offer had been made but had been rejected. Further strike action was being considered.
b) Group CQC Actions – There were no changes to the previous reported position. The CIC agreed that there was no assurance regarding the mandatory training compliance that was outstanding and requested a plan to be presented to the next meeting. Work with line-managers was ongoing to encourage protected time and to avoid DNAs (did not attends).
c) The Freedom to Speak Up Guardians at HUTH/NLAG had been recognised by the National Team for their Group Partnership working. Significant assurance was given due to the confidence in the FTSU guardians.
d) The CIC were impressed by the work ongoing regarding staff wellbeing and took significant assurance from the report presented.
e) Funding for the Domestic Abuse role for staff had ceased and this was now a risk to the organisation. The issue would be raised at Group Cabinet and the outcome presented to the CIC.

28 November 2024

a) Band 2/3 Job Description issue was discussed. This is a national issue but there was no national steer on how to resolve. Discussions were ongoing.
b) Healthcare Support Workers – Back pay discussions were ongoing with the Unions.
c) Flu vaccination rates for both organisations were around the national average at 30%, but this was low in comparison to previous years.
d) NLAG Nurse agency spend across the Group had reduced dramatically. Vacancies and retention were also improving.
e) Retention deep dive – There was an improving position and exit interviews were in place. Higher turnover was still being reported for estates, healthcare assistants and admin.

4.0 Matters on which the committees have requested additional assurance:

4.1 The committees requested additional assurance on the following items of business:

a) The Group Agency position was in a positive position with c£6.6m being saved in the first half of the financial year compared to spend in the same period for last year, mainly due to the reduction in registered nurse agency spend. There were still issues regarding consultant vacancy position but there were mitigations in place to address this. The Committee noted the good work, but there was still work to be done.
b) The CIC discussed the Medical Education funding and raised a concern that it could not be part of the Cost Improvement Programme. The Chief People Officer was managing this and was meeting with the Group CEX and Group CFO.
c) The consultant job planning process was being aligned across the Group. The Job Planning Policy was currently being reviewed by both Local Negotiation

Committees. The CIC agreed limited assurance due to there being more work to do.

d) There had been significant progress regarding e-Rostering across the Group. The CIC agreed reasonable assurance for this item.

28 November 2024

a) Additional assurance was requested regarding violence and aggression towards staff and a report to be brought back examining the issues around where the incidents were taking place and if there were any ethnical issues attached.
b) Apprenticeship Levy changes – a comprehensive report was received detailing the current apprenticeship work and the changes to the Levy. The CIC agreed significant assurance for the work being carried out.
c) Medical Education annual reports – HUTH had seen an increase in incivility reports and there were national issues impacting the Group regarding Physician Assistants. Reasonable assurance was agreed but further information was required.
d) WDES and WRES action plans were presented.
e) The CIC approved the proposal to remove NEDs from Appeal Panels.

5.0 Confirm or challenge of the Board Assurance Frameworks (BAFs):

4.2 The committees considered the areas of the BAFs for which it has oversight and has proposed the following change(s) to the risk rating or entry:

The committees considered the areas of the BAFs for which it has oversight and no changes are proposed.

The CIC received the progress on the refreshed Workforce BAF, including work around the gaps in controls and assurance and the actions required to address the gaps.

6.0 Trust Board Action Required

5.1 The Trust Boards are asked to:

- Note the escalations in Section 3.1.
- Note the areas for further assurance in section 4.1.

Tony Curry, Chair of the Committees in Common

28 November 2024

The Health Tree Foundation

Independent Chair Health Tree Foundation Trustees' Committee

Neil Gammon

Charity Manager, Health Tree Foundation

Lucy Skipworth

The Health Tree Foundation is the working name of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds.

NHS
Northern Lincolnshire
and Goole
NHS Foundation Trust

- Who are we?
- Circle of Wishes
- The difference charitable donations make
- What success looks like
- Contact The Health Tree Foundation Team

Who are we?

- **An official NHS Charity, The Health Tree Foundation is independently run through HEY Smile Foundation**

- **At the Health Tree Foundation we want to ensure that each and every time someone walks through the hospital doors – whether for emergency or planned treatment – the best available equipment is waiting for them, in a comfortable and welcoming environment.**

Who are we?

THE HEALTH TREE FOUNDATION
Grimsby's Hospital Charity

- Dedicated professional charity team including a manager, two fundraisers, Circle of Wishes coordinator, admin support and a Sparkle Officer
- Less than 20 Fund Zones, no more than 40 funds total
- Access to charitable funds available through simple website to all staff, patients, visitors and public

Circle of Wishes

THE HEALTH TREE FOUNDATION
Grimsby's Hospital Charity

The Circle of Wishes - A strategic approach which has helped us unlock restricted funds and allowed for committed spending plans to help improve patient experience;

- Simple online form to apply via our website
- Submitting your wish is simple but we do ask you consider these questions before you submit:

✓ Is there a clear patient benefit?
✓ Is your wish something the Trust should be providing for patients or hospitals already
✓ Would you be happy to donate towards this wish?

Sparkle Wishes Completed

Sensory Rooms

Dementia Friendly spaces

Sparkle Wishes Completed

Rainforest ward outdoor play area - DPOW

Skylights - Trustwide

Redecoration of Treatment Room – Disney Ward SGH

The difference charitable donations make

The New A&E Units at DPOW & SGH

The difference charitable donations make

Quiet Rooms

Urology Waiting Area at SGH

Improved Garden Spaces for Patients

The difference charitable donations make

Support books for Pediatric Epilepsy patients

RITA Machines

Pediatric Waiting Areas

The difference charitable donations make

Privacy Screens for patients

Birthday Cards!

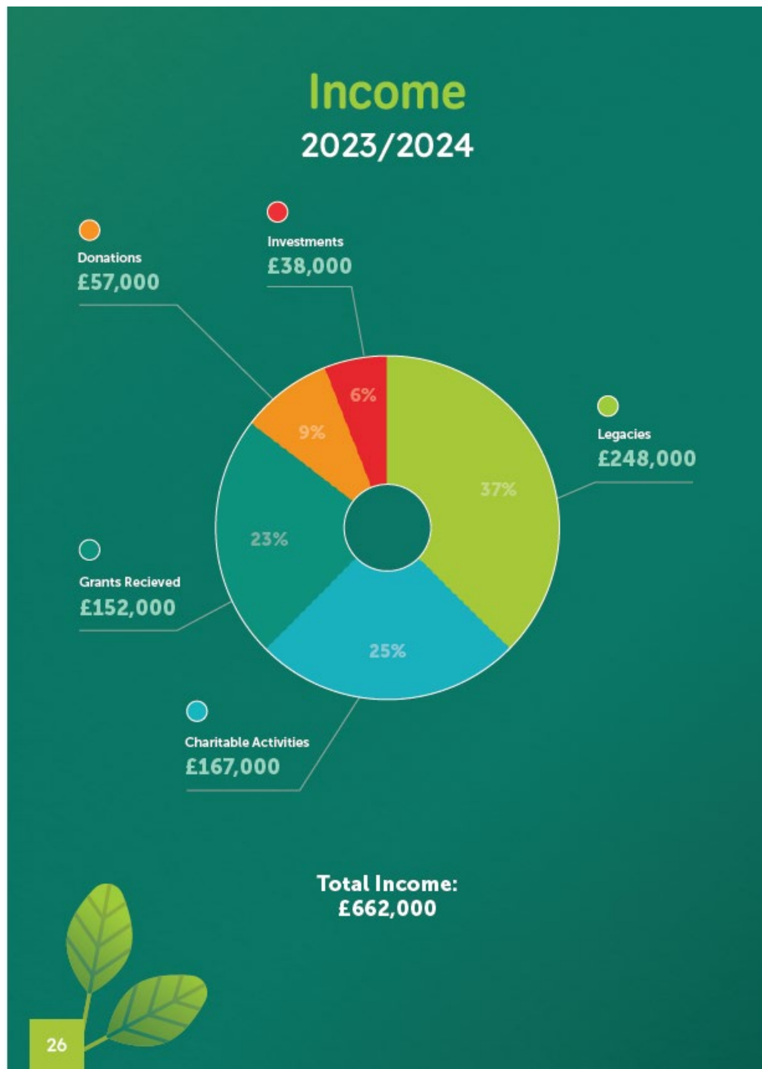
The Fishpond at DPOW

HTF Branded Lifts

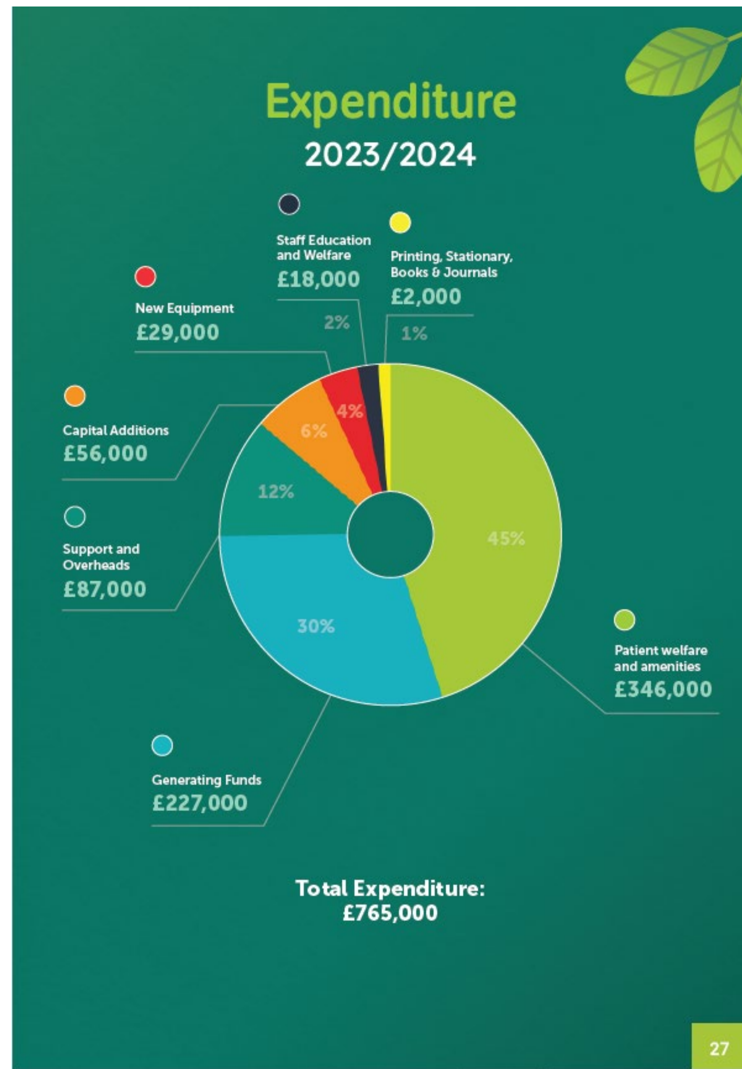
Fusion Biopsy Machine - DPOW

The Health Tree Foundation is the working name of the Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds.
The principal address is: Diana, Princess of Wales Hospital, Scartho Road, Grimsby, North East Lincolnshire, DN33 2BA
Registered charity number: 1054935 | T: 03033 304514 | E: hello@healthtreefoundation.org.uk | W: www.healthtreefoundation.org.uk

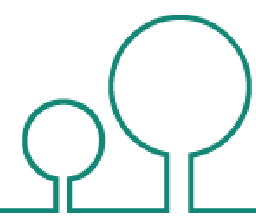
NHS
Northern Lincolnshire and Goole
NHS Foundation Trust



Income
2023/2024
Donations
£57,000
Investments
£38,000
Legacies
£248,000
Grants Recieved
£152,000
Charitable Activities
£167,000
6%
9%
37%
23%
25%
Total Income:
£662,000
26



Expenditure
2023/2024
Staff Education and Welfare
£18,000
Printing, Stationary, Books & Journals
£2,000
New Equipment
£29,000
2%
1%
Capital Additions
£56,000
4%
6%
12%
45%
30%
Support and Overheads
£87,000
Patient welfare and amenities
£346,000
Generating Funds
£227,000
Total Expenditure:
£765,000
27



What success looks like

HTF strives to be the "go-to" local charity, giving our supporters the confidence to know that their donations are being invested to help those who need it most, at the very heart of local NHS services

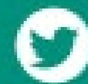
How can Governors help?

Contact the charity team on either:

Telephone: **03033 304514**

Email: **hello@healthtreefoundation.org.uk**

Thank you for your support!

Health Tree Foundation healthtreefoundation  HealthTree_NLAG

www.healthtreefoundation.org.uk

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Northern Lincolnshire and Goole
NHS Foundation Trust

THE HEALTH TREE FOUNDATION
Grimsby's Hospital Charity

Thank you so much for your time

www.healthtreefoundation.org.uk
hello@healthtreefoundation.org.uk

@HealthTree_NLAG

/healthtreefoundation

healthtreefoundation

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Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)011

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	Emma Sayner, Group Chief Financial Officer
Contact Officer/Author	Brian Shipley, Operational Director of Finance
Title of the Report	**NLaG Finance Update – Month 8**
Executive Summary	This report highlights the reported financial position for NLaG at Month 8 of the 2024/25 reporting period.
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	
Financial implication(s) (if applicable)	Contained within the report.
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ☐ Discussion ☐ Assurance ✓ Information ☐ Review ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

Finance Report Month 8

November – 2024/25

Kindness · Courage · Respect

Finance Overview

In-month I&E Performance – page 3

(£0.5m) The Trust reported a (£2.1m) in-month deficit for month 8, (£0.5m) adverse to plan.

Year to Date I&E Performance – page 3

(£0.8m) The Trust reported a (£4.2m) YTD deficit at the end of month 8, (£0.8m) adverse to plan.

I&E Forecast Outturn – page 4

(£3.3m) The Trust is forecasting a deficit of (£6.3m) based on a straight-line projection, (£6.3m) adverse to plan. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£3.3m).

YTD Cost Improvement Plan – page 5 to 6

£5.8m The Trust has delivered £24.5m in CIP against a YTD target of £18.7m, £5.8m ahead of plan and is forecasting £38.9m at year end, £1.4m ahead of plan. However, this is heavily reliant on non-recurrent savings.

Underlying I&E – page 7

(£46.3m) The Trust underlying position is estimated at a deficit of (£46.3m).

System Performance – page 8

(£12.9m) The HNY ICS reported a deficit of (£38.0m), a (£12.9m) adverse variance to plan for the first 8 months of the year.

Capital Expenditure – page 9

(£12.8m) Capital spend was (£12.8m) below plan at the end of November. Slippage on CDC schemes are the prime drivers.

Balance Sheet & Cash – pages 10 to 11

£32.6m The Trust cash balance at the end of November was £32.6m.

Elective Recovery Performance – page 14

(£2.2m) The Trust is behind the NHSE activity baseline targets by (£2.5m) and is forecasting to be (£2.2m) if no corrective action is taken. The Trust has discovered a reconciliation error for May SUS data that it expects to be corrected (£0.7m).

Temporary Staffing – pages 15

£9.8m The Trust has spent £32.8m on agency and bank pay. This is £9.8m lower than the same period in 2023/24. However, 23-24 included £1.6m Strike Costs vs £0.28m 24-25 YTD.

Key Risks

- ❑ CIP Delivery.
- ❑ Non-delivery of Elective Recovery Target.
- ❑ Winter pressures / unfunded Escalation Beds.
- ❑ Unidentified stretch income target
- ❑ Capital Expenditure profile
- ❑ Delivery of unidentified gap to achieve a balanced plan
- ❑ Requirement for Revenue Cash Support in Q4

Key Actions

- ❑ Reducing cost pressures - reliance on premium agency, minimising escalation beds and greater control of non-pay expenditure.
- ❑ Maximising planned care activity, reducing reliance on Independent Sector (IS) and Waiting List Initiative (WLI) premium costs.
- ❑ Delivering a challenging CIP programme - conversion of non-recurrent savings into recurrent delivery schemes and identifying new schemes.
- ❑ Reduce underlying run rate spend within Care Groups to mitigate unidentified gap to achieve a balanced plan.

Financial Performance Summary

The Trust ended November with a year-to-date (YTD) deficit of (£4.2m), (£0.8m) adverse to plan.

- **The Trust reported a (£2.1m) deficit in November, (£0.5m) adverse to plan.**
- Clinical Income is (£5.6m) below plan. The Trust is (£2.5m) down YTD against estimated NSHE Elective Recovery baselines. However this includes £0.7m relating to missed activity in the May SUS submission that is expected to be recovered. The remaining variance is due to Diabetes high-cost device income and Community Diagnostic Centre (CDC) income, all offset by expenditure underspends.
- Clinical Pay is £2.8m underspent year to date. Nursing agency remains significantly reduced on 23/24 levels and is supporting strong CIP performance. The Trust has incurred £0.23m strike costs YTD which has now been funded. 2024/25 Pay Awards have a residual unfunded gap of (£0.8m) YTD.
- Clinical non-pay was (£1.8m) overspent mainly due to Pathology activity, offset by income, Gynae Activity pressures and Community Equipment Store.
- Depreciation and Non-operating Items were £0.8m underspent due to interest received on cash balances and capital delays on CDCs.

	NLAG £m					
£million	CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical Income	44.7	41.7	(3.0)	366.7	361.1	(5.6)
Other Income	5.0	6.7	1.7	34.7	36.7	2.0
Total Operating Income	**49.7**	**48.4**	**(1.3)**	**401.4**	**397.7**	**(3.7)**
Pay Costs						
Clinical Pay	(27.4)	(25.8)	1.6	(218.4)	(215.6)	2.8
Other Pay	(6.8)	(6.7)	0.1	(55.0)	(55.0)	0.0
Total Pay Costs	**(34.2)**	**(32.5)**	**1.7**	**(273.4)**	**(270.6)**	**2.8**
Clinical Non Pay	(7.1)	(7.4)	(0.3)	(58.1)	(59.8)	(1.8)
Other Non Pay	(7.1)	(6.7)	0.4	(51.6)	(50.7)	0.9
Total Non Pay Costs	**(14.2)**	**(14.1)**	**0.1**	**(109.7)**	**(110.6)**	**(0.9)**
Total Operating Expenditure	**(48.4)**	**(46.6)**	**1.8**	**(383.1)**	**(381.2)**	**1.9**
EBITDA	**1.3**	**1.8**	**0.5**	**18.3**	**16.6**	**(1.7)**
Depreciation	(2.1)	(2.1)	(0.0)	(15.3)	(15.4)	(0.0)
Non Operating Items	(0.7)	(0.3)	0.4	(5.3)	(4.5)	0.8
Surplus/(Deficit)	**(1.4)**	**(0.5)**	**0.9**	**(2.4)**	**(3.3)**	**(0.9)**
Adjustments to adjusted financial performance	(0.1)	(1.5)	(1.4)	(1.1)	(0.9)	0.2
Adjusted financial performance Surplus / (Deficit)	**(1.5)**	**(2.1)**	**(0.5)**	**(3.5)**	**(4.2)**	**(0.8)**

EBITDA = Earnings Before Interest, Tax, Depreciation & Amortisation

See Appendix A on Page 13 for Detailed I&E Position

Financial Performance – Forecast Outturn (FOT)

The Trust is forecasting a deficit of (£6.3m) based on a straight-line projection, (£6.3m) adverse to plan. Mitigating actions are expected to reduce the deficit leaving an unidentified gap of (£3.3m).

The Trust is currently away from plan at the end of month 8 by (£0.8m) with a year to date deficit of (£4.2m). This is due to the gap in the cost of the pay award compared to the additional income received via the national increase in the Cost Uplift Factor / Education Contract.

A straight-line forecast projects a potential deficit of (£6.3m) against a balanced plan.

This has been adjusted for known seasonal variation in energy costs, planned completion of Capital programme, increasing depreciation charges, and an anticipated improvement in run-rate. The forecast also needs to be adjusted for the £14.6m of deficit funding received in M6, as 100% of the 24/25 allocation has been accounted for, increasing the adjusted run rate to a (£10.7m) deficit.

CIP delivery (including additional ERF income and opportunities identified by PA Consulting) are expected to improve on the current run rate delivery by a further £1.3m.

In addition, the Trust is expected to be able to release its annual leave provision of £6.1m.

The above actions reduce the deficit leaving an unidentified gap of (£3.3m) adrift of a balanced plan.

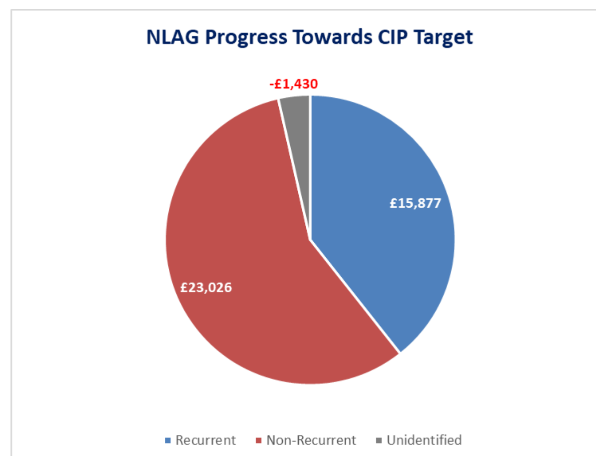
The Trust is formally reporting a plan compliant balanced forecast position.

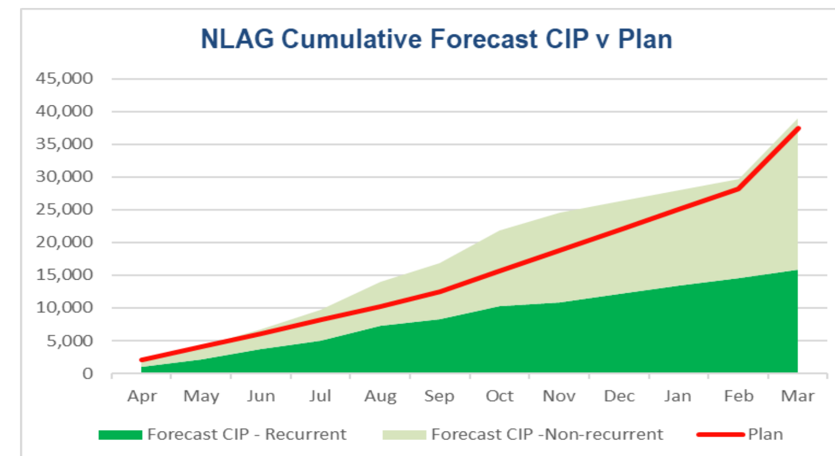
Forecast Bridge	£'m
YTD deficit (M8)	(4.2)
Straight line forecast	**(6.3)**
Seasonal Utilities & Drugs	(1.1)
Deficit Funding in M6 (100%)	(7.4)
Expected improvement to run-rate	6.1
Industrial Action	0.0
Depreciation and Interest Received	(2.0)
Adjusted Run Rate	**(10.7)**
Forecast CIP delivery	0.6
PA Consulting Opportunity	0.7
Annual Leave Provision	6.1
Unidentified Gap	3.3
Reported Forecast deficit	**0.0**
Plan	**0.0**
Variance	**0.0**

Financial Performance – CIP Delivery

At the end of November, the Trust has delivered £24.51m against the £18.73m year to date plan. Achievement of the annual plan is forecast but this is heavily reliant on significant non-recurrent central support.

Workstream	Year to Date at November 24			Forecast Year-end		
	Plan £000s	Actual £000s	Variance £000s	Plan £000s	Actual £000s	Variance £000s
Clinical Workforce - Medical Staff	1,556	3,310	1,754	2,568	4,558	1,991
Clinical Workforce - Nursing and Midwife	3,850	8,341	4,491	6,094	11,302	5,208
Clinical Workforce - Sci, Prof & Tech	2,180	2,274	94	3,621	3,355	-266
Corporate and Non-Clinical Workforce	2,674	2,813	139	3,569	3,612	44
Non-Pay and Procurement	2,002	1,344	-658	3,064	2,209	-855
Productivity & Transformation	3,546	178	-3,368	13,909	362	-13,547
Digital Transformation	48	84	36	77	164	86
Estates & Facilities	673	789	116	1,135	1,222	86
Income	606	1,049	443	909	1,321	412
Reserves	717	2,621	1,904	1,076	3,490	2,414
Technical	1,461	1,703	242	2,706	7,309	4,602
Variation to Target *	-581	0	581	-1,255	0	1,255
TRUST TOTAL EFFICIENCY PLAN	18,733	24,506	5,773	37,473	38,903	1,430





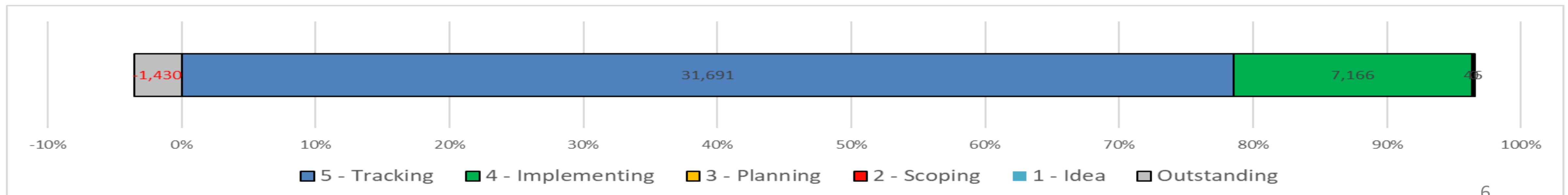
- The Trust has a £37.47m cost improvement programme for 2024/25
- In-month delivery was down against plan by £0.47m but still over-delivering against YTD plan by £5.78m. Only 24% of this in-month delivery was recurrent.
- The £17.54 Core programme (Care Group 3% and Corporate 7%) continues to over deliver and is contributing £7.66m YTD (£9.31m forecast full year) to the centrally held £19.94m (full year) unallocated target.
- Year to date the Care Groups have over-delivered by £7.45m, £0.97m in-month. The in-month has been driven by nursing and AHP vacancy factor, as well as nursing agency grip and control. Pathology Network, Acute and Emergency Medicine, and Family Services are all over delivering significantly whilst Patient Services and Major Trauma are the furthest from plan. The year-end forecast is £21.84m delivery against the £12.37m annual plan.
- Corporate Directorates over-delivered by £0.23m in November, against a plan of £0.43m and are now £0.21m over their £3.45m YTD plan. As with care groups this over delivery is largely vacancy factor. Only Estates and Facilities (within finance) and Chief Nurse are behind plan YTD. The year-end forecast position has improved and is now only £0.17k short of the 7%, £5.17m, plan.
- YTD the core programme over delivery is meeting the centrally held unallocated however achievement of the full £19.94m is dependent on significant non-recurrent central support.

Financial Performance – CIP Development

The Trust has a Cost Improvement Programme of £37.47m for the year. This has been allocated to Care Groups at 3% of expenditure budgets and 7% to Corporate totalling £17.54m with the remainder managed centrally. Currently plans of £38.90m are being developed however only £15.88m are recurrent.

- The Trust has a £37.5m cost improvement programme for 2024/25
  - 3% Care Groups £12.4m
  - 7% Corporate £5.2m
  - 7% Reserves & Technical £7.0m
  - Unallocated £13.0m
- The Trust is now forecasting delivery of its £37.43 plan although there is a substantial amount of non-recurrent central support. This is an improvement of £1.97m compared to October driven by additional delivery in the Care Groups and Corporate Directorates as well as central support.
- Currently £31.69m savings are in delivery and being tracked with a further £7.17m expected to commence imminently. £0.05m are in a planning phase.
- Chief Delivery Officer South, Patient Services and Major Trauma Network are the Care Groups with the biggest shortfall in plans, although overall Operations are forecasting a year end favourable variance of £9.48m.
- Chief Nurse and Estates and Facilities are the only corporate areas with shortfalls in their plans to deliver the 7% target.
- Work is on-going to develop deliverable productivity improvements in Theatres, Outpatients and Endoscopy. This is being led by the Transformation team. PA Consulting have also commenced support to review group cost efficiency.
- Although the Trust is now on track to deliver the annual target only £15.88m is recurrent which will impact the size of the programme required for 2025/26

2024/25 CIP PROGRAMME MATURITY



Underlying Position

The Trust underlying financial position is estimated at a deficit of (£46.3m)

- The Trusts estimated underlying deficit is estimated to be (£46.3m).
- Now bridging from the revised balanced plan for 2024-25 following receipt of non-recurrent deficit support funding (£14.9m) there are three main drivers:

1. The Trust is in receipt of specific Non-Recurrent Income support totalling £21.3m.
2. The Trust has historically relied on Non-Recurrent savings delivery to achieve its financial targets. This is forecast to be £15.1m within the current year's savings plan and an additional £7.9m in Technical Balance Sheet support. The Trust must look to convert non-recurrent savings schemes into recurrent schemes where possible.
3. The Trust has committed £0.7m to recurrent investments in year. (Straight to Test LGI £0.5m, Information Team Re-Structure £0.2m)
4. The Trust has a residual funding gap on the 24/25 Pay Award of (£1.2m).

£million	NLAG
2024/25 - Surplus/(Deficit) Plan	**0.0**
Non-recurrent Adjustments	
NR Additional Stretch Income Support	(4.0)
NR Depreciation Funding Support	0.0
NR Surge Funding Support	(2.5)
NR 24/25 Deficit Funding	(14.9)
NR CIP (Forecast)	(15.1)
NR Balance Sheet Flexibility	(7.9)
FYE 24/25 Plan	(1.2)
2024/25 New Investments	(0.7)
Underlying Deficit	**(46.3)**

System Financial Performance – November 2024

The ICB reported a YTD deficit of (£38.0m), (£12.9m) adverse variance to plan. The system is forecasting a balanced plan, but at this stage has an unmitigated gap of c. £64.1m.

Organisation	Year To Date (Month 8)			Forecast		
	Plan £000	Actual £000	Variance £000	Plan £000	Actual £000	Variance £000
Harrogate & District NHS Foundation Trust	(3,627)	(8,935)	(5,308)	0	0	0
Hull University Teaching Hospitals NHS Trust	(12,505)	(13,774)	(1,269)	0	0	0
Humber Teaching NHS Foundation Trust	(1,967)	(2,380)	(413)	0	0	0
Northern Lincolnshire & Goole NHS Foundation Trust	(3,417)	(4,213)	(796)	0	0	0
York and Scarborough Teaching Hospitals NHS Foundation Trust	(3,559)	(8,531)	(4,972)	0	0	0
Provider Total	**(25,075)**	**(37,833)**	**(12,758)**	**0**	**0**	**0**
Humber & North Yorkshire ICB	0	(182)	(182)	0	0	0
Full System Position	**(25,075)**	**(38,015)**	**(12,940)**	**0**	**0**	**0**

Capital Expenditure

Year-to-date capital expenditure is £13.1m against a £25.9m YTD plan, including IFRS16 and donated spend.

£million	Year to Date		
	Plan	Actual	Var.
Estates Major Schemes			
Ward/Department Refurbishment/Development	0.8	0.0	(0.8)
Day Surgery CHH	0.0	0.0	0.0
Theatres & IRT	0.0	0.0	0.0
Community Diagnostic Centres	15.5	7.5	(8.0)
Total Estates Major Schemes	**16.2**	**7.5**	**(8.7)**
Other Estates Schemes	0.3	0.0	(0.2)
IM&T Programme	2.2	0.6	(1.5)
EPR	0.0	0.0	0.0
Pathology LIMS	1.8	0.8	(1.0)
Equipment Renewal	0.9	0.3	(0.6)
Facilities Maintenance	3.6	1.8	(1.8)
Other Capital Expenditure	0.9	2.1	1.2
Total Capital Programme	**25.9**	**13.1**	**(12.8)**
Funded By:			
Internally Generated	14.5	6.7	(7.8)
PDC Funded	9.2	4.3	(4.9)
Donated	1.9	1.6	(0.2)
IFRS16	0.3	0.5	0.2
Disposals - Net Book Value	0.0	0.0	0.0
Total Funding	**25.9**	**13.1**	**(12.8)**

The Trust capital funding for 2024/25 is £38.4m. During November the centre agreed to defer the remaining PDC funding for EPR of £0.9m.

The actual spend to 30th November was £13.1m, against a plan of £25.9m. The in month spend was £3.5m.
The Trust is forecasting to underspend it's full year plan by £0.67m, this is at the request of the ICB, who will in turn overspend. The funding will be returned to the Trust in 2025/26.

Key variances are detailed below:

- Spend on both CDC schemes continues to be slow. The contractor for North East Lincs has issued an updated programme with the completion date of 24th Feb, this has not been accepted by the Trust. Despite increasing the contingency for this site, the contingency is now nearly zero again. Funding from North Lincs Council to support the Scunthorpe scheme is still outstanding, £1.3m.
- Pathology LIMS spend remains behind plan, the Trust is working with the supplier to revise the payment profile and a plan in order to commit all expenditure this year.
- The current digital spend is behind plan, further orders of £0.55m have been raised. The planned spend for EPR have now been approved by the Group Capital Committee.
- Facilities maintenance spend is behind plan, tenders are being evaluated and hopefully orders will be placed within the next month.
- The Equipment Group spend continues to be behind plan. Orders for £0.8m have been placed. Further replacement equipment has been approved, the procurement are working with the clinical teams to finalise the costs and paperwork.
- The year to date spend for IFRS16 is overspent, this is forecasting to be overspent for the full year. The Trust is currently liaising with the ICS regarding additional funding.

Balance Sheet

£ million	NLAG		
	Actual	Actual	In month
	31-Oct-24	30-Nov-24	movement
Fixed Assets	290.5	291.9	1.4
Other Investments	0.0	0.0	0.0
Current Assets			
Inventories	4.0	4.2	0.2
Trade and Other Debtors	25.6	24.4	(1.2)
Cash	43.0	32.6	(10.4)
Total Current Assets	**72.6**	**61.2**	**(11.4)**
Current Liabilities			
Trade and Other Creditors	(54.8)	(46.9)	8.0
Accruals	(20.3)	(20.6)	(0.3)
Other Current Liabilities	(15.9)	(15.5)	0.4
Total Current Liabilities	**(91.0)**	**(82.9)**	**8.1**
Net Current Liabilities	**(18.4)**	**(21.7)**	**(3.3)**
Debtors Due > 1 Year	0.7	0.7	0.0
Creditors Due > 1 Year	0.0	0.0	0.0
Loans > 1 Year	(5.6)	(4.2)	1.3
Finance Lease Obligations > 1 Year	(9.2)	(9.2)	0.0
Provisions - Non Current	(3.6)	(3.6)	0.0
Total Assets/(Liabilities)	**254.4**	**253.9**	**(0.5)**
TOTAL CAPITAL & RESERVES	**254.4**	**253.9**	**(0.5)**

Key Movements:

Current Assets

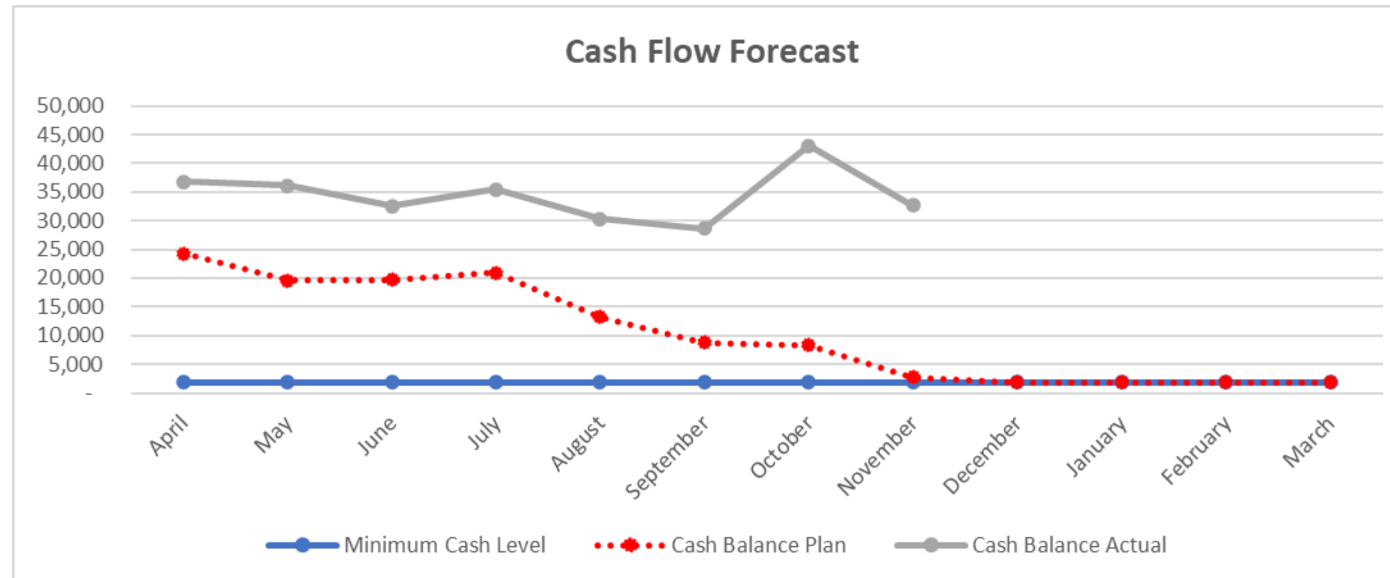
- Stock balances have increase by £0.2m in month, in pharmacy, pathology and community equipment stores.
- Trust NHS debtors have reduced following the receipt of the resident doctors 2023/24 pay award funding.
- Cash has reduced in month, the resident doctors pay award has been paid this month. The tax, ni and pension costs for October have also been paid, these were £5m more than previous months following the agenda for change pay award.

Current Liabilities

- The deferred income (included under other current liabilities) has only reduced by £0.6m in month despite the release of the November Health Education income. Income received in advance from both HNY & Lincs ICB has been deferred, £1.2m.
- Provisions under one year have continued to increase, this relates to ongoing pay dispute. The cost will increase by every month until a conclusion is reached.
- Both trade and other creditors reduced in month following the payment of the pay award for resident doctors and tax, ni and pensions costs relating to the previously paid agenda for change pay award.
- The total Better Payment Practice Code (BPPC) figures for the Trust continue to be above 90%; year to date figures are, 94.7% for value of NHS invoices paid with 30 days and 95% for number paid, a slight reduction in month. Non NHS invoices is 95.5% for value paid within 30 days and 95.8% for number paid, an increase in month. Monitoring of BPPC and communication to staff of the importance of authorising invoices will continue.

Cash Flow

Current forecast shows that the Trust is not expecting to require central cash if savings targets are achieved. The Trust will liaise with NHSE if this position changes and support is required.



£000's	April	May	June	July	August	September	October	November	December	January	February	March
Minimum Cash Level	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900	1,900
Cash Balance Plan	24,315	19,563	19,657	20,988	13,182	8,767	8,282	2,774	1,900	1,900	1,900	1,900
Cash Balance Actual	36,811	36,114	32,536	35,457	30,347	28,658	43,003	32,648				

Northern Lincolnshire and Goole NHS Foundation Trust

Appendices

Appendix A – Detailed I&E, Divisional Budgetary Performance & Reserves Summary

£million	NLAG £m					
	CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical Income	44.7	41.7	(3.0)	366.7	361.1	(5.6)
Other Income	5.0	6.7	1.7	34.7	36.7	2.0
Total Operating Income	**49.7**	**48.4**	**(1.3)**	**401.4**	**397.7**	**(3.7)**
Pay Costs						
Medical Staff	(10.5)	(9.1)	1.4	(81.8)	(80.1)	1.7
Nursing Staff	(11.9)	(12.0)	(0.1)	(97.6)	(97.6)	0.0
Scientific Therapeutic & Technical Staff	(5.0)	(4.7)	0.3	(39.0)	(37.9)	1.1
Total Clincial Pay	**(27.4)**	**(25.8)**	**1.6**	**(218.4)**	**(215.6)**	**2.8**
Admin & Clerical Staff	(5.0)	(4.9)	0.0	(40.6)	(40.7)	(0.1)
Maintenance Staff	(0.2)	(0.2)	0.0	(1.5)	(1.4)	0.1
Support Staff	(1.5)	(1.4)	0.0	(11.7)	(11.8)	(0.2)
Other Staff	(0.0)	(0.0)	0.0	(0.2)	(0.1)	0.1
Apprentice Levy	(0.1)	(0.1)	0.0	(1.1)	(1.1)	0.0
Total Other Pay	**(6.8)**	**(6.7)**	**0.1**	**(55.0)**	**(55.0)**	**0.0**
Total Pay Costs	**(34.2)**	**(32.5)**	**1.7**	**(273.4)**	**(270.6)**	**2.8**
Drugs	(3.1)	(2.9)	0.1	(26.1)	(26.5)	(0.4)
Clinical Supplies & Services	(4.0)	(4.4)	(0.4)	(32.0)	(33.3)	(1.4)
Total Clinical Non Pay	**(7.1)**	**(7.4)**	**(0.3)**	**(58.1)**	**(59.8)**	**(1.8)**
General Supplies & Services	(0.5)	(0.5)	(0.0)	(4.1)	(4.2)	(0.1)
Establishment Expenses	(0.6)	(0.7)	(0.0)	(5.2)	(5.1)	0.1
Other Establishment Costs	(1.4)	(1.4)	(0.0)	(11.2)	(11.2)	(0.1)
Premises and Fixed Plant	(2.3)	(2.2)	0.1	(16.0)	(15.8)	0.2
Purchase of Healthcare Services	(1.8)	(1.1)	0.6	(12.7)	(11.6)	1.1
Miscellaneous Expenditure	(0.2)	(0.2)	(0.0)	(0.8)	(1.1)	(0.3)
Education Expenditure	(0.1)	(0.2)	(0.1)	(1.1)	(1.2)	(0.1)
Consultancy Expenditure	(0.1)	(0.2)	(0.2)	(0.6)	(0.5)	0.1
Total Other Non Pay	**(7.1)**	**(6.7)**	**0.4**	**(51.6)**	**(50.7)**	**0.9**
Total Non Pay Costs	**(14.2)**	**(14.1)**	**0.1**	**(109.7)**	**(110.6)**	**(0.9)**
Total Operating Expenditure	**(48.4)**	**(46.6)**	**1.8**	**(383.1)**	**(381.2)**	**1.9**
EBITDA	**1.3**	**1.8**	**0.5**	**18.3**	**16.6**	**(1.7)**
Depreciation	(2.1)	(2.1)	(0.0)	(15.3)	(15.4)	(0.0)
Non Operating Items	(0.7)	(0.3)	0.4	(5.3)	(4.5)	0.8
Surplus/(Deficit)	**(1.4)**	**(0.5)**	**0.9**	**(2.4)**	**(3.3)**	**(0.9)**
Adjustments to adjusted financial performance	(0.1)	(1.5)	(1.4)	(1.1)	(0.9)	0.2
Adjusted financial performance Surplus / (Deficit)	(1.5)	(2.1)	(0.5)	(3.5)	(4.2)	(0.8)

Directorate	Care Group	NLAG (£m)					
		CM			YTD		
		Plan	Actual	Variance	Plan	Actual	Variance
Operations	Chief Delivery Officer	0.0	0.0	0.0	0.0	0.0	0.0
	Cancer Network	(0.5)	(0.4)	0.0	(2.9)	(2.8)	0.2
	Cardiovascular	(0.9)	(1.0)	(0.1)	(7.1)	(6.8)	0.2
	Digestive Diseases	(2.7)	(2.5)	0.3	(20.0)	(18.8)	1.1
	Head & Neck	(1.4)	(1.3)	0.0	(9.9)	(10.3)	(0.4)
	Major Trauma Network	(0.2)	(0.2)	(0.0)	(1.6)	(1.6)	(0.0)
	Patient Services	(1.6)	(1.7)	(0.1)	(12.9)	(13.1)	(0.2)
	Specialist Cancer and Support Services	(4.5)	(4.5)	(0.0)	(43.3)	(43.5)	(0.2)
	Theatres, Anaesthetics and Critical Care	(4.3)	(4.3)	(0.0)	(32.8)	(33.0)	(0.2)
	Sub Total Operations North	**(16.1)**	**(15.9)**	**0.2**	**(130.5)**	**(130.0)**	**0.5**
	Chief Delivery Officer	(0.1)	(0.1)	(0.0)	(0.6)	(0.7)	(0.2)
	Acute and Emergency Medicine	(6.1)	(5.8)	0.3	(44.9)	(41.5)	3.4
	Community, Frailty & Therapy	(4.2)	(4.1)	0.1	(31.9)	(32.2)	(0.2)
	Family Services	(4.7)	(4.6)	0.1	(34.6)	(34.7)	(0.1)
	Neuroscience	(0.7)	(0.7)	(0.0)	(5.0)	(5.0)	0.0
	Pathology Network Group	(2.2)	(1.9)	0.3	(16.0)	(15.1)	0.9
	Site Management & Discharge teams	(0.3)	(0.3)	0.0	(2.6)	(2.6)	0.0
	Specialist Medicine	(1.9)	(1.9)	0.0	(14.1)	(13.9)	0.2
	Specialist Surgery	(2.0)	(1.9)	0.1	(14.0)	(14.2)	(0.2)
	Sub Total Operations South	**(22.1)**	**(21.2)**	**0.9**	**(163.6)**	**(159.8)**	**3.8**
Total Operations		(38.2)	(37.2)	1.1	(294.1)	(289.8)	4.3
Corporate	Chief Executive	(0.1)	(0.2)	(0.1)	(0.9)	(1.1)	(0.1)
	Chief Medical Officer	(1.7)	(1.6)	0.1	(10.7)	(10.4)	0.3
	Chief Nurse Office	(2.0)	(2.1)	(0.0)	(15.9)	(16.0)	(0.1)
	Director of Assurance	(0.1)	(0.1)	0.0	(0.5)	(0.6)	(0.1)
	Director of People	(0.8)	(0.8)	0.1	(6.0)	(5.9)	0.1
	Director of Finance, Estates & Facilities	(3.6)	(3.9)	(0.3)	(27.8)	(28.9)	(1.1)
	Strategy and Partnerships	(0.4)	(0.3)	0.1	(2.7)	(2.6)	0.1
Total Corporate		(8.7)	(8.9)	(0.2)	(64.5)	(65.4)	(0.9)
Central Income, Reserves & Technical	Central Income	46.7	42.7	(4.0)	377.9	370.5	(7.4)
	Central Technical	(3.3)	(0.9)	2.5	(18.2)	(15.3)	2.9
	Unallocated CIP			0.0			0.0
	Reserves	2.2	3.7	1.5	(3.4)	(3.2)	0.2
Total Central Income, Reserves & Technical		45.5	45.5	(0.0)	356.3	352.0	(4.3)
Surplus / (Deficit)		(1.4)	(0.5)	0.9	(2.4)	(3.3)	(0.9)
Adjustments to adjusted financial performance		(0.1)	(1.5)	(1.4)	(1.1)	(0.9)	0.2
Adjusted financial performance Surplus / (Deficit)		(1.5)	(2.1)	(0.5)	(3.5)	(4.2)	(0.8)

£million	Opening Allocation	Residual Annual Budget	YTD Budget	YTD Expenditure	YTD Variance
Investments Reserve	12.4	6.1	2.8	0.0	**2.8**
Inflation Reserve	18.8	0.8	0.7	3.2	**(2.6)**
Agency Premium Reserve	15.1	0.0	0.0	0.0	**0.0**
Elective Recovery Reserve	5.5	4.3	2.5	0.0	**2.5**
TOTAL	51.9	11.1	5.9	3.2	2.7

Appendix B – Elective Recovery

The Trust is behind the NHSE activity baseline targets by (£2.5m). This includes (£0.7m) missed May SUS activity that is expected to be recovered. The Trust is forecasting to be (£2.9m) if no corrective action is taken.

£000's	YTD NLAG Target	YTD NLAG Actual	YTD NLAG Variance	YTD NLAG %
H&NY Contracts	48,562	46,567	(1,995)	96%
External Contracts	7,221	6,794	(427)	94%
Specialist	1,162	1,053	(109)	91%
Sub Total ERF	**56,945**	**54,414**	**(2,531)**	**96%**
A&G	595	595	0	N/A
Total	**57,540**	**55,009**	**(2,531)**	**96%**

£000's	Forecast NLAG Target	Forecast NLAG Actual	Forecast NLAG Variance	Forecast NLAG %
H&NY Contracts	72,094	69,489	(2,605)	96%
External Contracts	10,266	10,081	(185)	98%
Specialist	1,680	1,590	(90)	95%
Sub Total ERF	**84,040**	**81,160**	**(2,880)**	**97%**
A&G	892	892	0	N/A
Total	**84,932**	**82,052**	**(2,880)**	**97%**

Note – the Trust has also incurred penalties of £0.37m to reflect penalties relating to 2023/24 under-delivery.

Appendix C – Temporary Staffing Summary

Agency, Bank and Overtime Expenditure v's 2023/24

Type	Subjective Sub category	NLAG (£000's) 2023/24	2024/25	Variance
Agency	Medical Staff	8,902	7,538	1,365
	Nursing Staff	9,420	2,083	7,337
	Scientific, Therapeutic & Technical Staff	1,242	1,076	167
	Admin & Clerical Staff	310	238	72
	Maintenance Staff	0	0	0
	Other Staff	1	2	(2)
	Support Staff	2	0	2
Agency Total		19,878	10,938	8,940
Bank	Medical Staff	8,758	7,709	1,049
	Nursing Staff	8,269	8,222	48
	Scientific, Therapeutic & Technical Staff	757	835	(78)
	Admin & Clerical Staff	1,460	1,440	20
	Maintenance Staff	0	0	0
	Other Staff	0	0	0
	Support Staff	1,607	1,545	62
Bank Total		20,851	19,750	1,101
Overtime	Medical Staff	128	0	128
	Nursing Staff	725	848	(123)
	Scientific, Therapeutic & Technical Staff	713	934	(221)
	Admin & Clerical Staff	153	181	(28)
	Maintenance Staff	53	46	7
	Other Staff	0	0	0
	Support Staff	105	118	(13)
Bank Total		1,877	2,127	(250)
Grand Total		42,606	32,815	9,791

Total Bank & Agency Spend

Directorate	Care Group	NLAG (£000's) 2023/24	2024/25	Variance
Operations	Chief Delivery Officer	0	0	0
	Cancer Network	28	34	(5)
	Cardiovascular	571	352	219
	Digestive Diseases	2,360	1,462	898
	Head & Neck	1,859	1,543	316
	Major Trauma Network	307	151	156
	Patient Services	994	900	94
	Specialist Cancer and Support Services	1,430	1,707	(277)
	Theatres, Anaesthetics and Critical Care	3,967	2,343	1,624
	Sub Total Operations North	**11,516**	**8,492**	**3,024**
	Chief Delivery Officer	36	0	36
	Acute and Emergency Medicine	13,241	8,777	4,464
	Community, Frailty & Therapy	3,565	2,483	1,082
	Family Services	4,142	3,487	656
	Neuroscience	704	766	(62)
	Pathology Network Group	994	728	266
	Site Management & Discharge teams	422	208	214
	Specialist Medicine	1,928	1,886	42
	Specialist Surgery	2,043	1,797	246
	Sub Total Operations South	**27,076**	**20,133**	**6,944**
Total Operations		38,593	28,625	9,968
Corporate	Chief Executive	18	9	9
	Chief Medical Officer	232	163	69
	Chief Nurse Office	89	97	(8)
	Director of Assurance	0	0	0
	Director of People	127	70	57
	Director of Finance, Estates & Facilities	1,505	1,616	(110)
	Strategy and Partnerships	130	56	75
Total Corporate		2,101	2,010	91
Central Income, Reserves & Technical	Central Income	0	0	0
	Central Technical	35	53	(18)
	Unallocated CIP	0	0	0
	Reserves	(0)	0	(0)
Total Central Income, Reserves & Technical		35	53	(18)
Surplus / (Deficit)		40,729	30,688	10,041

NOTE

NLAG 24-25 Medical Staffing included YTD Strike Backfill costs of £0.28m.

NLAG 23-24 Medical Staffing included YTD Strike Backfill costs of £1.54m.

Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)012

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	Alison Hurley, Deputy Director of Assurance
Title of the Report	**Council of Governors Meetings – Timings and Format Review**
Executive Summary	The purpose of this report is to provide a summary of the feedback received from the MS Forms survey – CoG 2025 Meetings – Timings and Format Review. It was agreed within the Council of Governors (CoG) Annual Review Meeting (ARM) held on 22 August 2024 to canvass the views of Executives, Non-Executive Directors (NEDs) and Governors on the CoG meeting schedule for 2025. The Council of Governors are asked to note the outcome of the review and agree any necessary changes to the schedule in Appendix A.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ☐ Information ✓ Discussion ✓ Review ☐ Assurance ☐ Other – please detail below:

Updated 3 December 2024

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Northern Lincolnshire and Goole
NHS Foundation Trust

CoG Meetings – Current Timings & Format Review for 2025 Meetings

All Executives, Non-Executive Directors and Governors were offered the opportunity to complete the MS Forms survey to review current timings and the format of the 2025 CoG meetings (as per Appendix A). The reviews could be undertaken online in less than two minutes.

We received a response from 19 colleagues (out of a potential 28).

2025 COG MEETING SURVEY	
CoG Meetings - Review current timings and format	**Responses from the survey**
1. Are you happy with the current CoG meeting schedule for 2025 (usually in person at 14:00 – 17:00 hours)	➢ Yes 13 responses ➢ No 6 responses (see below)
2. Alternatively, would you prefer CoG meetings to be in in the……….	➢ Morning 2 responses ➢ Evening 2 responses ➢ Other 2 responses (see below)
3. If you selected 'Other' in question 2 please provide more details	➢ 25/02/25 - 17:30 -19:00 - NED/Governor Teams meeting (in same week) 04/09/25 - decouple NED Highlight Reports from Annual Members Meeting and reschedule as Teams meeting to be held during previous two weeks 17:30 - 19:00 16/04/25 and 17/07/25 - consideration be given to moving spring/summer meetings to late afternoon/early evening 09/01/25 and 05/11/25 meetings as planned ➢ Afternoon meetings from 13:30 – 16:30 hours

2025 COG MEETING SURVEY		
CoG Meetings - Review current timings and format	**Responses from the survey**	
4. Would you prefer CoG meetings to be held….	➢ In person ➢ Virtually via MS Teams ➢ Hybrid – A mixture of in person and virtual ➢ Alternate between in person and virtual ➢ Other	0 responses 3 responses 2 responses 1 response 0 responses
General comments	➢ Face to face meetings in the Summer months (but finishing before 17:00 to avoid the traffic) and virtual in the Winter months ➢ Or evening meetings if they are virtual, as I recognise that evenings might be easier for some Governors	

Dec 2024

Appendix A

MEETING SCHEDULE - 2025

	Quarter 4 (24/25)			Quarter 1 (25/26)			Quarter 2 (25/26)			Quarter 3 (25/26)		
MEETING	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**
Governors												
Council of Governors (2.00 pm - 5.00 pm, with exceptions as stated)	09.01.25	25.02.25 (9.00 am - 10.30 am) **NED & Governor only Meeting**		16.04.25			17.07.25		04.09.25 (1.30 pm - 5.00 pm) **AMM & Highlight Reports**		05.11.25	

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Council of Governors Business Meeting

Agenda Item No: CoG(25)013

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	**Governors, Executive Directors, Non-Executive Directors and Other Directors Register of Interests**
Executive Summary	The report provides the current Register of Interests for Governors, Executive Directors, Non-Executive Directors and Other Directors as of January 2025.
Background Information and/or Supporting Document(s) (if applicable)	Standards of Business Conduct Policy (DCP120) and Conflicts of Interest Policy for Governors (DCP228)
Prior Approval Process	Register of Interest (ROI) system
Financial implication(s) (if applicable)	
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

REGISTER OF GOVERNORS' INTERESTS
JAN 2025 (v1.0)

GOVERNOR NAME	INTERESTS	DATE
PUBLIC GOVERNORS – EAST & WEST LINDSEY		
Jenny Aspinwall	➢ TBC	TBC
Jeremy Baskett	➢ Louth Town Councillor ➢ Working for Integrated Care Board (ICB) as an NHS Job Evaluator	21.08.2024 21.08.2024
Dr Gorajala Vijay	➢ None	27.11.2024
PUBLIC GOVERNORS – GOOLE & HOWDENSHIRE		
Rob Pickersgill	➢ Chair – Asselby Parish Council, Howden, East Yorkshire ➢ Managing Director and 50% shareholder at W Hallam Castings Ltd, Thorne, Doncaster (private company) ➢ Member of Howden Medical Practice PPG ➢ Fellow, Chartered Institute of Public Finance and Accountancy (CIPFA) ➢ Member of National Economic Policy Committee, MAKE UK (UK Manufacturers' representative body)	02.01.2025
Brent Huntington	➢ Trustee Friends of Oakhill, Goole ➢ Member of Montague Practice PPG ➢ Board member Goole & Airmyn IDB	16.12.2024
Clare Woodard	➢ Deputy Chief Executive Officer for HEY Smile Foundation	16.12.2024
PUBLIC GOVERNORS – NORTH LINCOLNSHIRE		
Kevin Allen	➢ Volunteer worker at SGH ➢ Local Authority Governor at Scunthorpe C E Primary School ➢ Local Authority Governor at Enderby Road Infants School	19.12.2024
Paula Ashcroft	➢ Persons Voice Co-ordinator for North Lincolnshire Council	16.04.2024
Caroline Ridgway	➢ Employed by City Health Care Partnership as a Podiatrist	16.12.2024
Wendy Lawtey	➢ None	19.11.2024
Vacancy	➢	
PUBLIC GOVERNORS – NORTH EAST LINCOLNSHIRE		
Diana Barnes	➢ None	02.01.2025
Michael Bateson	➢ Board member/Trustee of local charity Friendship at Home	29.10.2024

David James	➢ Military Care Navigator for Lincolnshire Maternity and Neonatal Programme (Better Births Team)	16.04.2024
Ian Reekie	➢ Director of Lincs Inspire Venues & Enterprises and Member of the Board of Trustees at Lincs Inspire	09.10.2024
Vacancy	➢	

STAKEHOLDER GOVERNORS		
Cllr David Howard – East Riding of Yorkshire Council	➢ Self employed – David Howard trading as Production Values ➢ East Riding of Yorkshire Councillor - Howden Ward and Town Councillor – Howden ➢ Trustee for Moorland Charity in Goole and Howden Shire Hall	20.08.2024
Vacancy – North East Lincolnshire Place	➢	
Emma Mundey – North Lincolnshire Place	➢ Assistant Director of Transformation & Integration within N Lincs for Humber & North Yorkshire Integrated Care Board	30.12.2024
Cllr Paul Henderson – North East Lincolnshire Council	➢ None	18.07.2024
Vacancy – North Lincolnshire Council		
Vacancy – Lincolnshire Council		

STAFF GOVERNORS		
Ahmed Aftab	➢ Director of Sazin Eyecare Limited ➢ Consultant Ophthalmologist - St Hugh's Hospital, Grimsby: Spamedica, Bolton: Lindsey Suite, Scunthorpe ➢ Member of British Medical Association with different local, regional and national roles ➢ Staff Governor	06.02.2024 16.04.2024 24.12.2024
Corrin Manaley	➢ Staff Governor	17.12.2024
Dr Sandeep Saxena	➢ Staff Governor	29.11.2024
Jackie Weavill	➢ Staff Governor	16.12.2024

Executive Directors and Other Directors Register of Interests **At both the Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) and Hull University Teaching Hospitals NHS Trust (HUTH)**	
Name and position	**Interests**
Amanda Stanford, Group Chief Nurse	None.
Andy Haywood, Group Chief Digital Information Officer	Previous employer was a digital health consultancy that could potentially bid for services within the Trust. Procurement steps in place to remove Andy from any decision making and to ensure full transparency.
Aswathi Shanker, South Bank Managing Director	None.
Clive Walsh, Interim Site Chief Executive - North	Yet to declare (start date 4th November, 2024)
David Sharif, Group Director of Assurance	None.
Dr Kate Wood, Group Chief Medical Officer	Family member is Trust employee - Theatres Manager at Diana, Princess of Wales Hospital Grimsby (DPOWH). Associate for AQUA. Trustee of WISHH Charity (HUTH).
Emma Sayner, Group Chief Finance Officer	Yet to declare (start date 2nd December, 2024)
Ivan McConnell, Group Director of Strategy and Partnerships	None.
Jonathan Lofthouse, Group Chief Executive Officer	Group Chief Executive Officer for Northern Lincolnshire and Goole NHS Foundation Trust, as part of HUTH and NLAG working in a Group model. This includes attending the NLAG Council of Governors when requested. Wife Volunteers with the Look Good Feel Better work with the Queens Cancer Centre.
Neil Rogers, North Bank Managing Director	Director of own limited company – Neil Rogers Healthcare Management Solutions Ltd which is currently dormant.
Sarah Tedford, Interim Site Chief Executive - South	Yet to declare (start date 2nd December, 2024)
Simon Nearney, Group Chief People Officer	Director at Cleethorpes Town FC / The Linden Club. Family members working at NLAG and HUTH. Family member working at Hull City Council.

Non-Executive Directors at NLAG Register of Interests	
Name and position	**Interests**
Gillian Ponder, Non-Executive Director and Senior Independent Director	None.
Julie Beilby, Non-Executive Director	None.
Linda Jackson, Vice Chair/Non-Executive Director	Associate Non-Executive Director at HUTH. Family members working at NLAG and HUTH.
Sean Lyons, Group Chair at both NLAG and HUTH	Family member is a Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Simon Parkes, Non-Executive Director	Director of Lincoln Science and Innovation Park (Unremunerated). Lay Canon and Chair of the Finance Committee of Lincoln Cathedral. Deputy Vice Chancellor and Chief Operating Officer of the University of Lincoln.
Stuart Hall, Associate Non-Executive Director	Non-Executive Director/Vice Chair HUTH. Family member is a Lay Member of Yorkshire Clinical Senate. Member of Advisory Committee on Clinical Excellence Awards.
Susan Liburd, Non-Executive Director	Managing Director and Principal Consultant of Sage Blue. Director and Trustee of British West India Regiments Heritage Trust CIC.

Non-Executive Directors at HUTH Register of Interests	
Name and position	**Interests**
Dr Ashok Pathak, Associate Non-Executive Director	Works as a medical expert for Medical Appeals Tribunals. Family members are surgeons at St James Hospital, Leeds.
Dr David Sulch, Non-Executive Director	Medicolegal reports on patients in the fields of stroke, geriatric or general medicine (split roughly 80:20 between defendant and claimant work). I have reported on the care of patients treated at HUTH and NLaG previously but do not do so now.
Helen Wright, Non-Executive Director	Permanent role as Group FD of Eltherington Group Ltd – 3 days per week commencing 1st September 2024
Jane Hawkard, Non-Executive Director	Director of JJJ+L Holdings Ltd (July 2020)
Linda Jackson, Associate Non-Executive Director	Vice Chair/Non-Executive Director at NLAG. Family members working at NLAG and HUTH.
Professor Laura Treadgold, Non-Executive Director	As the Dean of the Faculty of Health Science at the University of Hull (since 02/01/24 – ongoing), the Faculty has a large research portfolio which receives funding from external bodies to undertake research.
Sean Lyons, Group Chair at both NLAG and HUTH	Family member is a Registered Adult Nurse at The Rotherham NHS Foundation Trust.
Stuart Hall, Vice Chair	Associate Non-Executive Director at NLAG. Famliy member is a Lay Member of Yorkshire Clinical Senate. Member of Advisory Committee on Clinical Excellence Awards.
Tony Curry, Non-Executive Director	None.

Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business

Meeting Agenda Item No: CoG(25)014

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	David Sharif, Group Director of Assurance
Title of the Report	**Board Assurance Framework (BAF)**
Executive Summary	The Executive Summary is included in the attached report.
Background Information and/or Supporting Document(s) (if applicable)	All supporting documents are included in the report.
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each CIC with final receipt and approval agreed at the Board
Financial implication(s) (if applicable)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	No Immediate EDI concerns
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Front Sheet
Boards-in-Common

Meeting name	Boards-in-Common
Meeting date	12 December 2024
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	Rebecca Thompson, Deputy Director of Assurance
Title of the Report	Board Assurance Framework (BAF)
Executive Summary	The following report highlights the Q2 risk ratings for: • BAF risk 1 – Staff Support – Current risk score = 20 • BAF risk 2 – Performance – Current risk score = 20 • BAF risk 3 – Patients – Current risk score = 20 • BAF risk 4 – R&I – Current risk score = 12 • BAF risk 5 – Partnerships – Current risk score = 12 • BAF risk 6 – Digital – Current risk score = 16 • BAF risk 7 – Capital – Current risk score = 15 • BAF risk 8 – Financial Sustainability – Current risk score = 25

For these risks, both individually and in combination more generally for all strategic risks, robust management and oversight is required to preserve and nurture the Group's reputation and credibility for patients and broader stakeholders.

Executive leads have reviewed their risks' content following the October 2024 Boards-in-Common meeting. This work has given the content of the BAF a more strategic focus and enabled the assurance directorate to develop the BAF reporting providing colleagues access to a BAF dashboard via Teams. This approach enables colleagues to explore the BAF more dynamically, reviewing controls, assurances, risk appetites and actions across all risks.

To avoid duplication, the format of this report uses extracts from this BAF dashboard, whilst preserving all the sections from the prior format. We would welcome feedback on this format.

Recommendations:

The Boards-in-Common are asked to:

- Note and review the BAF risks
- Note that the risks have been recalibrated.
- Note the high-level Risks aligned to the BAF risks contained in this presentation.

Hull University Teaching Hospitals NHS Trust

Northern Lincolnshire and Goole NHS Foundation Trust

Background information and/or Supporting Document(s) (if applicable)	Further on this agenda is the quarterly risk register report which provides further detail on the high-level risks and range of operational, in-year risks.
Prior Approval Process	The BAF is considered at the Group Cabinet Risk and Assurance Committee and quarterly each Committees-in-Common, with final receipt and approval agreed at the Board.
Implications for equality, diversity and inclusion, including health inequalities	No immediate EDI Concerns
Financial implication(s)	The actions being taken to mitigate the risks should produce more efficient systems and processes across the Group
Recommended action(s) required	☑ Approval ☑ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other

NHS
Humber Health Partnership

Board Assurance Framework
Boards-in-Common

Purpose of the report

The purpose of the report is to update the Boards-in-Common regarding the Group's strategic risks.

The Board assurance framework is designed to help drive the Boards' agenda, achieve its strategic objectives and ensure that the Group's reputation and credibility for patients and broader stakeholders is preserved and nurtured.

Structure of the report

Overleaf, a table summarises the current assessment for each risk:

- The risk description;
- The risk owner/s;
- The current risk score (and whether a change from the previous report);
- The target score (the maximum acceptable);
- The optimum score; and
- The risk appetite category.

The subsequent pages additionally set out, by each risk (over three pages each):

#1

- The strategic risk description;
- The last review date;
- The current risk score in a 5 by 5 matrix applicable to the risk appetite for this risk category; and
- The risk appetite statement relevant to the matrix (for information).

#2

- The controls and assurances and their respective gaps

#3

- The actions being taken to mitigate the current gaps;
- An estimated completion date; and
- The lead officers involved.

Within the limitations of current systems, a list of high-level risks is provided relevant to these Committees-in-Common after the above details. Further on this agenda is the quarterly risk register report which provides further detail on the high-level risks' actions and mitigations and a range of further operational, in-year risks.

NHS Humber Health Partnership

Board Assurance Framework Current assessment

The table below summarises the current assessment for each risk. The following pages provide further detail for each risk.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
1	Staff support	WEC	We aim to support our staff. However, if we fail to embed a compassionate leadership and address poor working conditions, then a failure to act in the long-term and develop our leaders, will result in worsening retention rates and higher levels of disengagement from staff surveys.	Simon Nearney, Group Chief People Officer	20		07/10/24	Balanced	12	8
2	Performance	PEF	We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.	Clive Walsh, Group Chief Delivery Officer	20		23/10/24	Open	16	4
3	Patients	QS	We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.	Kate Wood, Group Chief Medical Officer, Amanda Stanford, Group Chief Nurse	20		09/10/24	Cautious	9	4
4	Research and innovation	QS	We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.	Kate Wood, Group Chief Medical Officer	12		29/10/24	Balanced	12	4
5	Partnerships	TB	We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.	Jonathan Lofthouse, Group Chief Executive, Ivan McConnell, Group Chief Strategy & Partnerships Officer	12		06/11/24	Balanced	12	4

NHS Humber Health Partnership

Board Assurance Framework
Current assessment

The table below summarises the current assessment for each risk. The following pages provide further detail for each risk.

ID	Heading	CiC	Strategic risk	Risk owner/s	Latest score	Score change	Scored date	Appetite	Max target score	Optimal risk
6	Digital	CAMP	We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.	Kate Wood, Group Chief Medical Officer	16		25/10/24	Open	9	6
7	Capital	CAMP	We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands and access issues for our patients.	Mark Brearley, Group Chief Financial Officer	15		23/10/24	Open	9	4
8	Financial sustainability	PEF	We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.	Mark Brearley, Group Chief Financial Officer	25		23/10/24	Open	15	9

Risk #1 – Staff Support

The tables below and opposite provides score

Strategic objective
Supporting our teams today

Strategic risk category	Current score
Staff support	20

Strategic risk

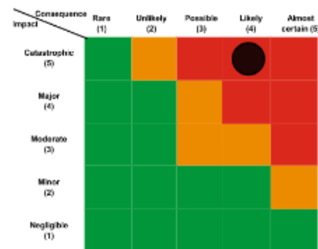
We aim to support our staff. However, if we fail to embed a compassionate leadership and address poor working conditions, then a failure to act in the long-term and develop our leaders, will result in worsening retention rates and higher levels of disengagement from staff surveys.

Committee
Workforce, Education and Culture

Lead
Simon Nearney, Group Chief People Officer

Last review date
Monday, October 07, 2024

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 8 (L:4, C:2)

Appetite statement

Our staff are the most important aspect is delivering safe, effective care and a good experience to our patients. Our willingness to accept workforce risks is balanced and open in nature. Whilst we have the highest levels of ambition for our workforce and their development, we will accept some level of likelihood or range of negative consequences to our workforce in the pursuit of better patient care, more local decision-making, improved productivity, innovation and better ways of working.

Control	Tier
Annual Care Group Workforce plans	1
CESR Programme	1
EDI Steering Group	2
Group Senior Management Team (was EMC) will receive escalation reports from the Group Workforce Transformation Committee	2
HR Directors Chairs meeting (NHS Employers)	2
HUTH People Strategy (2024 expiry)	1
International recruitment drives	1
Leadership Strategy	2
NLAG People Strategy (2024 expiry)	1
Required Learning Steering Group	2
Site IPR meetings	1
Talent management team for international recruitment	1
Workforce Transformation Committee	1

Assurance	Tier
Annual Safer Staffing Report	2
Certificate of Eligibility for Specialist Registration metrics to Group Workforce Transformation Committee	2
Integrated Performance Report	1
Junior Doctor Rostering Internal Audit Report	2
Smart Cards Internal Audit Report	2
Workforce Report to HNY and Care Partnership ICB Workforce Board	2
Workforce Report to Pay and Agency meetings	2

Gaps in control (and Action ID)	5	6	7	8	Total
Hard to recruit roles in medical specialities	1	1	1		3
Healthcare Assistant issues, not enough grip and high turnover	1	1			2
Sufficient attraction, to recruit and retain staff to work in the area	1	1	1	1	4
Total	3	3	2	1	9

Assurance gaps (and Action ID)	5	6	7	Total
Consultant vacancy position		1	1	2
Frequent culture and staff experience measures			1	1
Plans to address ageing workforce profile	1			1
Total	1	1	2	4

ID	Action	Completion date	Update	Update date
5	Group People Strategy 2025-28 to be developed and launched 2025	01/01/25		08/10/24
6	Launch new recruitment drives using the Group name to attract high calibre candidates	31/10/24		08/10/24
7	Cultural Transformation action plan development	31/10/24		08/10/24
8	Group Leadership network and training programme - November 2024	30/11/24		08/10/24

Humber Health Partnership

Board Assurance Framework
Risk #2 - Performance

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Achieving upper quartile performance

Strategic risk category	Current score
Performance	20

Strategic risk

We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.

Committee

Performance, Estates and Finance

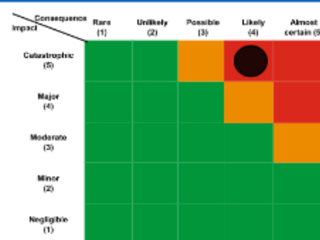
Lead

Clive Walsh, Group Chief Delivery Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 16 (L:4, C:4)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

Control	Tier
Annual Winter Plan with clear safe escalation processes	1
Planned Care Board	1
Site IPR meetings	1
Urgent Care Board	1

Assurance	Tier
Integrated Performance Report	1
Planned Care Board reporting to Performance, Estates & Finance CiC	1
Urgent Care Board reporting to Performance, Estates & Finance CiC	1

Gaps in control (and Action ID)	19	20	21	28	31	Total
Absence of a comprehensive demand and capacity model		1				1
Data quality issues in supporting metrics					1	1
Lack of timely / realtime performance reporting (eg weekly dashboard)	1					1
Lack of trajectory setting to support robust performance management	1			1		2
Weak culture of improvement/change management			1			1
Total	2	1	1	1	1	6

Assurance gaps (and Action ID)	31	Total
Absence of routine data quality monitoring	1	1
Total	1	1

ID	Action	Completion date	Update	Update date
19	Closer working with BI to produce performance reports			
20	Strategic Bed Review (based on optimum LoS)	30/06/25		
21	Embed QI Methodology	31/01/25		
28	Work being monitored via South and North Site Reviews (SS, OA2 - expected impacts from key actions in UEC improvement plan to KPIs (four hour performance, Doctor 1 Seen time, ambulance handover)and NS OA6 - FDS for cancers			
31	Delivery of BI investment and data quality strategy	31/05/25		

Board Assurance Framework
Risk #3 - Patients

The tables below and opposite provides score and further

Strategic objective
Listening to our patients and keeping them safe

Strategic risk category	Current score
Patients	20

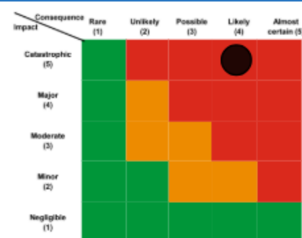
Strategic risk
We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.

Committee
Quality and Safety

Lead
Amanda Stanford, Group Chief Nurse
Kate Wood, Group Chief Medical Officer

Last review date
Wednesday, October 09, 2024

Current score and risk appetite (Cautious)



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement
Safe and high-quality patient outcomes are vital. Our willingness to accept clinical quality and safety risks is balanced and cautious. Whilst we accept that safe, clinical practice is a priority, we will accept some clinical risks if we improve patient care and outcomes overall and our work does not result in any abnormal deviations from acceptable standards.

Control	Tier
Accrediation Frameworks	1
Freedom to Speak Up Guardian	1
Incident Reporting culture	2
Infection Control Committee	2
Maternity and Neonatal Assurance Group	1
National Best Practice	1
National Guidance	1
Nurse Training and Education	1
Patient Experience and Learning	1
Patient Safety and Learning Group	2
Peer Review Process	2
Professional Standards - LNC	1
Quality Improvement Strategy	1
Risk and Compliance Group	1
Safe Staffing Models	1
Site IPR meetings	1
Statutory and Mandatory Training	1
Strategic Safeguarding Board	1

Assurance	Tier
Annual Safer Staffing Report	2
Complaint levels	1
CQC Action Plan	1
CQC findings and reports	1
Friends and Family Test reporting	1
Incident reporting	1
Integrated Performance Report	1
Maternity Neonatal Assurance Group	2
Ouputs from QI Programme	2
Risk Management metrics	1
Statutory and mandatory compliance levels	1
Ward accreditation metrics	1

Gaps in control (and Action ID)	12	13	14	15	16	30	To
Absence of Group Clinical Strategy						1	
Comprehensive safety culture	1	1		1			
Data quality issues in supporting metrics	1						
Lack of consistent basic hygiene compliance				1			
Low midwife establishment		1					
Maternity telephone triage					1		
Robust EQIA process			1				
Strong speak up and reporting culture				1			
Total	2	2	1	3	1	1	

Assurance gaps (and Action ID)	11	12	13	15	Total
Poor regulatory status		1	1		2
PSIRF Processes not embedded		1		1	2
Risk Management process not fully embedded	1				1
Total	1	2	1	1	5

ID	Action	Completion date	Update	Update date
11	Develop and publish Risk Management strategy	01/04/25		09/10/24
12	Develop and publish Quality and Safety Strategy	01/01/25	1st Draft	09/10/24
13	Develop and publish Nursing, Midwifery and AHP Strategy	01/04/25	1st Draft	09/10/24
14	Embed EQIA process (outlined in six-month finance report for 2024-25)	01/04/25	PA Consulting support being explored	24/10/24
15	Develop and embed a Peer Review process	31/03/25		10/10/24
16	Reconfigure existing triage resources and devise options for provision across obstetrics and neonatal services	13/12/24		10/10/24
30	Develop and publish Clinical Services strategy	31/01/25	Obstetric, Paeds and Neonatal review to	01/11/24

Board Assurance Framework
Risk #4 – Research and Innovation

NHS Humber Health Partnership

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Developing research and innovation capabilities

Strategic risk category	Current score
Research and innovation	12

Strategic risk

We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts.

Committee

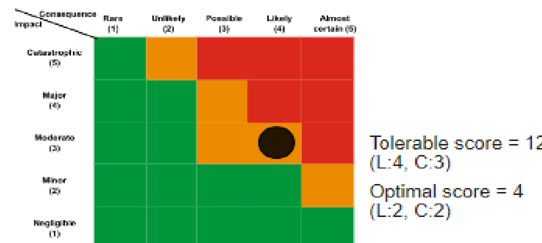
Quality and Safety

Lead

Kate Wood, Group Chief Medical Officer

Last review date

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

Control	Tier
Available research service capacity eg labs	1
Business cases	2
Financial clarity over existing research resources	2
Innovation infrastructure	1
Protected time	1
Research and innovation strategy	1
Research Committee	1
Senior research team	1

Assurance	Tier
External agency reviews	1

Gaps in control (and Action ID)	29	Total
Lack of compelling research and innovation strategy	1	1
Lack of extensive collaboration and credibility	1	1
Total	2	2

Assurance gaps (and Action ID)	29	Total
Lack of available protected time for research and skilled resources to develop innovation	1	1
Total	1	1

ID	Action	Completion date	Update	Update date
29	Develop and publish research and innovation strategy	31/01/25	draft by end of November, Cabinet in December	29/10/24

NHS
Humber Health Partnership

Board Assurance Framework
Risk #5 - Partnerships

The tables below and opposite provides score and further

Strategic objective
Playing an active role in our health and care system

Strategic risk category	Current score
Partnerships	12

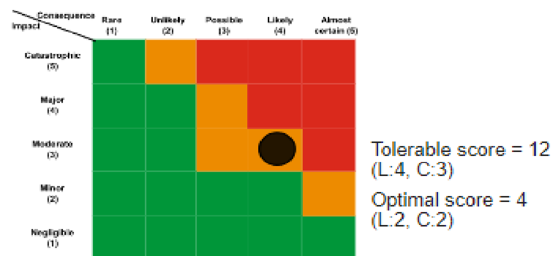
Strategic risk
We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward-facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.

Committee

Lead
Ivan McConnell, Group Chief Strategy & Partnerships Officer
Jonathan Lofthouse, Group Chief Executive

Last review date
Wednesday, November 06, 2024

Current score and risk appetite (Balanced)



Tolerable score = 12 (L:4, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement
Our willingness to accept partnership risks is balanced and open in nature. We wish our engage with a range of partners to deliver our agenda, some of whom may by more innovative or experimental nature and have a limited track record as a result. We are prepared to accept a reasonable level of challenge and setback on the basis of our ability to monitor and manage the risks.

Control	Tier
Humber and North Yorkshire Collaboration of Acute Providers	1
Integrated Care Board	1
Place Boards	1

Assurance	Tier
Positive Task and finish participation	1

Gaps in control (and Action ID)	32	Total
Ad hoc and limited partnerships / relationships with local academic bodies and businesses	1	1
Inconsistent and shallow engagement across region	1	1
Lack of partnership strategy and identification of common opportunities and priorities	1	1
Variable quality of engagement with Place Boards	1	1
Total	4	4

Assurance gaps (and Action ID)	32	Total
Lack of shared areas of work and priorities	1	1
Total	1	1

ID	Action	Completion date	Update	Update date
32	Develop and publish partnership strategy	31/12/24		

Humber Health Partnership

Board Assurance Framework
Risk #6 - Digital

The tables below and opposite provides score and further details for the above risk.

Strategic objective

Developing our digital infrastructure

Strategic risk category	Current score
Digital	16

Strategic risk

We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.

Committee

Capital and Major Projects

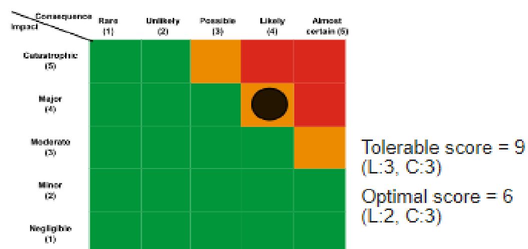
Lead

Kate Wood, Group Chief Medical Officer

Last review date

Friday, October 25, 2024

Current score and risk appetite (Open)



Tolerable score = 9 (L:3, C:3)

Optimal score = 6 (L:2, C:3)

Appetite statement

Our willingness to accept transformation delivery risks is open and entrepreneurial in nature. We wish our local leaders to make changes for the benefit of their patients without routine recourse to executive permission. We accept the potential consequences because we recognise the need to change and capability of our workforce to make the right decisions.

Control	Tier
Digital Strategy	1
EPR Business case	1
Executive digital governance	1
Financial management education for directors and budget holders	2
Financial Strategy	1
ICB Digital Governance	1
Long term Financial Model	1
Supplementary business cases eg DrDoctor, Electronic Document Management System	1

Assurance	Tier
Internal audit reviews eg arising from the National Cyber Security Centre's Cyber Assessment Framework (CAF) and the Data Security and Protection Toolkit	1
Self-assessment of CAF	2

Gaps in control (and Action ID)	25	Total
Lack of comprehensive oversight of all digital investment and management	1	1
Weak commercial and contractual grip and control	1	1
Total	**2**	**2**

Assurance gaps (and Action ID)	25	26	Total
Gaps in financial tracking and funding	1		1
Lack of technical expertise from the Board		1	1
Total	**1**	**1**	**2**

ID	Action	Completion date	Update	Update date
25	Produce and publish Digital Strategy - covering governance, staffing, resourcing, and engagement necessary to achieve objectives	31/01/25	draft to be presented to CEO at Cabinet by December	25/10/24
26	Board development programme and use of external expertise	31/12/25		

Board Assurance Framework
Risk #7 - Capital

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Using major capital effectively

Strategic risk category	Current score
Capital	15

Strategic risk

We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands and access issues for our patients.

Committee

Capital and Major Projects

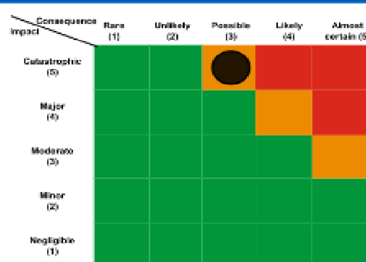
Lead

Mark Brearley, Group Chief Financial Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 9 (L:3, C:3)

Optimal score = 4 (L:2, C:2)

Appetite statement

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

Control	Tier
Business cases	2
Effective E&F governance structures	1
Effective management of operational estates risks	1
Financial management education for directors and budget holders	2
Financial Strategy	1
Long term Financial Model	1
Qualified and accredited engineers	1
Regulatory frameworks	1

Assurance	Tier
Compliance outcomes from regulators	1
Riddor performance	2
Status of operational estates risks and actions from risk register	1

Gaps in control (and Action ID)	24	Total
Absence of comprehensive Estates Strategy	1	1
Total	**1**	**1**

Assurance gaps (and Action ID)	Total
Total	

ID	Action	Completion date	Update	Update date
24	Develop Group estates strategy	28/02/25		

Humber Health Partnership

Board Assurance Framework
Risk #8 – Financial Sustainability

The tables below and opposite provides score and further details for the above risk.

Strategic objective
Achieving financial sustainability

Strategic risk category	Current score
Financial sustainability	25

Strategic risk

We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.

Committee

Performance, Estates and Finance

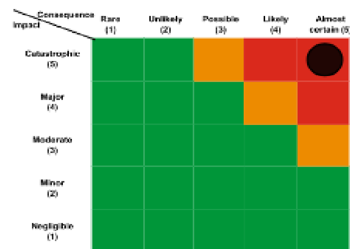
Lead

Mark Brearley, Group Chief Financial Officer

Last review date

Wednesday, October 23, 2024

Current score and risk appetite (Open)



Tolerable score = 15 (L:3, C:5)

Optimal score = 9 (L:3, C:3)

Appetite statement

Our willingness to accept financial or value for money risks is mainly open in nature. We are prepared to make less certain investments for a better future that may risk an adverse financial impact on the basis of our ability to assess and gain benefits and minimise risks.

Control	Tier
Board capability and education	2
Budgetary control system	2
Business cases	2
Cash management controls	2
Cost Improvement Programme	1
Financial management education for directors and budget holders	2
Financial Planning Improvement Board	2
Financial Strategy	1
High functioning Finance department advice and guidance	2
ICS finance model	3
Long term Financial Model	1

Assurance	Tier
Budget control reports	1
Exception reporting on Standing Financial Instructions and Standing Orders compliance	2
Internal audit review of key financial systems	1
In-year operational plan progress	2

Gaps in control (and Action ID)	22	23	Total
Absence of Group Finance Strategy founded on clinical and estates strategies		1	1
Out of date Long Term Financial Model	1		1
Total	**1**	**1**	**2**

Assurance gaps (and Action ID)	Total
Total	

ID	Action	Completion date	Update	Update date
22	Develop five-year long term financial model	31/03/25		23/10/24
23	Develop comprehensive finance strategy	31/03/25		23/10/24

Board Assurance Framework
High-level risks

Any high-level risks being captured in Datix and Ulysses from across the Group would be highlighted here. There are no current high level risks linked to Partnerships.

Risk ID	Risk Opened Date	Corporate Function/Care Group	Risk Handler	Risk Title	Risk Rate Score
3217	29/06/23	Specialist Cancer And Support Services	Ruth Kent	Breast Imaging workforce depletion	20
3325	25/04/24	Family Services	Vijayalakshmi Hebbar	Delays in Children being reviewed in Cardiac Clinic	20
3983	29/06/21	Specialist Cancer And Support Services	Colley, Mr Peter	There is a risk to patient safety, accreditation, and quality of the Rt Physics service due to insufficient staff establishment	20
4032	21/12/21	Specialist Cancer And Support Services	Colley, Mr Peter	Potential non compliance with the IR(ME)R legislation for incident investigation and mandatory reporting	20
2244	20/06/17	Cancer Network	Neil Rogers	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16
2245	20/06/17	Specialist Surgery	Greg Haire	Risk to Overall Performance : Non compliance with RTT incomplete target	16
2592	17/09/19	Specialist Surgery	Greg Haire	Risk to Overall Performance: Cancer Waiting / Performance Target 62 day	16
2898	30/03/21	Acute And Emergency Medicine	Victoria Marshall	Medical Staff - Mandatory Training Compliance	16
3808	02/12/20	HUTH Improvement Programme - Corporate Functions	Krstenic, Mrs Wendy	CDB TSSNSI: Time limited, externally funded posts	16
3810	02/12/20	HUTH Improvement Programme - Corporate Functions	Krstenic, Mrs Wendy	CDB TSSNSI: Staffing Resource	16
3840	11/12/20	HUTH Improvement Programme - Corporate Functions	Dyble, Mrs Debra	CDB NOP MDT: Future investment	16
3842	11/12/20	HUTH Improvement Programme - Corporate Functions	Dyble, Mrs Debra	CDB NOP MDT: Inadequate Local Resource	16
3918	03/03/21	Acute And Emergency Medicine	Weerasekera, Dr Chaminda	Lack of Adequate Substantive Consultant Workforce in Acute Medicine	16
3919	03/03/21	Digital Services	Faruqi, DR Shoaib	E-Radiology Results System: Results not being Actioned Appropriately	16
4130	23/11/22	Specialist Medicine	Hutton, Mr James	Funding provision for 7 day IP DSN Service within Diabetes	16
4148	30/11/22	Specialist Medicine	Aye, Dr Mo	Capacity Shortfalls in DEXA scanning	16
4343	24/04/24	Specialist Cancer And Support Services	Maliakal, Dr Paul	There is a risk to patient care due to the inability to deliver extension of a regional Mechanical Thrombectomy service	16
4344	25/04/24	Cardiovascular	Buxton, Tracie	Risk to patient diagnostic/treatment delays due to	16

NHS Humber Health Partnership

Board Assurance Framework
Next steps and recommendations

Next steps

Each CiC will receive a quarterly update on the BAF for review and approval.

The management of the high-level risks will continue to be assessed through the Care Groups, the Risk and Compliance Group and the escalation processes in place.

The Executive Team will continue to review their strategic risks between CICs and the Group Cabinet Risk and Assurance Committee will recommend any changes to risk ratings or BAF risks to the CICs. Final decisions will be made at the Boards-in-Common.

Recommendations

The Boards-in-Common are asked to:

- Note and review the BAF risks.
- Note that the risks have been recalibrated.
- Note that this strategic risk relating to Partnerships has not been presented or reviewed by any of the CICs.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)015

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	Clive Walsh, Site Chief Executive North Ivan McConnell, Group Chief Strategy and Partnerships Officer
Contact Officer/Author	Adam Creeggan, Group Director of Performance Jackie Railton, Deputy Director, Planning and Performance Louise Topliss, Head of Performance Maria Wingham, Head of Performance
Title of the Report	**Integrated Performance Report (IPR)**
Executive Summary	This report provides details of performance achieved against key national performance, quality and governance indicators defined in the NHSE Single Oversight Framework (SOF)
Background Information and/or Supporting Document(s) (if applicable)	
Prior Approval Process	Submitted to Performance, Estates and Finance Committee in Common (27 November 2024) and Trust Boards-in-Common (12 December 2024)
Financial implication(s) (if applicable)	Report references delivery of activity versus plan with inherent links to income generation via block contract or Elective Recovery Fund
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	Report references delivery of access targets, with inherent links to equity of access across the Group
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Integrated Performance Report

MONTH 7: October 2024 Performance

September 2024 for Cancer data
Produced November 2024

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1. Executive Summary

This report provides an overview of the Group's performance across a range of metrics with specific detail in relation to each individual Trust.

Domain	HUTH Performance	NLAG Performance	Commentary
RTT Long Waits • 104 weeks • 78 weeks • 65 weeks • 52 weeks	**October 2024** **0** **0** **14** **2,614**	**October 2024** **0** **1** **5** **577**	• Continued improvement in reducing >65week volumes at both Trusts. Care Groups focused on the clearance first outpatient waits over 40 weeks to sustain delivery of 65 weeks • Increase in 52 week waits at HUTH (+237). Slight reduction in 52 week waits at NLaG (-58). • One breach of the <78week standard at NLaG resulted from a historic pathway recording error that was identified and corrected in month.
Diagnostic 6w Performance	**October 2024** **17.4%**	**October 2024** **17.4%**	• HUTH has shown an improvement in performance in October of -6.1% set against the previous month and is ahead of planned trajectory. **NLaG deteriorated slightly by 0.5%.** In both cases the in-month change reflects (a) a significant increase in DEXA scans at HUTH, and (b) equalisation of DEXA access times across the Group via the transfer of patients from HUTH to NLAG. ○ Key modalities showing improvement in month at HUTH are DEXA 25.2% compared to 55.7% as detailed above. Gastroscopy 17.2% compared to 26.3% previously following the decontamination room refurbishment. ○ NLaG is showing a reduction in performance which is being driven by DEXA at 16.6% compared to 3.8% in the previous month – this relates to the acceptance of mutual aid patients from HUTH.
Cancer 62 day Performance (all sources)	**September 2024** **51.0%**	**September 2024** **52.5%**	• Both Trusts in Tier 1 for Cancer delivery; working with NE&Y Regional Office on recovery assurance • 62-day performance at NLaG improved by 5.0%. 62-day performance at HUTH impacted by radiotherapy (treatment), oncology capacity (treatment planning), and prostatectomy surgical (treatment option OPAs & treatments) capacity, compounded by late IPTs • +63 day backlog test and challenge meetings in place and resulting in improvement at NLaG (below trajectory & improving). HUTH remains static (IPTs very late in pathway, urology surgical capacity & LGI diagnostic delays).
ED: 4 hour standard (Type 1 & 3) 78% by March 2025	**October 2024** **58.9%** **Trust compliance** **70.3% (plan 76.5%)** **Acute Footprint compliance (incl. Bransholme & ERCH)**	**October 2024** **72.4%** **Trust compliance** **74.9% (plan 76.3%)** **Acute Footprint compliance (incl. Goole UTC)**	• In month attendance levels at both Trust were significantly highly than plan at both Trusts. • HUTH Type 1 performance in October of 40.4% as per plan (40.4%). Type 3 performance (HRI UTC) was 97.7% in October. • NLaG Type 1 performance was 51.2% and Type 3 was 99.4%. NLaG combined type 1 and 3 performance was 72.4% in September, slightly below the 73% target trajectory. • ED performance across both geographical footprints was below plan.

2. Pathway Summary – Benchmark Report – Elective Care

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 24	0	**2,377**			23
RTT 65 Week Breach	Sep 24	-	15			63
RTT 78 Week Breach	Sep 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Sep 24	18.0	**62.3**			66
RTT 95th Percentile Non-Admitted Waiting Time	Sep 24	18.0	**54.6**			47
RTT Admitted Treatment Within 18 Weeks	Sep 24	90.0%	**56.0%**			62
RTT Average (Median) Admitted Waiting Time	Sep 24	9.0	**13.8**			62
RTT Average (Median) Non-Admitted Waiting Time	Sep 24	5.0	**7.3**			83
RTT Average Wait for Incomplete	Sep 24	7.00	**14.8**			42
RTT Incomplete 18 Week Standard	Sep 24	92.00%	**57.0%**			38
RTT Incomplete 92nd Percentile	Sep 24	-	44.2			38
RTT Incomplete Pathways With a DTA	Sep 24	25.0%	15.2%			45
RTT Non-Admitted Treatment Within 18 Weeks	Sep 24	95.0%	**70.9%**			72
RTT Total Clock Starts	Sep 24	-	19,717			91
RTT Total Clock Stops	Sep 24	-	18,403			92
RTT Total Incompletes	Sep 24	-	79,557			17

NLAG

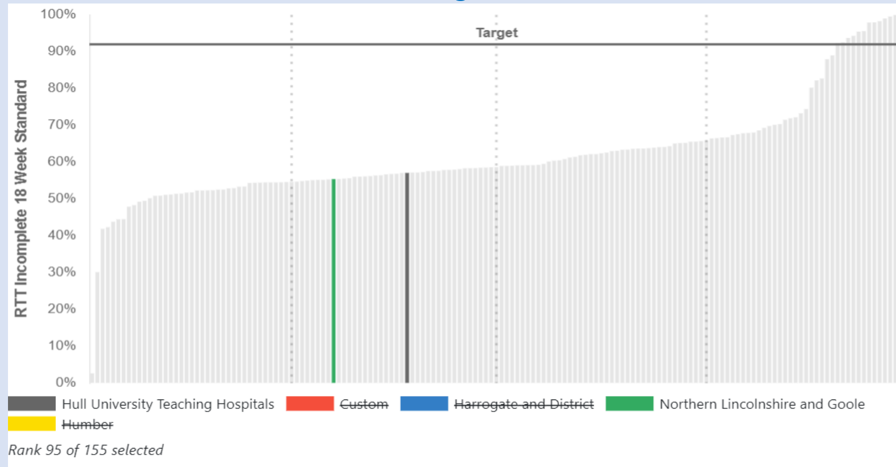
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
RTT 52 Week Breach	Sep 24	0	**635**			61
RTT 65 Week Breach	Sep 24	-	11			65
RTT 78 Week Breach	Sep 24	0	0			100
RTT 95th Percentile Admitted Waiting Time	Sep 24	18.0	**59.0**			75
RTT 95th Percentile Non-Admitted Waiting Time	Sep 24	18.0	**51.9**			57
RTT Admitted Treatment Within 18 Weeks	Sep 24	90.0%	**53.7%**			50
RTT Average (Median) Admitted Waiting Time	Sep 24	9.0	**15.3**			51
RTT Average (Median) Non-Admitted Waiting Time	Sep 24	5.0	**12.9**			27
RTT Average Wait for Incomplete	Sep 24	7.00	**15.6**			30
RTT Incomplete 18 Week Standard	Sep 24	92.00%	**55.4%**			29
RTT Incomplete 92nd Percentile	Sep 24	-	40.8			60
RTT Incomplete Pathways With a DTA	Sep 24	25.0%	13.7%			53
RTT Non-Admitted Treatment Within 18 Weeks	Sep 24	95.0%	**59.7%**			31
RTT Total Clock Starts	Sep 24	-	8,015			43
RTT Total Clock Stops	Sep 24	-	8,169			54
RTT Total Incompletes	Sep 24	-	42,857			45

2. Pathway Benchmarking & Trend – Elective Care

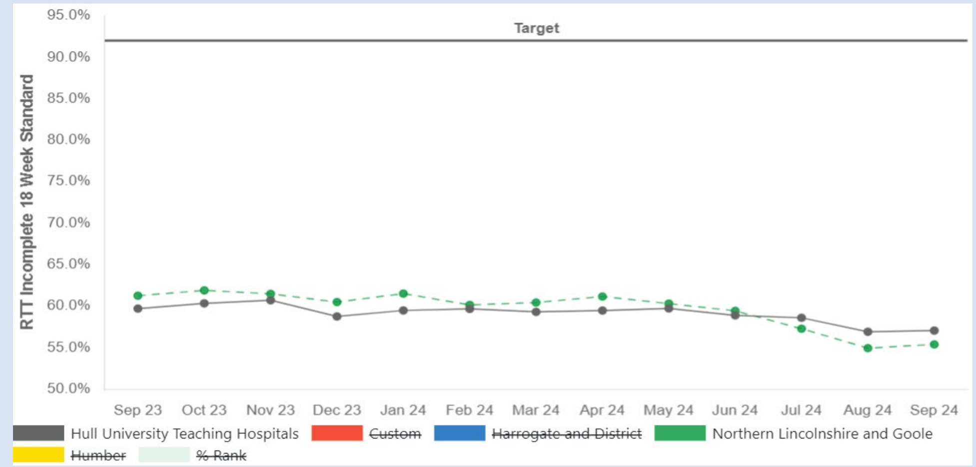
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

RTT – Incomplete Standard

Ranking Chart

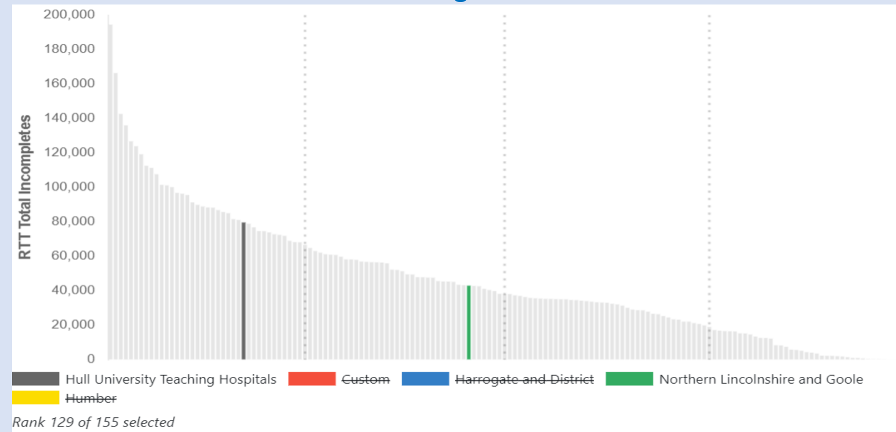


Trend Chart

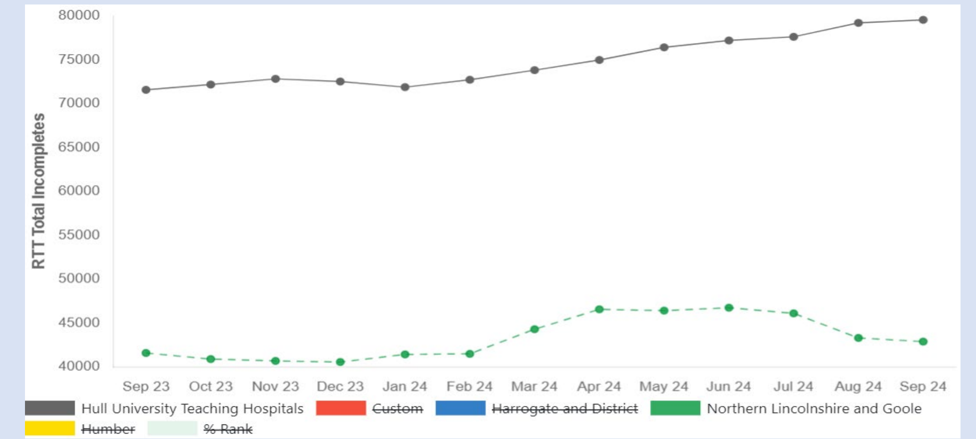


RTT – Total Waiting List Volume

Ranking Chart

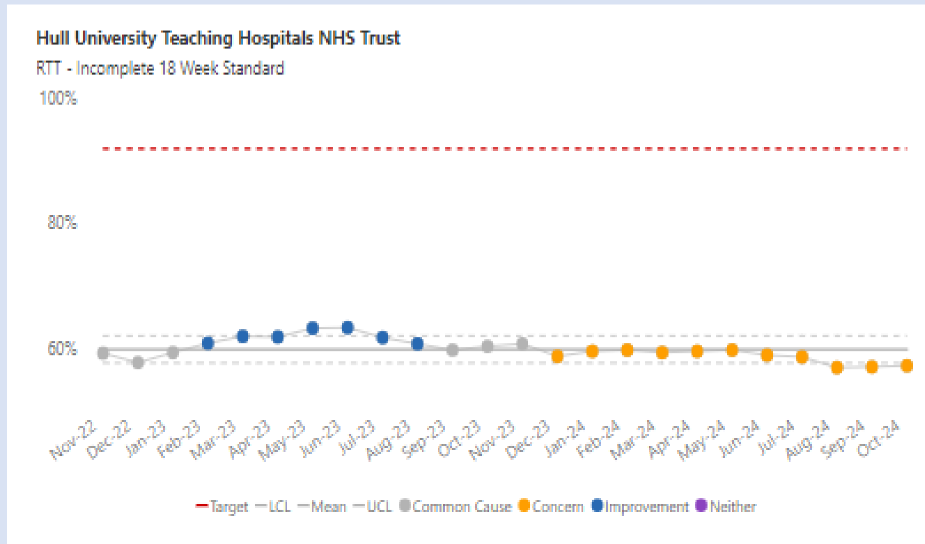


Trend Chart



3. Referral to Treatment - HUTH

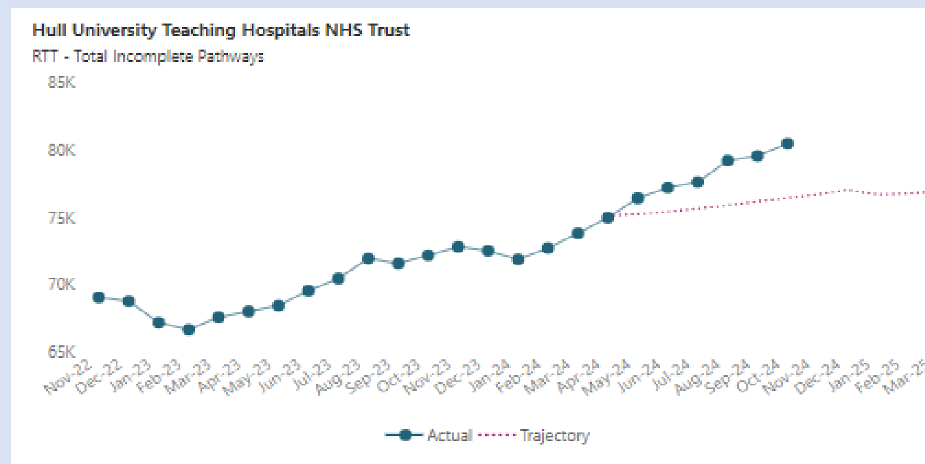
Compliance



Key Themes

- October 18 week RTT performance of 57.3% is broadly unchanged previous months.
- Waiting list volume continues to increase despite above plan pathway completion levels and now stands at 80,488. This predominately reflects an increase in referrals (all sources) of 6.4% YTD. Actions agreed with the wider HYN System to reduce GP referral demand specifically have not been deployed due, in part, to GP collective action.
- 58% of patients on the PTL are awaiting a first outpatient appointment. Largest volumes in ENT, Ophthalmology, Dermatology, Cardiology and Neurology
- 3.2% of patients are waiting over 52 weeks compared to 2.7% at the start of the financial year.
- Average wait for incomplete pathway is 14 weeks but remains broadly stable i.e. not increased despite the increase in PTL size.

Critical Enabler



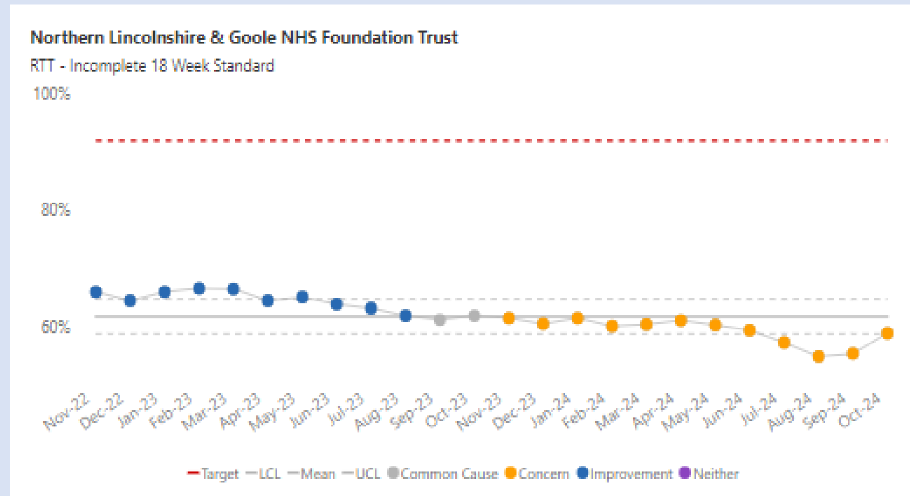
Actions

Critical actions being progressed through RTT Delivery Group:

- Increase first outpatient activity to restore 19/20 baseline. Where 19/20 baseline is being achieved Care Groups have identified additional activity schemes over and above the 24/25 operational plan to achieve additional Elective Recovery Funds income
- Care Groups reviews to decrease waits for first outpatient activity >40 weeks.
- Reallocate follow up outpatient activity without a procedure.
- Remedial admin action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume.

4. Referral to Treatment - NLAG

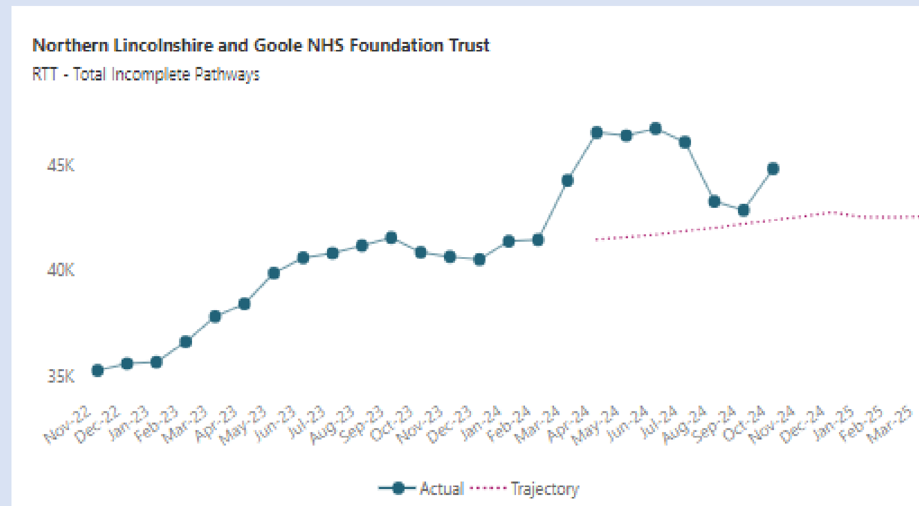
Compliance



Key Themes

- October performance of 58.9% shows an improvement of 3.5% on the previous month. This is a mathematical benefit relating to the correction of ASI inclusion in the waiting list total at NLAG - from 7 October 2024 a cohort of 3,000 pathways have been added into the PTL which were previously not reported. These are referrals awaiting triage which should be reported under national rules. This will mean that the RTT PTL baseline of 42k was under-reported and the new baseline will be circa 45k although not reflected in the planning trajectory for 24/25.
- RTT waiting list volume is above trajectory at 44,482. As above, in month growth reflects the correction of ASI inclusion.
- Detailed review of all outstanding pathway events requiring admin transaction is ongoing.

Critical Enabler



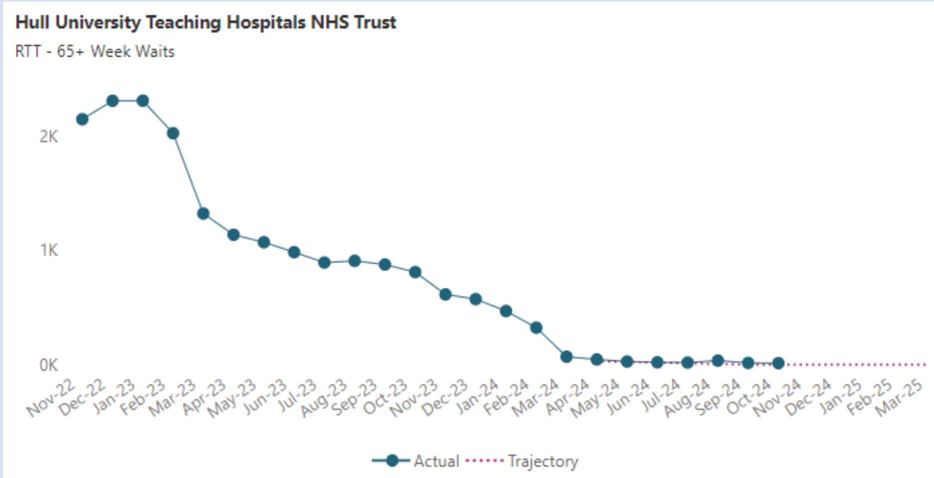
Actions

Critical actions being progressed through RTT Delivery Group

- Increase first outpatient activity and decreased waits for first outpatient activity >13 weeks.
- Decrease follow up outpatient activity without a procedure.
- Care Groups have deployed additional activity over and above the 24/25 operational plan underpinned by Elective Recovery Funds
- Remedial action plans deployed to resolve pathway outcome recording delays to reduce total waiting list volume which have stabilised growth. Recruitment to 10 x validators underway and interim admin resourcing sourced via HUTH RTT team, medical records, etc.
- RTT Insights Model now deployed to NLAG improving management oversight and scrutiny of PTL.

5. Referral to Treatment – 65w Waits - HUTH

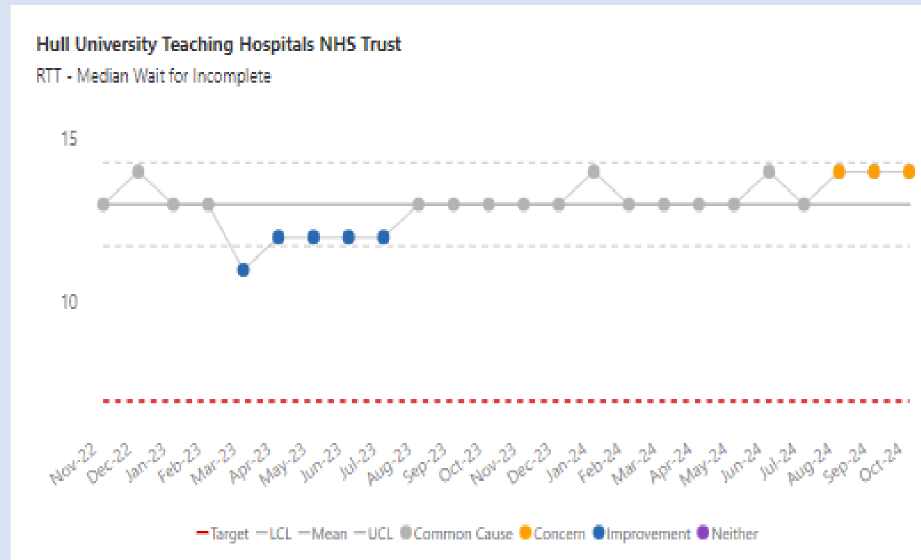
Compliance



Key Themes

- 13 patients exceeded 65 weeks at the end of October which was a reduction of 2 on the previous month.
- The Trust position is among the best nationally.
- Risks identified relating to November delivery: -
    - ENT – additional weekend capacity is being delivered.
    - Plastic Surgery – a plan is in place for provision additional weekend lists to support the complex delayed breast reconstruction (DIEP requires 3 session day)
    - Sub-contract agreed with Trent Cliffe to provide mitigation in Plastic Surgery.
    - Delays in offering admission dates leading to unreasonable offers and patient choice breaches.

Critical Enabler



Actions

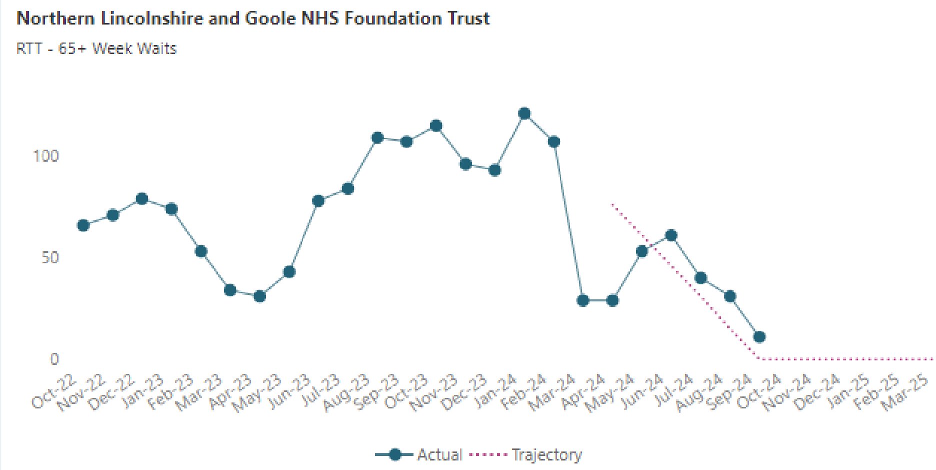
1. Elimination of >78w waits by end of June 2024 - delivered
2. Elimination >65w waits by end of September 2024 – not delivered
3. New control total of 8 x 65w waits for HHP at the end of December 2024
4. Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in ENT. Additional insourced activity in place.
- Continued focus at speciality level of patients dated and/or risks now focussed to eliminate the number of >65-week waits by the end of October 2024
- Delivery of 24/25 operating plan activity extension plans.
- Additional weekend waiting list initiatives to create capacity in Plastic surgery, Breast Surgery and ENT.
- Current growth in 52 week backlog presents an ongoing risk.

6. Referral to Treatment – 65w Waits - NLAG

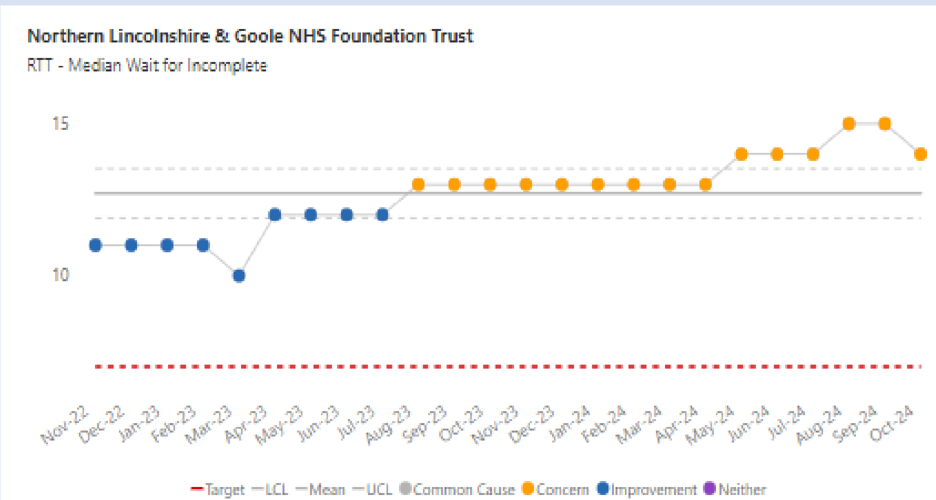
Compliance



Key Themes

- 1 x 78w breach reported at the end of October. This was an in-month validation of a pathway error in T&O. Unfortunately, the patient could not be accommodated due to clinical reasons prior to month end.
- Reduction in 65w waits at the end of October with 5 breaches compared to 11 in the previous month. Forecast for end of November is currently 4 with all risks being micro-managed.
- Deterioration in median waits from 10 weeks to 14 weeks (national standard 7 weeks) since March 2022

Critical Enabler



Actions

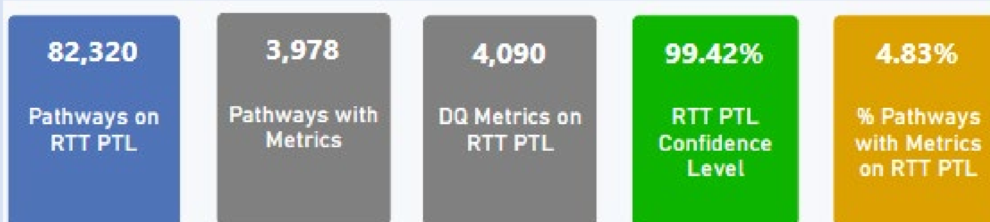
- Clear >78w waits by end of June 2024 - delivered
- Clear >65w waits by end of September 2024 – not delivered but reduced
- New control total of 8 x 65w waits for HHP at the end of December 2024
- Reduce >52w waits by end of March 2025

Critical actions being delivered through the RTT Delivery Group

- Reduce first outpatient waits to <40 weeks, with the main challenge in Paediatrics (ADHD). Additional insourced activity in place.
- Delivery of 24/25 operating plan activity extension plans.
- Community Dental capacity and 65w breach risks – mitigated with weekend theatre lists but need sustainable solution
- Earlier planning of offering admission dates to reduce unreasonable offers and then patient choice breaches, alongside revised Group Access Policy.

7. Referral to Treatment – Data Quality - HUTH

Compliance

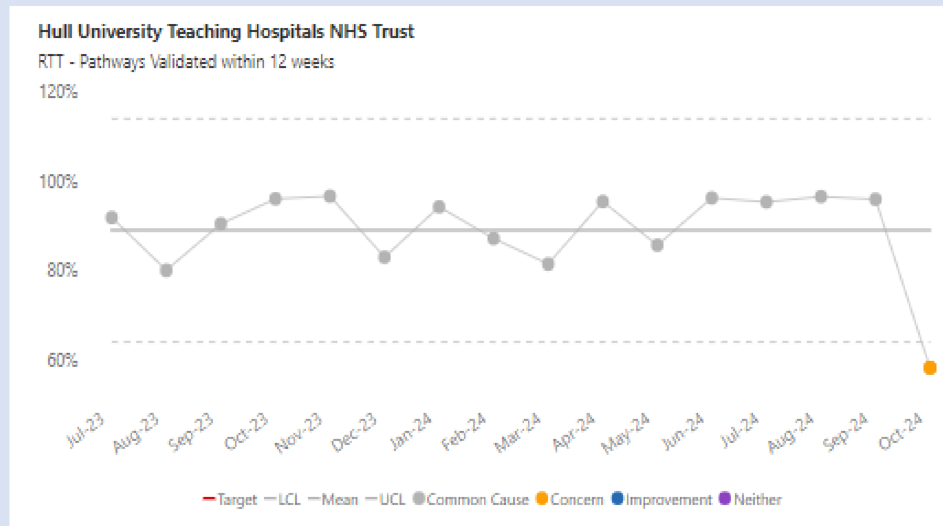


Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

The Trust has robust oversight arrangements in place to support timely validation, these are monitored by RTT BI data quality reports in conjunction with the LUNA system, with established escalation processes in place. LUNA is currently reporting that the Trust has a 99.42% confidence level for RTT PTL data quality.

Critical Enabler



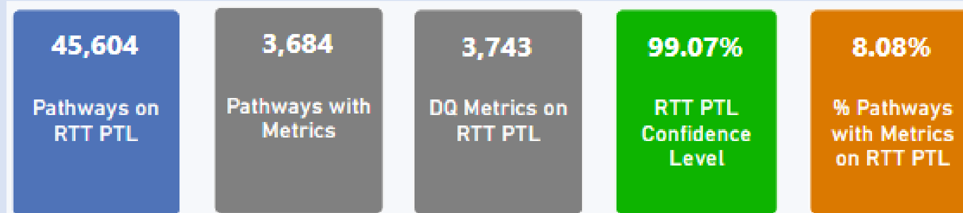
Actions

Critical actions to be taken:

- Business as usual process in place between the Performance and CAS teams
- BI data quality reports are used to monitor weekly and escalation processes are in place.
- Focus by CAS on ensuring the pathways over 12 weeks have an up-to-date validation comment
- Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation of 500 pathways at each Trust underway w/c 11th November 2024 for 2 weeks.

8. Referral to Treatment – Data Quality - NLAG

Compliance

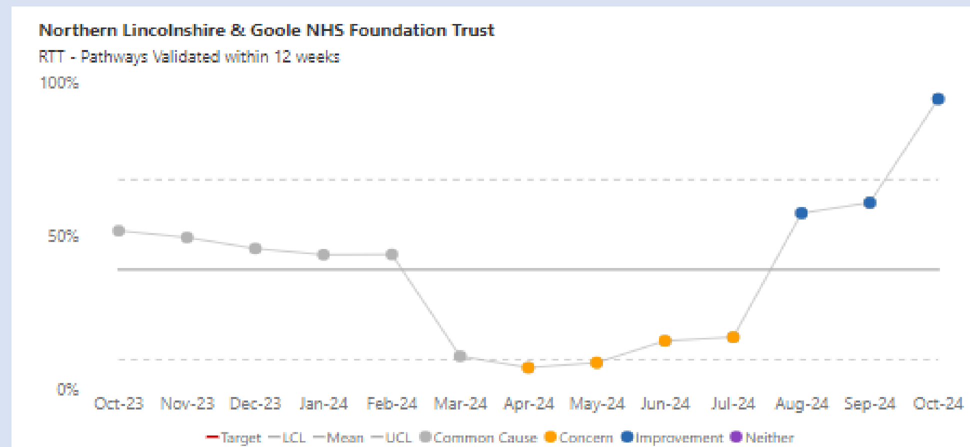


Key Themes

It is an NHSE mandated reporting requirement for Board to receive oversight of RTT Data Quality.

- LUNA data quality is showing a reduction in the confidence rate to 99.07% which is an improved position.
- The predominant sub metric generating the DQ flag is pathways validated every 12 weeks the latest data shows sustained improvement against the 90% standard following admin delays in transacting pathway events post Lorenzo deployment.

Critical Enabler

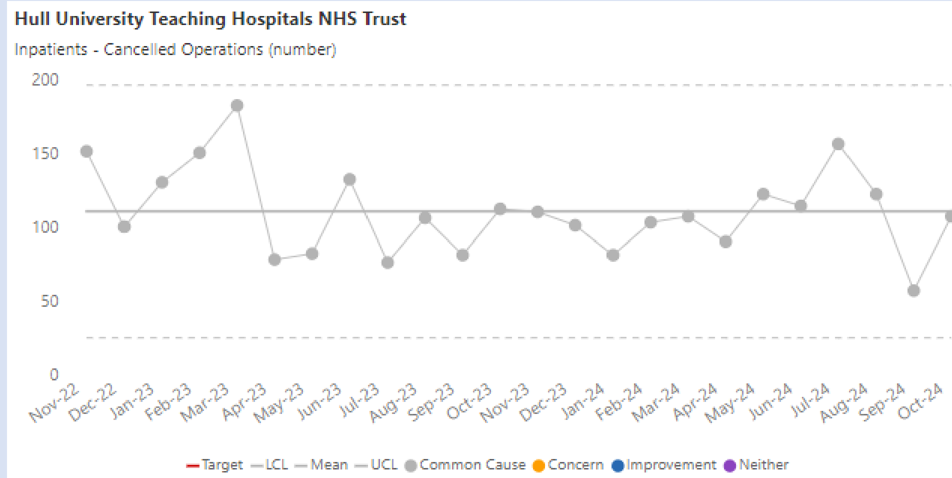


Actions

- Patient Services to reduce the number of unvalidated pathways and other key DQ reports including un-outcomed clinic and admission attendances to proactivity improve incomplete pathway management.
- Focus on improving up-to-date validation / tracking comments to
- RTT Insights Dashboard training completed in August/September 2024.
- Source Group Artificial Intelligence report commissioned to deliver a one-off insight into the data quality opportunity on the RTT PTL. Proof of concept sample validation underway w/c 11th November 2024 for 2 weeks.

9. Cancelled Operations - HUTH

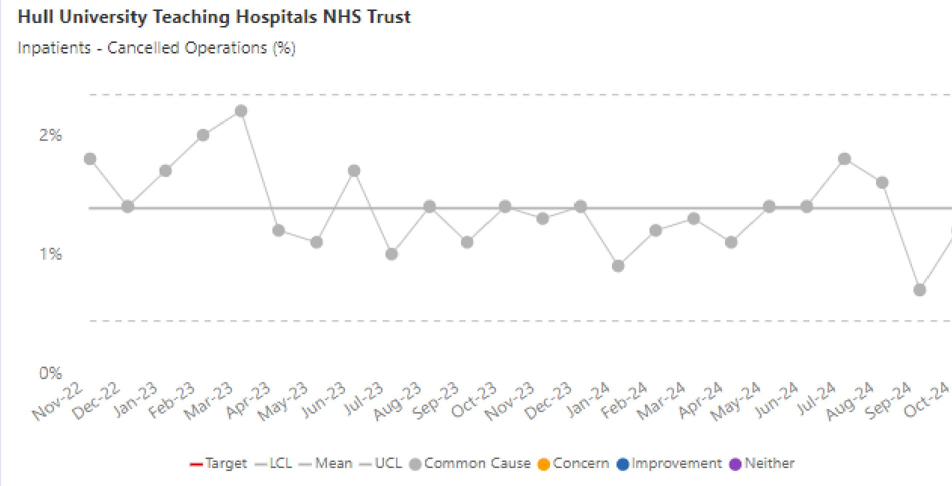
Compliance



Key Themes

- In October there were 107 cancelled operations on the day for non-clinical reasons which is a significant improvement on previous months and represents 1.2% of admissions.
- The largest reasons were –
  - No Theatre Time – 40
  - Emergency case – 17
  - Bed unavailable - 15
  - No anaesthetist – 12
- The main specialties for cancellations on the day are –
  - Interventional Radiology – 16 (Emergency cases)
  - Gynaecology – 14 (No Theatre Time)
  - Vascular Surgery – 13 (No Beds)

Critical Enabler

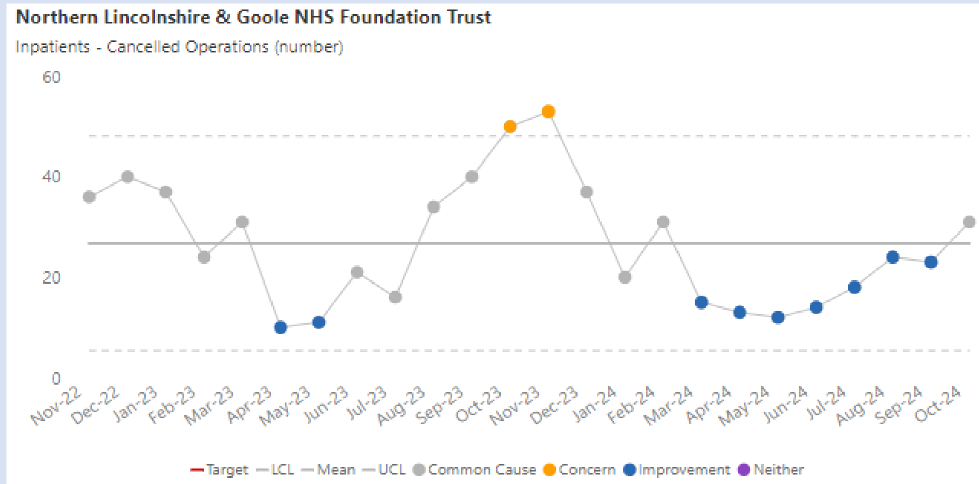


Actions

- Group level cancelled operations Standard Operating Procedure (SOP) developed and deployed with the Operations Director for Theatres responsible for approving all on the day cancellations
- Robust cancelled operations performance monitoring systems deployed at Group level including 28 day re-bookings reviewed weekly by Site Managing Director
- Review of cancellations trends and themes escalated to the speciality / pre-assessment teams.
- Focus in operational meetings regarding beds required for elective procedures to take place with review of 7/5/2 day pre-op to commence in Orthopaedics and ENT.
- 85% Capped utilisation report and actions going out to all Care Groups from 17th June.
- Progress GIRFT actions for High Volume Low Complexity activity.

10. Cancelled Operations - NLAG

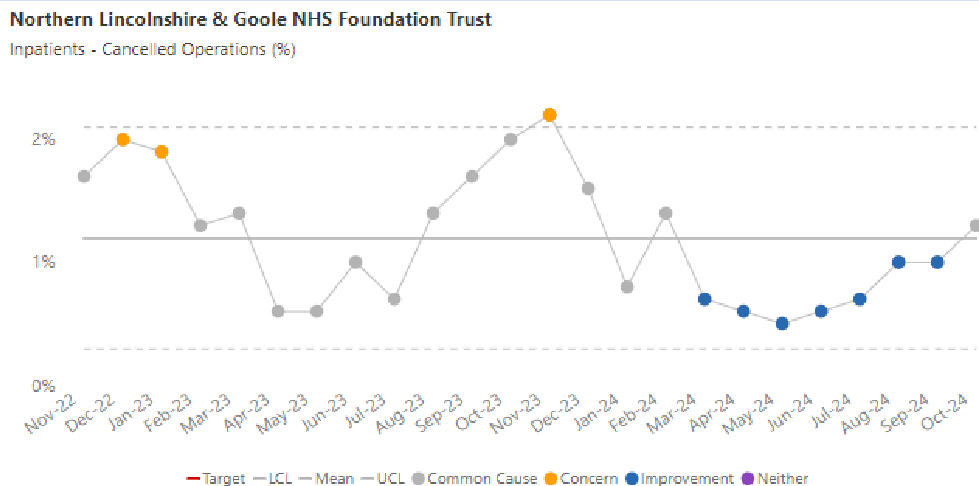
Compliance



Key Themes

- In October there were 31 cancelled operations on the day for non-clinical reasons which is a deterioration on previous months and represents 1.3% of admissions.
- The largest reasons were –
  - 12 Theatre list over-run
  - 8 Anaesthetist unavailable
  - 4 Emergency cases
  - 3 Surgeon unavailable
- The main specialties for cancellations on the day are –
  - General Surgery – 9 (No Anaesthetist)
  - Trauma & Orthopaedics – 8 (Emergency cases)
  - Ophthalmology – 5 (No Consultant)

Critical Enabler

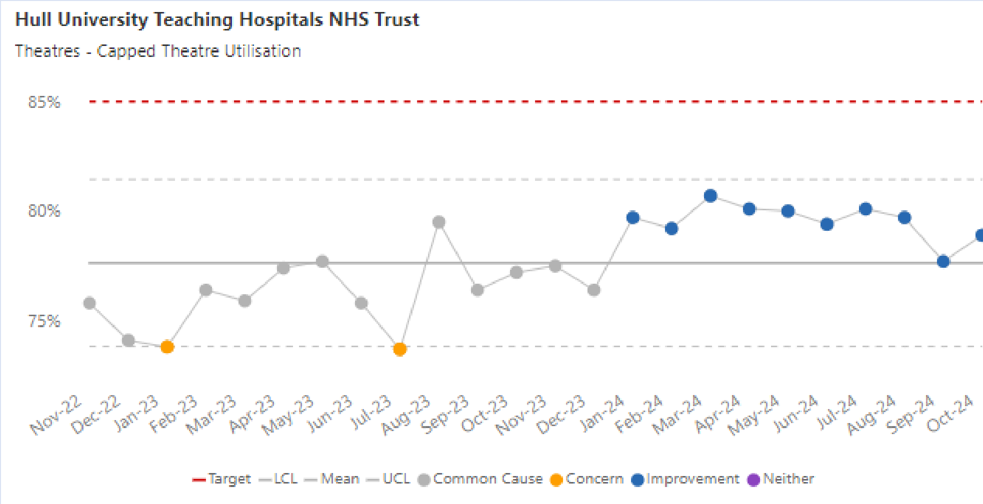


Actions

- Enhanced BIU support to report national data set and eliminate DQ issues.
- Additional daily scrutiny and feed back to specialities regarding capped utilisation and the additional minor patient to be added to all lists not delivering 85% utilisation.
- HUB commenced at GDH 10th June 2024, to support LoS and GIRFT standards improvement.
- Working with NHSE/GIRFT on improvement recommendations
- Reviewing all opportunities to sweat current assets.
- Cancelled operations Standard Operating Procedure (SOP) has been reissued at Group level with the Operations Director for Theatres responsible for approving on the day cancellations
- Standing down or lifting sessions SOP completed and deployed.

11. Capped Theatre Utilisation - HUTH

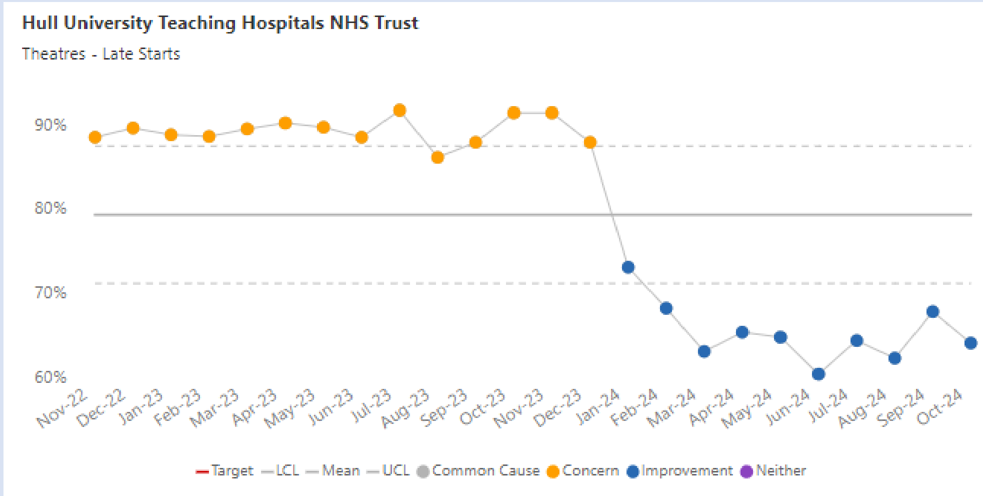
Compliance



Key Themes

- Improvement in capped theatre utilisation with latest Model Hospital data showing performance at 83% placing the Trust in the highest quartile nationally.
- Internal reporting at 78.9% for capped theatre utilisation for October.
- Day Case capped theatre utilisation has improved to 73.6% - improving this element of delivery is the critical enabler to improve to the aggregate activity standard of 85%.
- HUTH specifically commended on delivery of capped utilisation improvement by Professor Tim Briggs, Chair of GIRFT and NHSE National Director for Clinical Improvement & Elective Recovery.
- Decrease in late starts to 64% (methodology 0 minutes = late start)

Critical Enabler

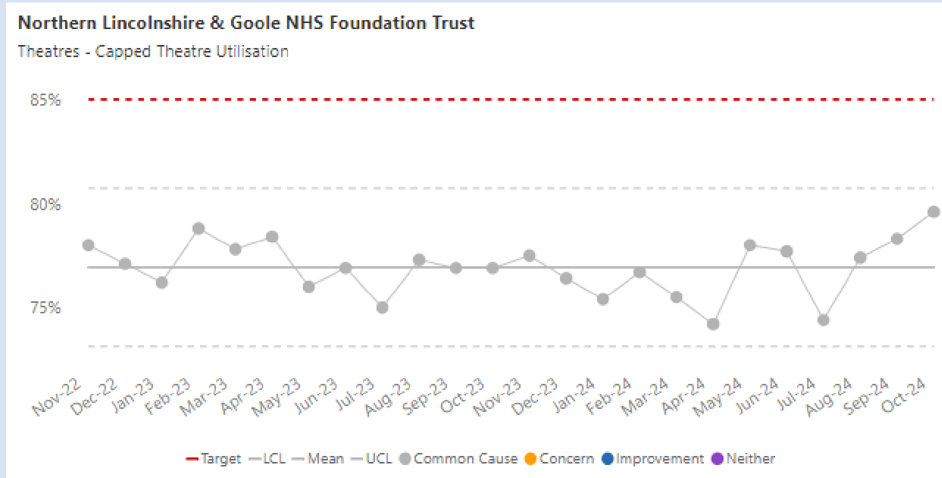


Actions

- Theatre Data Quality dashboard in place which is managed daily by the Theatres, Anaesthetics and Critical Care Group
- Theatres Insights Model being implemented –training roll out commenced at both Trusts.
- Improve recording of day case touch points in ORMIS
- Implementation in June of 1 extra patient per day case list for any list at <85% capped utilisation

12. Capped Theatre Utilisation - NLAG

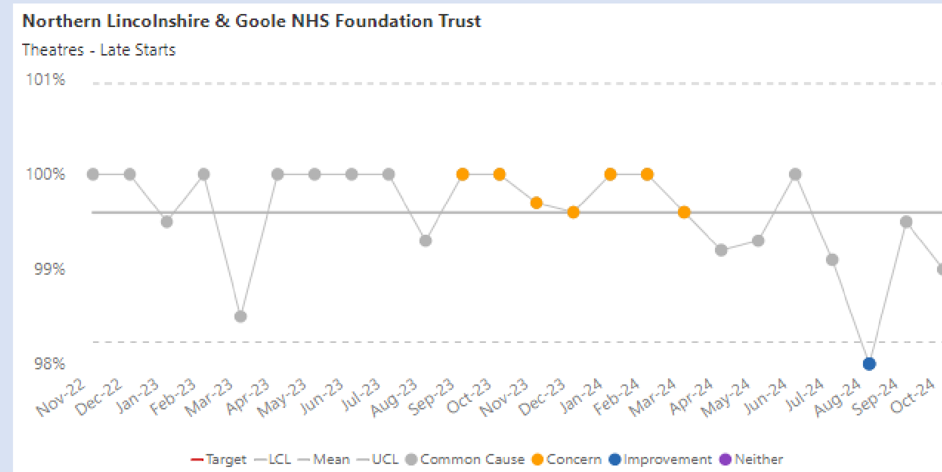
Compliance



Key Themes

- In the lower quartile nationally at 74.2% on Model Hospital, however, internal reporting shows improvement at 79.6%.
- This reflects ongoing issues with data alignment to Model Hospital methodologies, with delay in rectification linked to redirection of all available analytical resource to activity reporting for income generation post Insource data warehouse deployment.
- Theatre late starts issue at NLAG with 99% of sessions starting late in October 2024 on the zero-minute measure, however, reduced on those stating over 10 minutes.

Critical Enabler



Actions

- CAP working group established with Theatre and Analytical leads to apply learning from HUTH analysts on improvement work undertaken on data quality issues with the fortnightly submissions to Model Health and the methodologies applied.
- BI reporting being reviewed due to issues with how the theatre sessions are recorded on WebV, currently sessions are not differentiated between day case and elective theatres, which creates significant issues based on Model Hospital calculation methodologies.
- Implementation of 1 extra patient per day case list for any list at <85% capped utilisation

13. Pathway Summary – Benchmark Report – Diagnostics

NB: National benchmarking data is a month in arrears due the NHSE publication timetable

HUTH

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Sep 24	5.00%	1.4%			82
Barium Enema	Sep 24	5.00%	0.0%			100
Colonoscopy	Sep 24	5.00%	**44.7%**			13
Computed Tomography	Sep 24	5.00%	**9.7%**			24
Cystoscopy	Sep 24	5.00%	**38.6%**			22
DEXA Scan	Sep 24	5.00%	**55.7%**			4
DM01 Waiting <13 Weeks	Sep 24	100.00%	**94.5%**			42
Diagnostic activity levels - Audiology Assessments	Sep 24	-	533			59
Diagnostic activity levels - Barium Enema	Sep 24	-	40			81
Diagnostic activity levels - CT	Sep 24	-	5,925			68
Diagnostic activity levels - Colonoscopy	Sep 24	-	162			30
Diagnostic activity levels - Cystoscopy	Sep 24	-	354			87
Diagnostic activity levels - Dexa Scan	Sep 24	-	681			94
Diagnostic activity levels - Echocardiography	Sep 24	-	594			34
Diagnostic activity levels - Endoscopy	Sep 24	-	899			44
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 24	-	97			54
Diagnostic activity levels - Gastroscopy	Sep 24	-	286			37
Diagnostic activity levels - Imaging	Sep 24	-	14,453			68
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 24	-	4,875			64
Diagnostic activity levels - Total	Sep 24	-	17,062			63
Diagnostic activity levels - Urodynamics	Sep 24	-	33			68
Diagnostics - 6 Week Standard	Sep 24	5.00%	**23.5%**			36
Diagnostics - 6 Week Standard Reversed	Sep 24	95.00%	**76.5%**			36
Echocardiography	Sep 24	5.00%	**47.2%**			20
Electrophysiology	Sep 24	5.00%	-			-
Gastroscopy	Sep 24	5.00%	**26.3%**			28
Magnetic Resonance Imaging	Sep 24	5.00%	3.3%			62
Neurophysiology	Sep 24	5.00%	**17.8%**			45
Non-obstetric Ultrasound	Sep 24	5.00%	**16.2%**			30
Urodynamics	Sep 24	5.00%	**66.7%**			14

NLAG

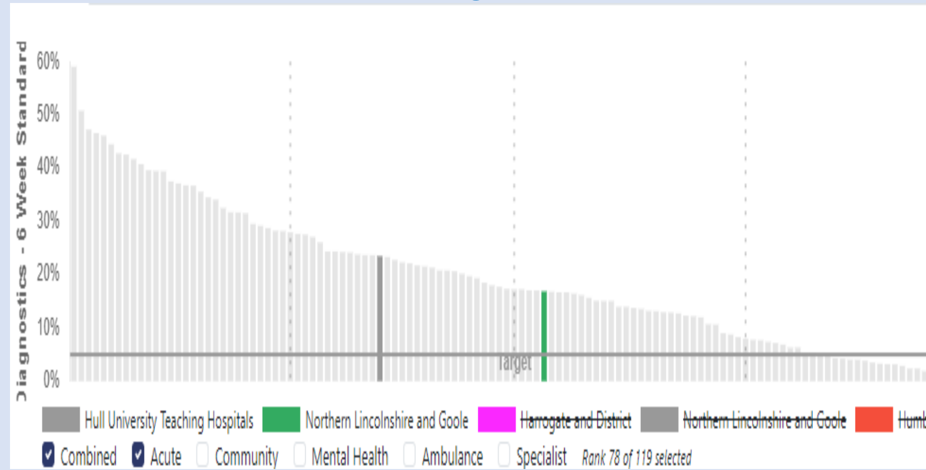
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Audiology	Sep 24	5.00%	**52.5%**			25
Barium Enema	Sep 24	5.00%	2.4%			45
Colonoscopy	Sep 24	5.00%	**7.8%**			61
Computed Tomography	Sep 24	5.00%	3.2%			49
Cystoscopy	Sep 24	5.00%	**23.8%**			41
DEXA Scan	Sep 24	5.00%	3.8%			34
DM01 Waiting <13 Weeks	Sep 24	100.00%	**96.5%**			53
Diagnostic activity levels - Audiology Assessments	Sep 24	-	457			54
Diagnostic activity levels - Barium Enema	Sep 24	-	134			96
Diagnostic activity levels - CT	Sep 24	-	11,241			97
Diagnostic activity levels - Colonoscopy	Sep 24	-	551			82
Diagnostic activity levels - Cystoscopy	Sep 24	-	583			99
Diagnostic activity levels - Dexa Scan	Sep 24	-	291			52
Diagnostic activity levels - Echocardiography	Sep 24	-	925			53
Diagnostic activity levels - Endoscopy	Sep 24	-	2,126			95
Diagnostic activity levels - Flexi Sigmoidoscopy	Sep 24	-	251			96
Diagnostic activity levels - Gastroscopy	Sep 24	-	741			88
Diagnostic activity levels - Imaging	Sep 24	-	20,200			88
Diagnostic activity levels - Non Obstetric Ultrasound	Sep 24	-	3,766			49
Diagnostic activity levels - Total	Sep 24	-	24,121			88
Diagnostic activity levels - Urodynamics	Sep 24	-	161			96
Diagnostics - 6 Week Standard	Sep 24	5.00%	**16.9%**			51
Diagnostics - 6 Week Standard Reversed	Sep 24	95.00%	**83.1%**			51
Echocardiography	Sep 24	5.00%	**36.9%**			30
Gastroscopy	Sep 24	5.00%	**5.2%**			65
Magnetic Resonance Imaging	Sep 24	5.00%	**10.4%**			40
Neurophysiology	Sep 24	5.00%	**46.8%**			26
Non-obstetric Ultrasound	Sep 24	5.00%	**9.6%**			42
Urodynamics	Sep 24	5.00%	**9.5%**			80

14. Pathway Benchmarking & Trend – Diagnostics

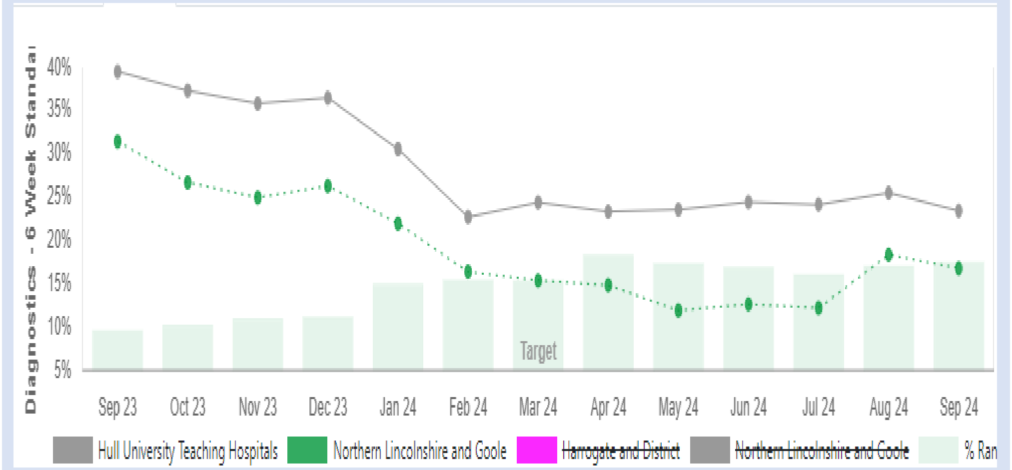
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

Diagnostics – 6 week Performance Standard

Ranking Chart

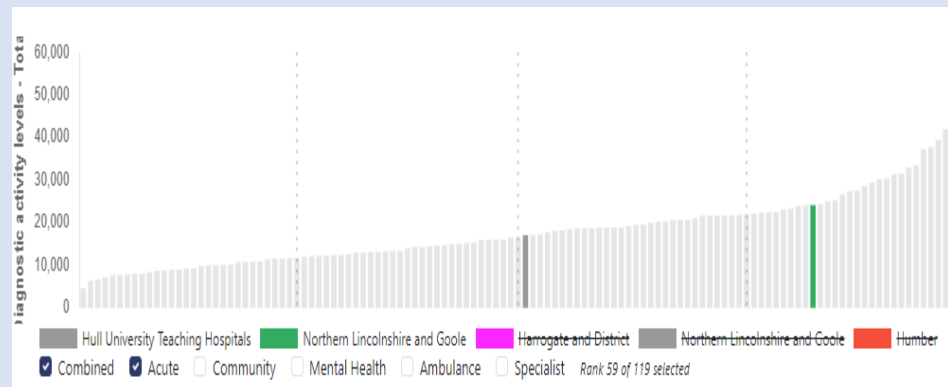


Trend Chart

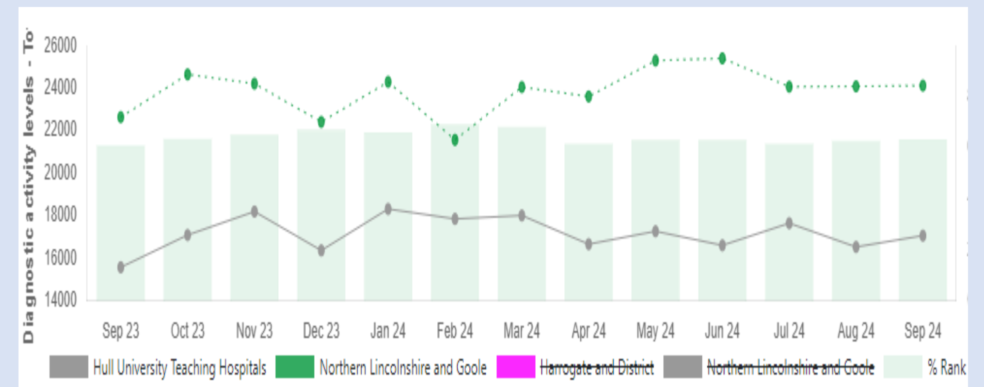


Diagnostics – Activity

Ranking Chart

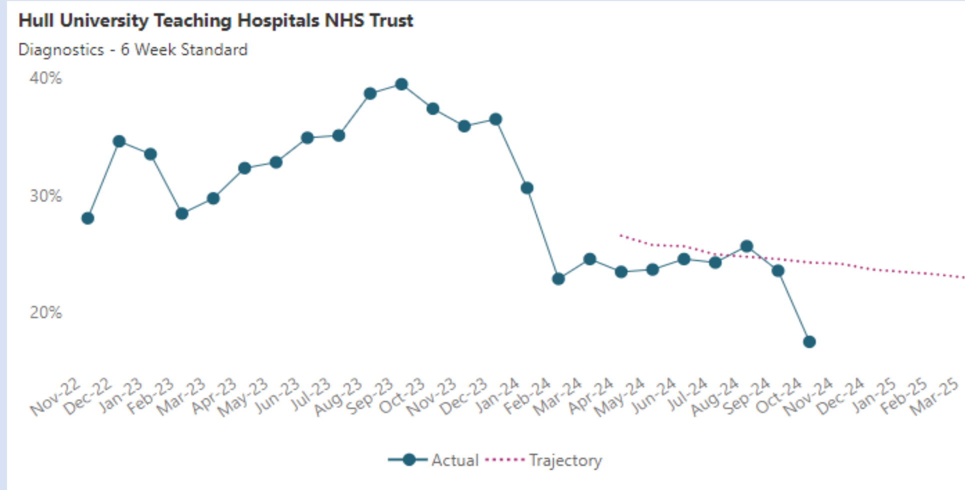


Trend Chart



15. Diagnostic 6 Week Standard - HUTH

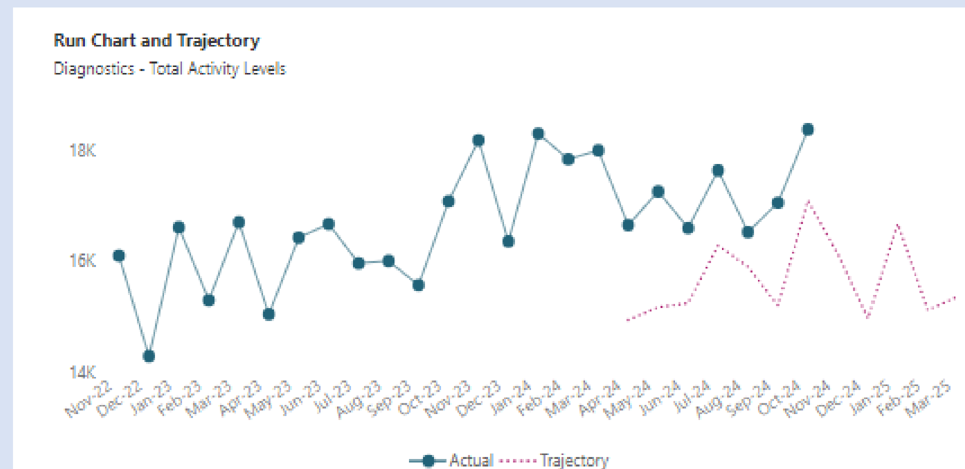
Compliance



Key Themes

- Improvement in performance in October to 17.4%, (an improvement of 6.1%). This places the Trust significantly ahead of trajectory.
- The most notable increase in performance was in DEXA which fell to 25.2% in October compared to 55.7% in September. This relates a significant increase in throughout at HUTS and to the transfer of 50 patient to NLaG to equalise wait times across the Group.
- Most modalities at HUTH increased activity levels over 23/24 and into 24/25. Whilst ahead of delivery trajectory, aggregate diagnostic compliance has remained static in recent months – noting the mathematical impact of DEXA mutual aid outlined above.

Critical Enabler

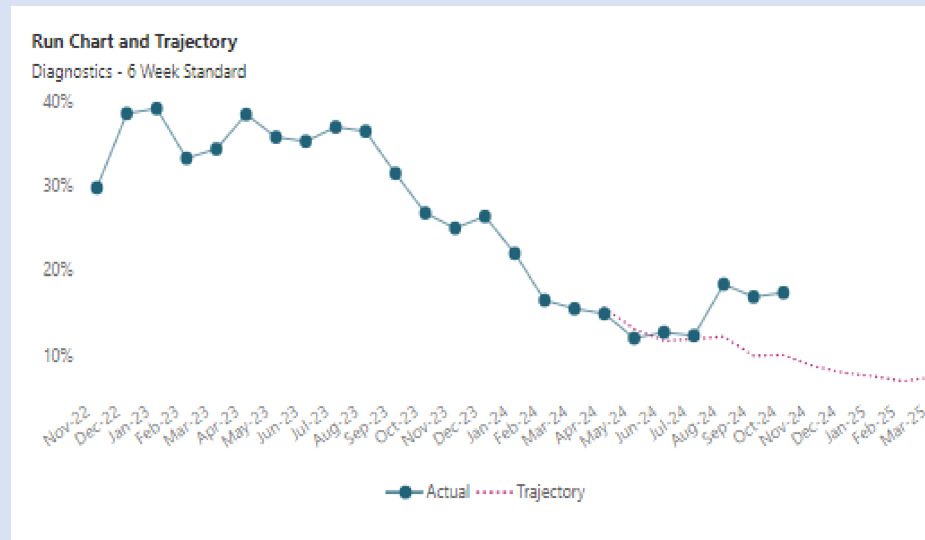


Actions

- Critical actions in place:
  - Services have developed improvement plans to create additional diagnostic activity levels and utilise mutual aid opportunities across the Group.
  - Dedicated investment case approved to address DEXA waiting list backlog via increased throughput and testing volume capacity.
  - Tender exercise completed for NOUS to create additional capacity.
  - Validation of DMO1 activity recording underway to support performance and forecasting going forward.

16. Diagnostic 6 Week Standard - NLAG

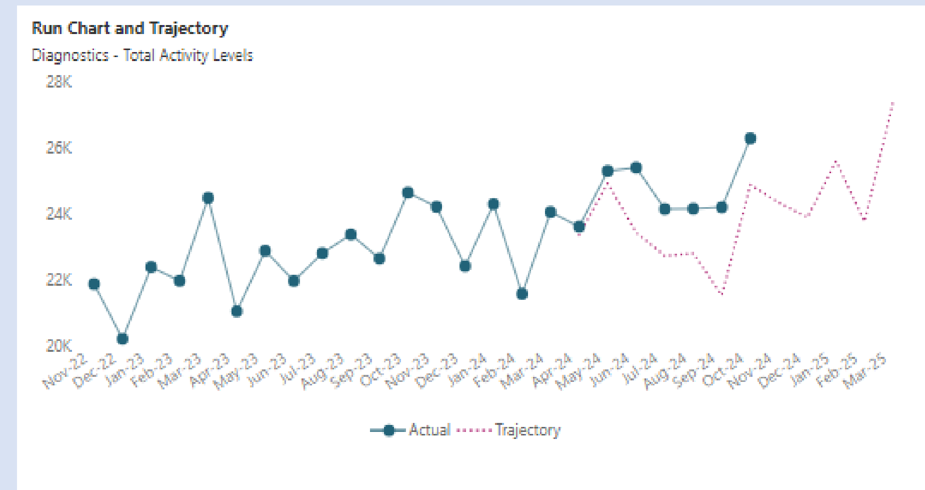
Compliance



Key Themes

- Slight reduction in performance for October at 17.4%, a 0.5% shift from 16.9% in September - noting this includes the impact of the mutual aid transfer of DEXA patients from HUTH.
- Aggregate (all modality) compliance is supported through the increased activity levels in imaging.
- Imaging activity recording varies at both Trusts. NLAG reports based on body parts scanned, rather than overall scan volume, which leads to NLAG having higher reported activity levels than HUTH. Both practices technically align to national guidance.

Critical Enabler



Actions

- Operating Plan commitments significantly extend diagnostic activity levels in 24/25.
- Further activity stretch plans have been deployed to create additional diagnostic activity levels above the annual plan and utilise mutual aid opportunities across the Group. Where associated investment plans have been approved operational teams are commencing implementation either through use of WLIs, locums, substantive appointments, or Independent Sector.
- To mitigate capacity shortfalls relating to staffing in Neurophysiology on the South Bank enhanced workforce arrangements have been deployed to reduce backlog.
- Ultrasound increasing capacity with use of IS. CDC comes online in November which will also improve the position.

17. Pathway Summary – Benchmark Report – Cancer Waiting Times

HUTH

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 24	93.00%	78.4%			36
Cancer 2 Week Wait Breast Symptomatic	Sep 24	93.0%	60.5%			20
Cancer 28 Day Faster Diagnosis	Sep 24	75.0%	76.7%			53
Cancer 28 Day Faster Diagnosis - Acute Leukaemia	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Brain Tumours	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 24	75.0%	96.5%			74
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 24	75.0%	97.2%			74
Cancer 28 Day Faster Diagnosis - Children's Cancer	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 24	75.0%	62.2%			39
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Sep 24	75.0%	28.6%			10
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 24	75.0%	90.0%			92
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 24	75.0%	36.6%			5
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 24	75.0%	83.3%			67
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Sep 24	75.0%	84.5%			35
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 24	75.0%	91.2%			93
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 24	75.0%	46.2%			16
Cancer 31 Day All Stages	Sep 24	96.0%	77.4%			3
Cancer 31 Day First Treatment	Sep 24	96.00%	80.7%			4
Cancer 31 Day Subsequent Treatment	Jul 24	96.0%	68.4%			2
Cancer 31 Day Subsequent Treatment - Drugs	Sep 24	96.0%	96.2%			13
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 24	96.0%	71.6%			10
Cancer 62 Day All Routes	Sep 24	85.00%	51.0%			7
Cancer 62 Day Consultant Upgrade	Sep 24	85.0%	37.0%			1
Cancer 62 Day Screening	Sep 24	90.0%	46.8%			22
Cancer 62 Day Urgent Suspected	Sep 24	85.00%	53.6%			19
Cancer of bronchus; lung	Sep 24	1.00	1.1			32

NLAG

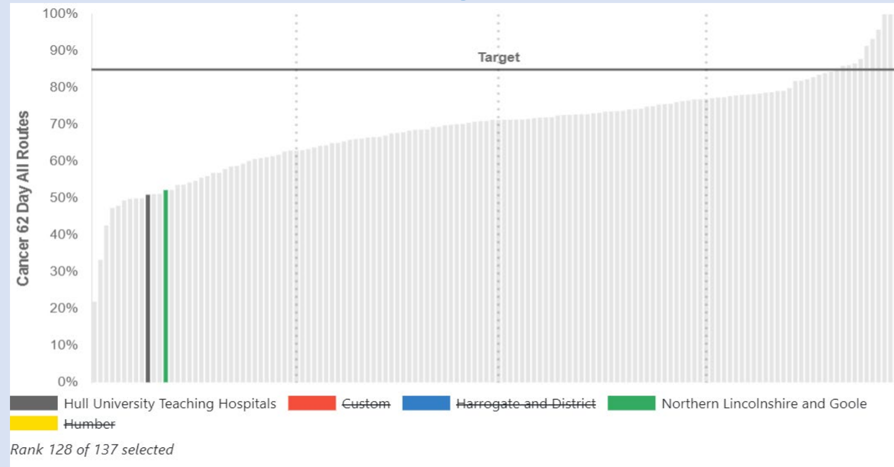
Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
Cancer 2 Week Wait	Sep 24	93.00%	96.2%			89
Cancer 2 Week Wait Breast Symptomatic	Sep 24	93.0%	100%			100
Cancer 28 Day Faster Diagnosis	Sep 24	75.0%	73.6%			30
Cancer 28 Day Faster Diagnosis - Breast Cancer	Sep 24	75.0%	96.3%			72
Cancer 28 Day Faster Diagnosis - Breast Symptoms	Sep 24	75.0%	96.8%			68
Cancer 28 Day Faster Diagnosis - Gynaecological Cancer	Sep 24	75.0%	54.5%			25
Cancer 28 Day Faster Diagnosis - Haematological Malignancies	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Head & Neck Cancer	Sep 24	75.0%	59.6%			8
Cancer 28 Day Faster Diagnosis - Lower Gastrointestinal Cancer	Sep 24	75.0%	65.1%			55
Cancer 28 Day Faster Diagnosis - Lung Cancer	Sep 24	75.0%	66.7%			20
Cancer 28 Day Faster Diagnosis - Missing or Invalid	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Other Cancer	Sep 24	75.0%	40.0%			27
Cancer 28 Day Faster Diagnosis - Sarcoma	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Skin Cancer	Sep 24	75.0%	-			-
Cancer 28 Day Faster Diagnosis - Testicular Cancer	Sep 24	75.0%	100%			100
Cancer 28 Day Faster Diagnosis - Upper Gastrointestinal Cancer	Sep 24	75.0%	82.4%			71
Cancer 28 Day Faster Diagnosis - Urological Malignancies	Sep 24	75.0%	74.5%			84
Cancer 31 Day All Stages	Sep 24	96.0%	97.1%			80
Cancer 31 Day First Treatment	Sep 24	96.00%	96.9%			71
Cancer 31 Day Subsequent Treatment	Jul 24	96.0%	98.8%			74
Cancer 31 Day Subsequent Treatment - Drugs	Sep 24	96.0%	99.0%			42
Cancer 31 Day Subsequent Treatment - Radiotherapy	Sep 24	96.0%	100%			100
Cancer 62 Day All Routes	Sep 24	85.00%	52.3%			9
Cancer 62 Day Consultant Upgrade	Sep 24	85.0%	45.2%			1
Cancer 62 Day Screening	Sep 24	90.0%	50.0%			27
Cancer 62 Day Urgent Suspected	Sep 24	85.00%	53.8%			21
Cancer of bronchus; lung	Sep 24	1.00	1.1			38

18. Pathway Benchmarking & Trending – Cancer Waiting Times

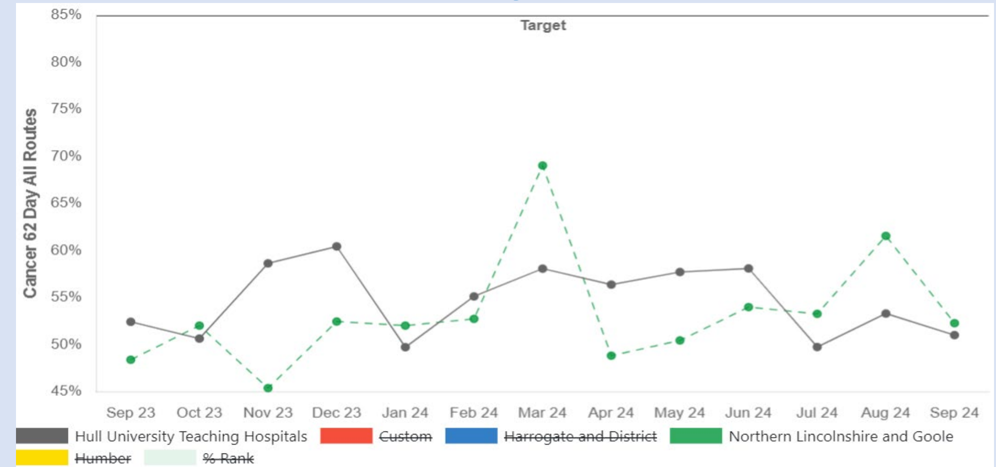
NB: National benchmarking data is a month in arrears due the NHSE publication timetable

62 Day Performance

Ranking Chart

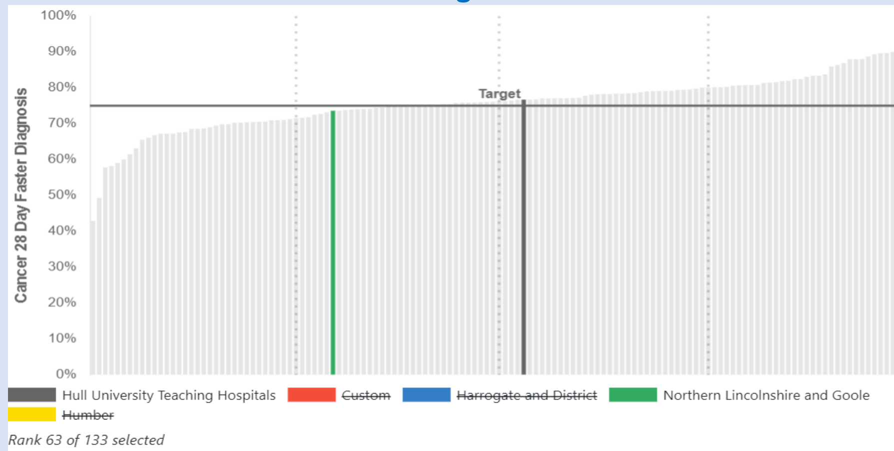


Trending Chart

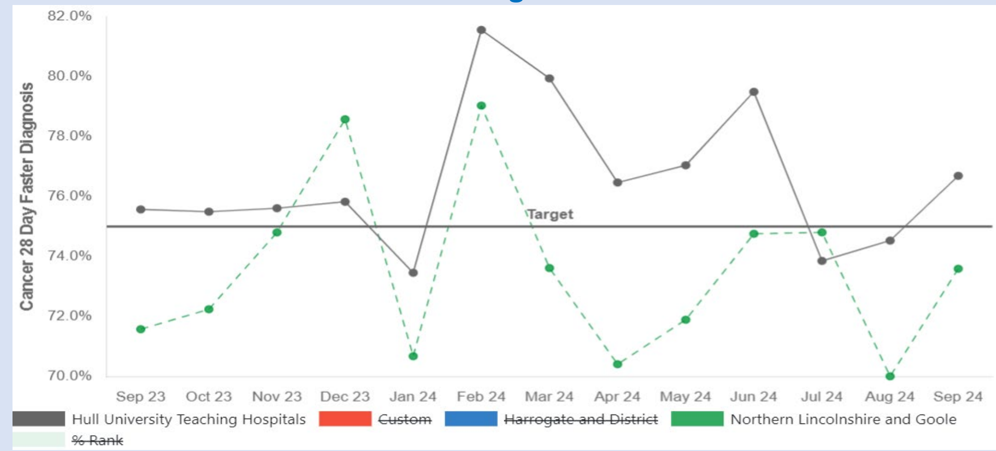


Faster Diagnosis Performance

Ranking Chart

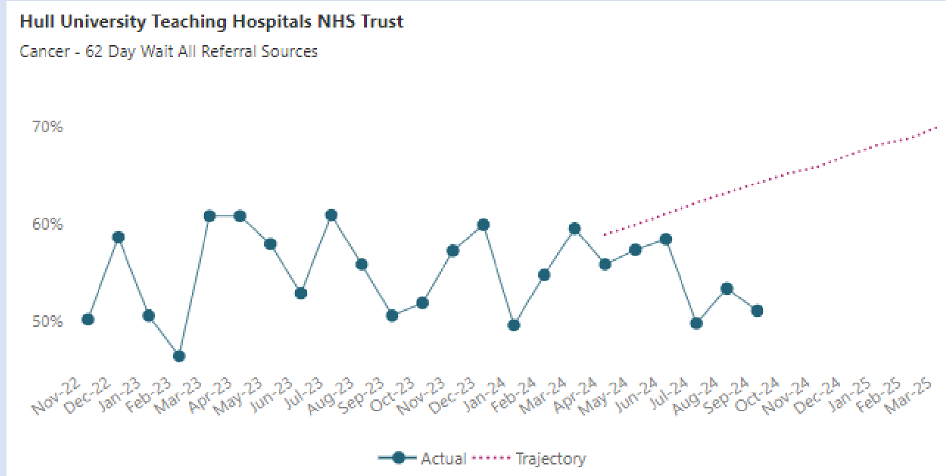


Trending Chart



19. 62 Day Cancer Performance - HUTH

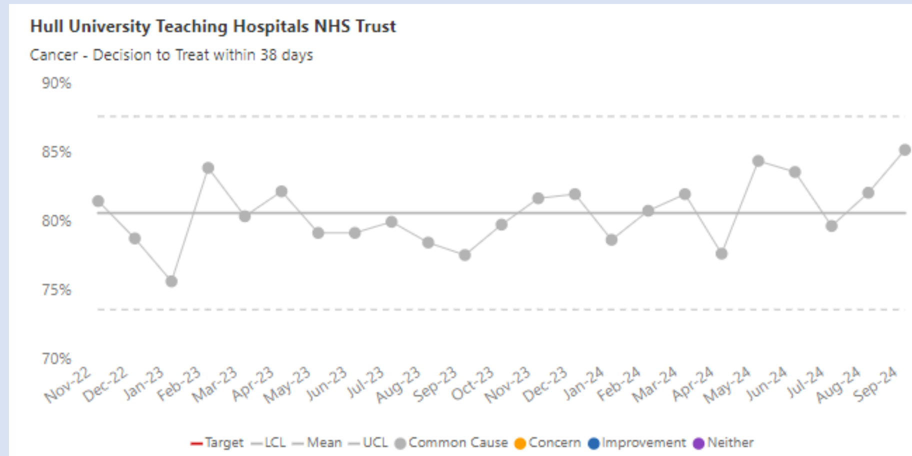
Compliance



Key Themes

- 51% performance for September 2024 (2.2% reduction compared to August 2024)
- Breast – delays in pathway related to 1st OPA capacity, not yet recovered into 62-day RTT
- Skin – delays in pathway related to 1st OPA capacity; consultant dermatologist & plastic surgeon vacancies – recovering in FDS & 62-day RTT
- Lung/Thoracic – Nav Bronch equipment failure; improvement required to pool patients to avoid differential waiting times in Thoracic service plus late IPTs and impact of radiotherapy/SABR capacity
- LGI - Endoscopy diagnostic capacity plus patient fitness, compliance & consultant capacity
- Upper GI deterioration under investigation – delays in front end triage highlighted to the Care Group
- Radiotherapy recovery plan continues (12 months from November 2023) & mutual aid from Lincoln
- Oncology capacity (vacancies plus increased demand) – clinical prioritisation in Breast & Urology
- Histology TATs - SHYPS TAT Improvement Plan; escalation to Oversight Committee (Aug 2024)
- Late IHTs – Lung, Gynae and Urology: focussed work in Urology within the Group & Lung with Y&S Trust

Critical Enabler



Actions

IHTs

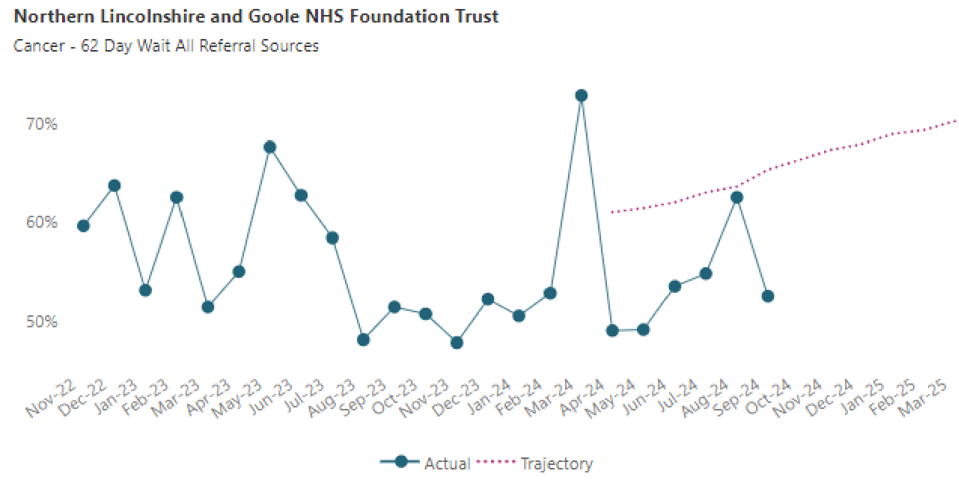
- Inter-Group review of the Urology IPTs – Group-wide urology improvement project
- Joint work with Y&S on Lung late IPTs, no specific themes identified; Y&S and NLAG consultant vacancies are a further concern
- Lung whole pathway review undertaken 28 June 2024 – North & South bank combined event, project plan to deliver including LHC
- Gynaecology (South Bank) workshop on 11/09/2024 – action plan to prioritise & deliver

Workforce

- Plastic Surgery & Dermatology capacity – x4 vacant consultant posts wef mid-April 2024; focussed effort to maintain PTL; delays in approval for recruitment
- Urology consultant vacancies – impacted by annual + compassionate leave, significant delays with outpatient & surgical capacity; x1 locum secured plus robotic surgeon mutual aid being explored
- Radiotherapy recovery plan mobilised – however increased referrals & increased complexity; formal review September 2024 at 9 months

20. 62 Day Cancer Performance - NLAG

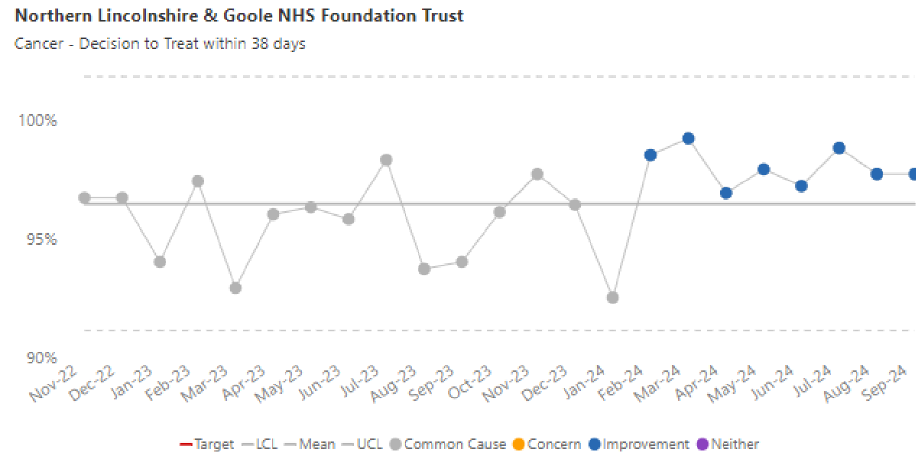
Compliance



Key Themes

- September performance at 52.5% (9.7% reduction on August 2024 performance) – main cause is LGI performance dip & much reduced +63 day backlog overall
- IPT transfer delays continue, performance impact 7-10% due to breach attribution in Lung & Urology pathways; both have front end pathway delays to be addressed.
- Lung - capacity for OPAs, diagnostics & oncology appointments (to determine surgical vs. oncology treatment). Lung physician vacancies x 2 – in recruitment, previous difficulties and retention issues Additional support for Lung cancer pathway tracking identified and in place
- LGI – endoscopy capacity/patient-initiated delays during August/September 2024 Urology surgical capacity (vacancy)
- H&N – pathways issues to resolve; multiple diagnostics and histology not marked 31/62
- Gynaecology – OPA and diagnostic capacity issues, review of tracking/pathway management underway. Additional tracking support identified and in place since end Aug.
- Histology TATs - % within 10 days and overall TATs being analysed by Path Links; provider continues to be below the England average for 10-day TATs

Critical Enabler

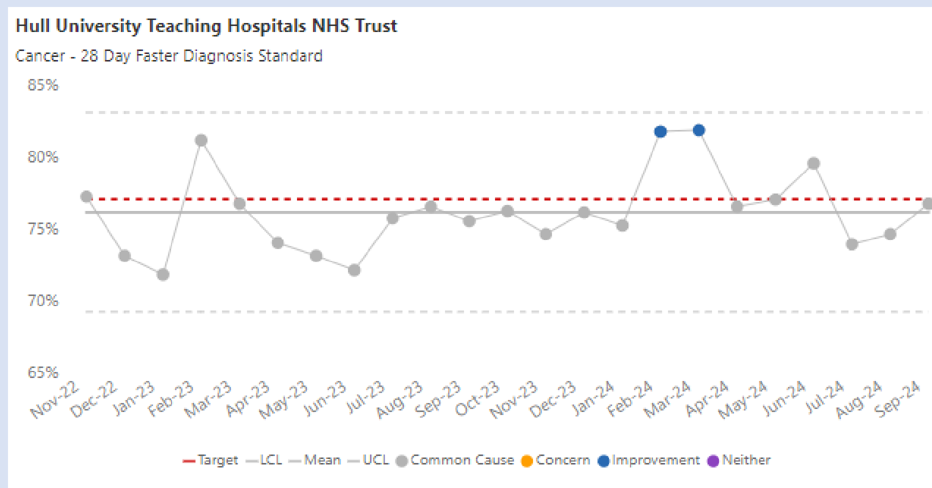


Actions

- Capacity constraints – consultant vacancies, imaging/diagnostic delays & pathology TATs
- Engagement with front end pathway improvement opportunities
- Histology TATs – TAT recovery plan Path Links
- Impact of Targeted Lung Health checks – increasing volume of patients on Screening pathway
- PET CT capacity constraints and PMSA dose limitations
- IPT – factors affecting the inter-Group performance

21. 28 Day Faster Diagnosis Standard - HUTH

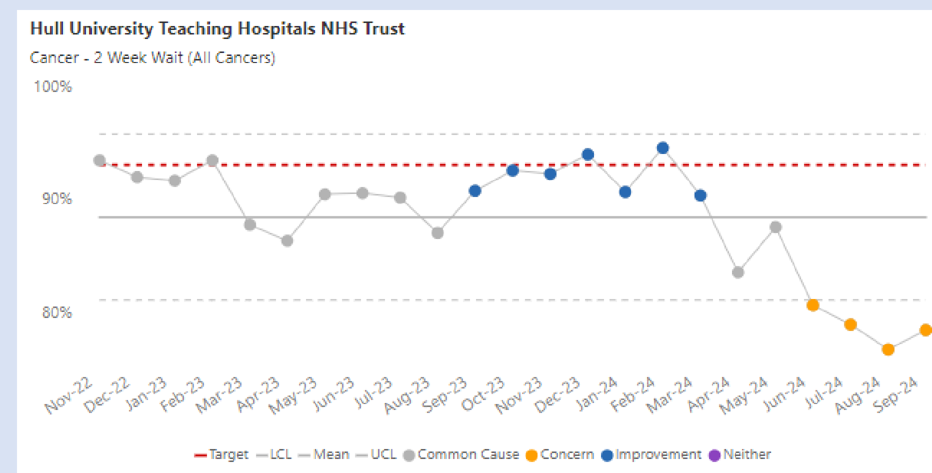
Compliance



Key Themes

- September 2024 –performance of 76.7% (10 more compliant pathways would have achieved 77%) against the national target/Trust trajectory of 77%
- Deterioration for Head & Neck and Skin – alerted to both Care Groups and through Group performance structure; related largely to workforce •Head & Neck: x18 breaches dated outside Day 28 – largely capacity constraints
- Skin: x 24 breaches dated outside Day 28 – Capacity constraints within the service (vacancies x4 plus compassionate leave)
- Significant improvement seen in Breast, now achieving from September 2024
- Lung achieving the trajectory for September 2024 following validation/review of breaches; also ongoing validation for October 2024
- Colorectal deterioration with endoscopy and consultant capacity being the issues
- Urology deterioration with reporting delays for prostate biopsies, consultant capacity (1st OPAs prostatectomy IPTs, surgical capacity & results clinic capacity), now compounded by compassionate leave

Critical Enabler



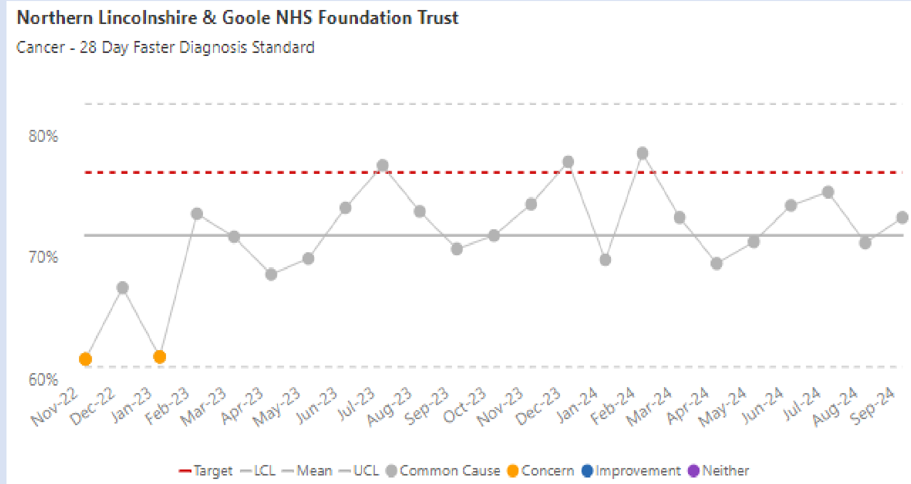
Actions

Increased focus on outpatient stage of treatment

- Skin & Head and Neck – significant capacity constraints for 1st seen appointment impacting on FDS performance
- Improvement seen in Breast for September 2024 (provisional)
- Endoscopy recovery plan and actions to support LGI USC and Bowel Screening pathways
- LGI & Urology – on-going improvement projects, plus consultant recruitment

22. 28 Day Faster Diagnosis Standard - NLAG

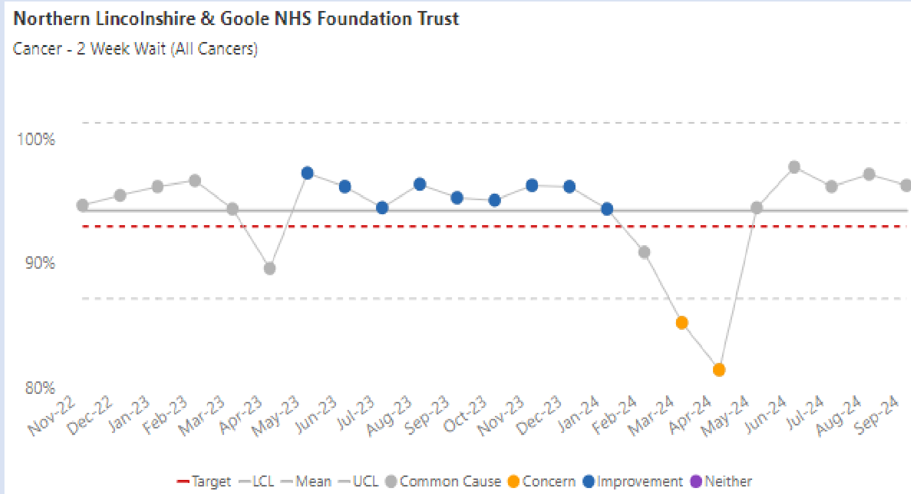
Compliance



Key Themes

- September performance was 73.3%
- Delays in histology/diagnostic reporting are common
- Screening performance continues to reduce compliance against FDS standard
- Delays in communicating 'non-cancer diagnoses' results – improvements indicated in Oct 2024 performance
- All tumour sites above 70% with Gynae and H&N below 75%).

Critical Enabler



Actions

FDS Delivery Improvement plans developed and signed off via the Cancer Delivery Group – priorities:

- Screening service breach review and actions from themes
- Timely outcome processes – Gynae, Lung and Head & Neck
- Histology – marked 31/62 or stepped down to benign pathway
- Improvement project group actions delivered – Lung, Gynae & Urology

23. Pathway Summary – Benchmark Report – Unscheduled Care

HUTH

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Oct 24	78.00%	58.9%			4
A&E - 4 Hour Standard (Type 1)	Oct 24	78.0%	40.4%			2
A&E - 4 Hour Standard (Type 2 or 3)	Oct 24	95.0%	97.7%			43
A&E - Conversion Rate	Oct 24	25.0%	24.9%			20
A&E - DTA to Admission >12 Hours	Oct 24	0.0%	15.7%			34
A&E - DTA to Admission >12 Hours#	Oct 24	0.0	575.0			25
A&E - DTA to Admission >4 Hours	Oct 24	10.00%	42.1%			36
A&E - Left Without Being Seen	Sep 24	5.00%	9.4%			4
A&E - Reattendance Rate	Sep 24	5.0%	9.4%			32
A&E - Time to Initial Assessment	Sep 24	15.0	23.0			8
A&E - Time to Treatment	Sep 24	60.0	112.0			8
A&E - Total Time in A&E	Sep 24	160.0	235.0			7
A&E - Total Time in A&E (Admitted)	Sep 24	180.0	163.0			83
A&E - Total Time in A&E (Non-Admitted)	Sep 24	140.0	260.0			1
A&E Attendances All	Oct 24	-	14,647			51
A&E Attendances Type 1	Oct 24	-	9,919			57
A&E Attendances Type 3	Oct 24	-	4,728			56
Emergency Admissions Type 1	Oct 24	-	3,652			38
Emergency Admissions via A&E	Oct 24	-	3,652			36
Friends & Family A&E Score	Sep 24	85%	68%			7
Other Emergency Admissions	Oct 24	-	2,344			10
Total Emergency Admissions	Oct 24	-	5,996			23

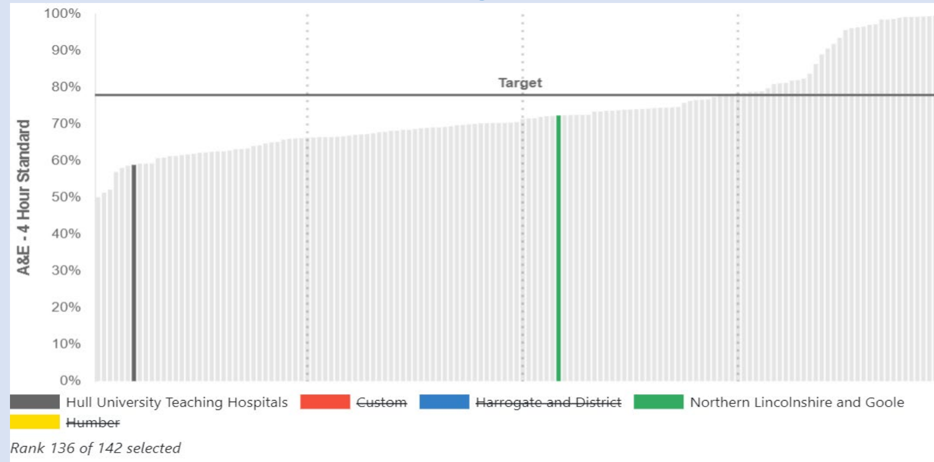
NLAG

Indicator	Period	Target	🏆	SPC	Last 12 Months	Centile
A&E - 4 Hour Standard	Oct 24	78.00%	72.4%			55
A&E - 4 Hour Standard (Type 1)	Oct 24	78.0%	51.2%			24
A&E - 4 Hour Standard (Type 2 or 3)	Oct 24	95.0%	99.4%			71
A&E - Conversion Rate	Oct 24	25.0%	35.5%			0
A&E - DTA to Admission >12 Hours	Oct 24	0.0%	15.3%			35
A&E - DTA to Admission >12 Hours#	Oct 24	0.0	859.0			9
A&E - DTA to Admission >4 Hours	Oct 24	10.00%	27.0%			64
A&E - Left Without Being Seen	Sep 24	5.00%	2.3%			82
A&E - Reattendance Rate	Sep 24	5.0%	9.0%			43
A&E - Time to Initial Assessment	Sep 24	15.0	19.0			13
A&E - Time to Treatment	Sep 24	60.0	50.0			74
A&E - Total Time in A&E	Sep 24	160.0	146.0			77
A&E - Total Time in A&E (Admitted)	Sep 24	180.0	-			-
A&E - Total Time in A&E (Non-Admitted)	Sep 24	140.0	130.0			77
A&E Attendances All	Oct 24	-	15,820			45
A&E Attendances Type 1	Oct 24	-	8,854			70
A&E Attendances Type 3	Oct 24	-	6,966			37
Emergency Admissions Type 1	Oct 24	-	5,610			10
Emergency Admissions Type 3	Oct 24	-	-			-
Emergency Admissions via A&E	Oct 24	-	5,610			9
Friends & Family A&E Score	Sep 24	85%	78%			41
Other Emergency Admissions	Oct 24	-	497			61
Total Emergency Admissions	Oct 24	-	6,107			20

24. Pathway Benchmarking & Trending – Unscheduled Care

A&E - 4 Hour Performance

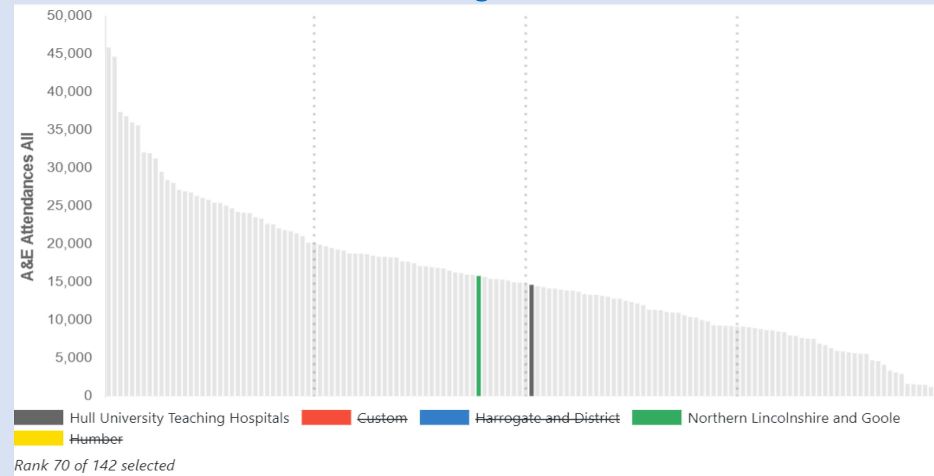
Ranking Chart



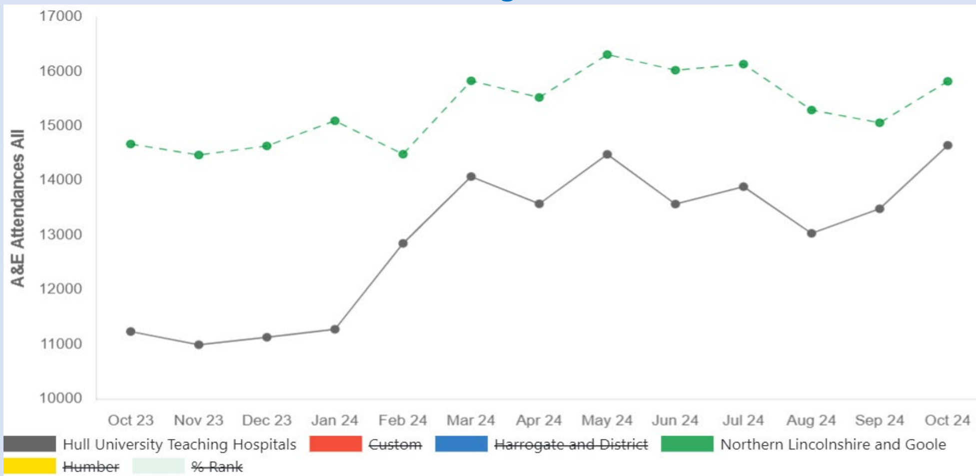
Trending Chart

A&E – Attendances

Ranking Chart



Trending Chart



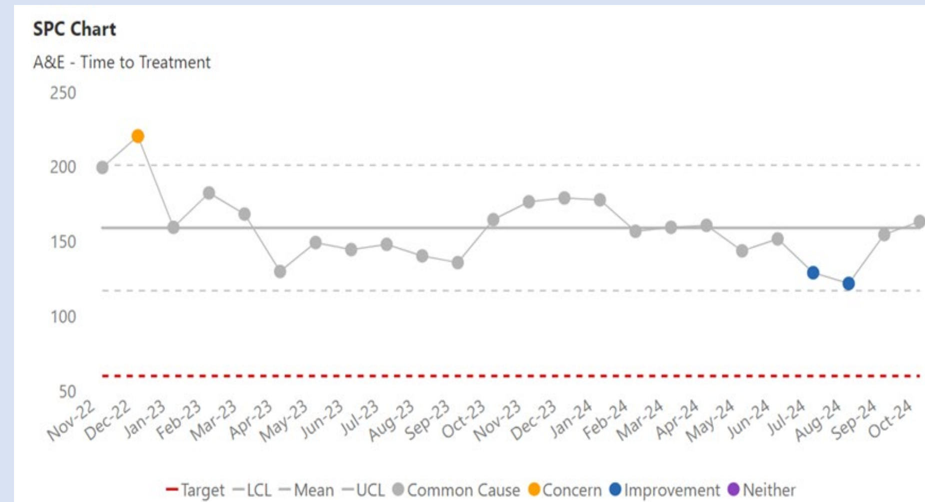
25. Emergency Care Standards – 4 hour Performance - HUTH

Compliance

Key Themes

- Compliance step change relates to inclusion of HRI UTC in HUTH formal reporting from Feb '24
- A&E 4 Hour standard (all types) was 58.9% in October (plan 62%)
- Type 1 performance in October of 40.4% is in line with the 24/25 operating plan target of 40.0%.
- Type 3 performance (HRI UTC) was 97.7% in October against the 95% target. Attendances at UTC remain significantly below planned levels.
- HUTH remains within the lowest quartile for patients seen by a clinician within 60 minutes of arrival. Time to treatment was 163 minutes in October against 60 minutes target time (a deterioration from August at 122 mins)

Critical Enabler



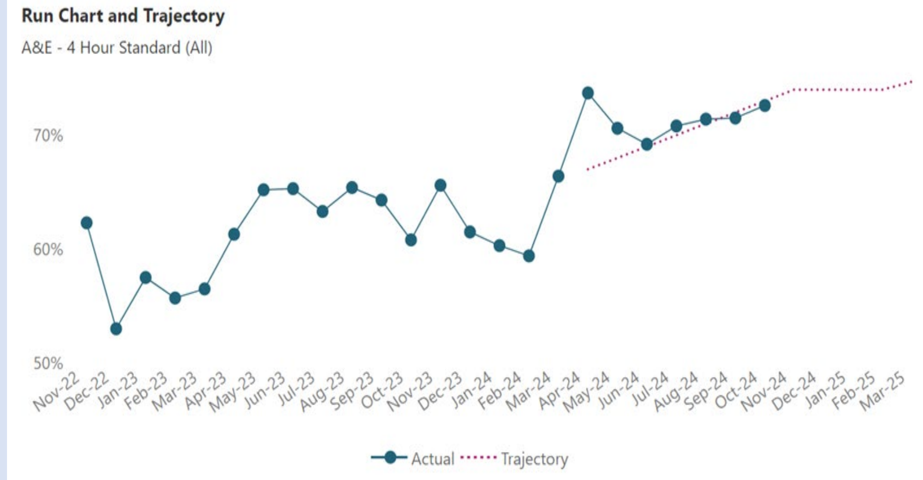
Actions

3 critical objectives identified. Improvement since project initiation in February 2024, however flow pressures experienced within the ED during September have led to a deterioration in performance:

1. Reducing non-admitted breaches:- Increased from 2,497 in August to 3,710 in October
2. Time to first clinician:- Deterioration from mean of 121.9 in August to mean of 176 in October
3. Improved frailty assessment: :- Deterioration from 457.2mins in August to 609 mins in October for total time in department for patients >65 years of age (target time of 160 minutes)
4. Patient flow outside ED also being prioritised: - Implementation of SAFER Bundle, Discharge Lounge, Surgical SDEC, designated cover of GIM wards and reduction of NCTR.
   Community capacity including diversionary pathways from ED being progressed with partners

26. Emergency Care Standards – 4 hour Performance - NLAG

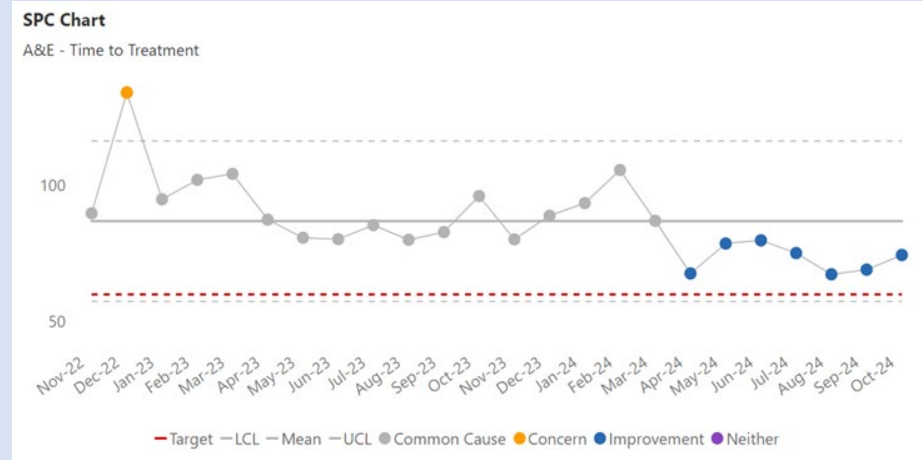
Compliance



Key Themes

- Combined type 1 and 3 performance was 72.4% in October, slightly below the 73% target trajectory.
- Total attendances in October were 15,819, comprising 8,853 Type 1 attendances (below plan) and 6,966 Type 3 attendances (above plan).
- Time to treatment was 74 minutes in October, a slight deterioration on the August position.

Critical Enabler



Actions

3 critical objectives identified. Improvement since project initiation in February 2024: Reducing non-admitted breaches.

1. Reducing non-admitted breaches: - slight increase from 2,318 in August to 2,406 in October.
2. Time to first clinician: - Slight deterioration in performance against this metric in October (74 minutes compared to 67.4 mins in August)
3. Improved frailty assessment: - Increase in waiting time from 239.3mins in August to 252 minutes in October for total time in department for patients >65 years of age (target time of 160 minutes)
4. Patient flow outside ED also being prioritised: - CDU now functional across both sites, impact being monitored. Patient flow outside ED also being prioritised. Implementation of SAFER Bundle, designated cover of GIM wards and reduction of NCTR.

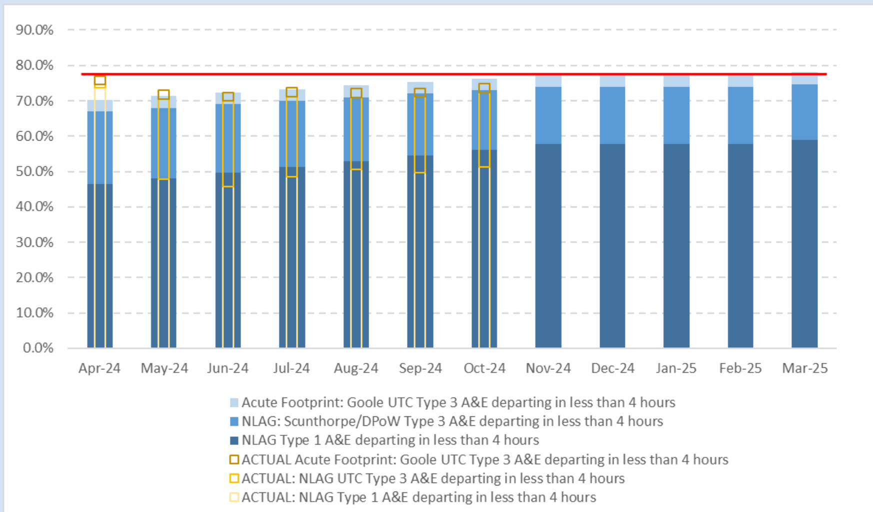
27. Acute Footprint Compliance – A&E

Compliance - HUTH

Key Themes

- As per NEY Region/HNY ICB instruction, 2024/25 trajectories are predicated on 78% delivery as an Acute Footprint by March '25.
- Acute footprint delivery of 70.3% against a plan of 76.3%.
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance was 40.4% in line with plan of 40.4%.
  - Type 3 co-located activity compliance of 18.5% versus plan of 22%
  - Non co-located compliance was 11.4% versus plan of 14.1%

Compliance - NLAG

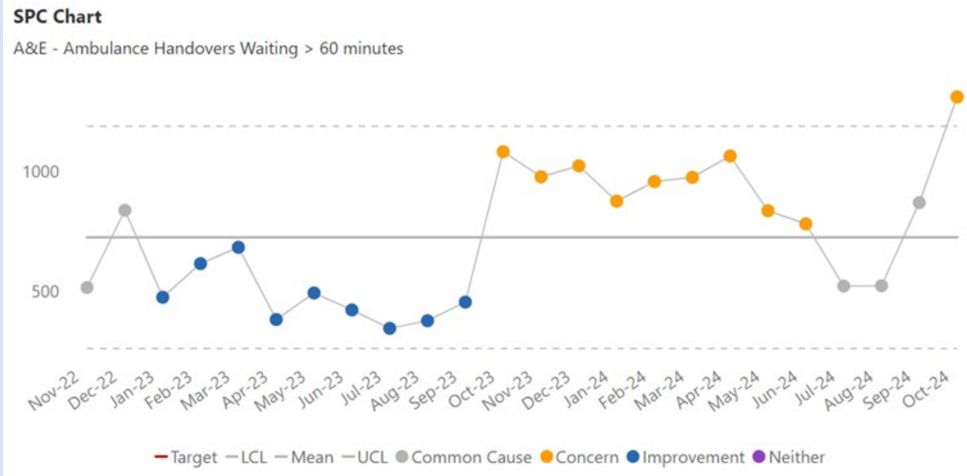


Key Themes

- Acute footprint delivery of 76.3% against a plan of 73%
- Breaking the plan/delivery into constituent parts:
  - Type 1 compliance was 51.2% versus plan of 56.2%.
  - Type 3 co-located activity compliance of 21.2% versus plan of 16.8%
  - Non co-located compliance was 2.5% versus plan of 3.0%

28. Ambulance Handovers >60 minutes - HUTH

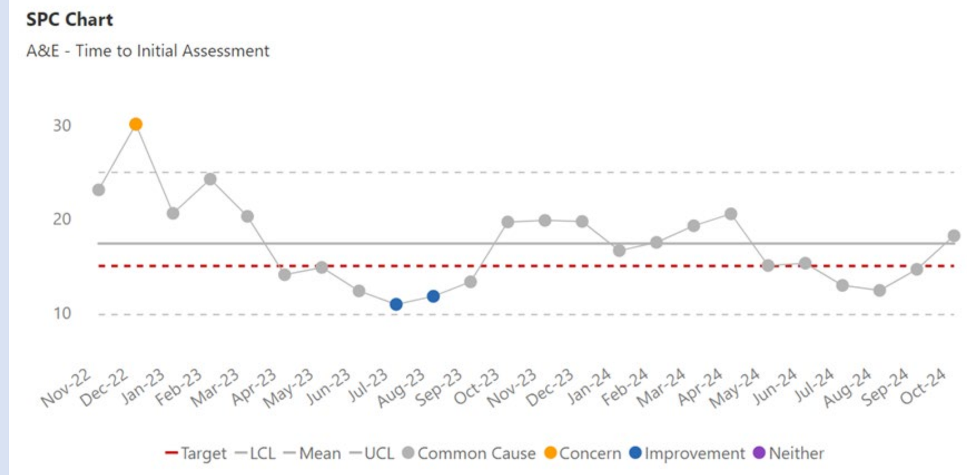
Compliance



Key Themes

- Month on month reduction in the number of ambulance handovers >60 minutes from Feb to August as part of recovery programme, however, notable deterioration at HUTH in September (869) and October (1,311).
- Root cause of handover delays linked to patient volumes in A&E which increased sharply in October, resulting in compression of available assessment spaces.
- Pressure on staffing levels that cover all elements of ED has increased due to an increase in non-admitted activity seen via ECA/ED. Action plan being progressed to align capacity and demand within ED establishment.

Critical Enabler

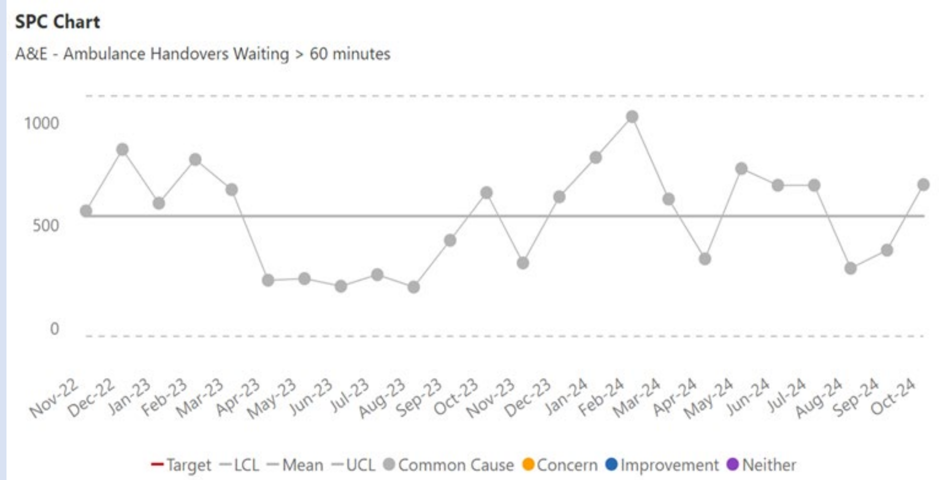


Actions

- Time to initial assessment in October was 18 minutes, a slight deterioration in performance compared to previous months
- Triggers and Escalation/SOP for ambulance handovers is being reviewed and adapted linked to national OPEL system, enabling 30-minute Cat 2 responses for YAS.
- Work with YAS to bring forward clinical assessment through proposing changes to current practice.

29. Ambulance Handovers >60 minutes - NLAG

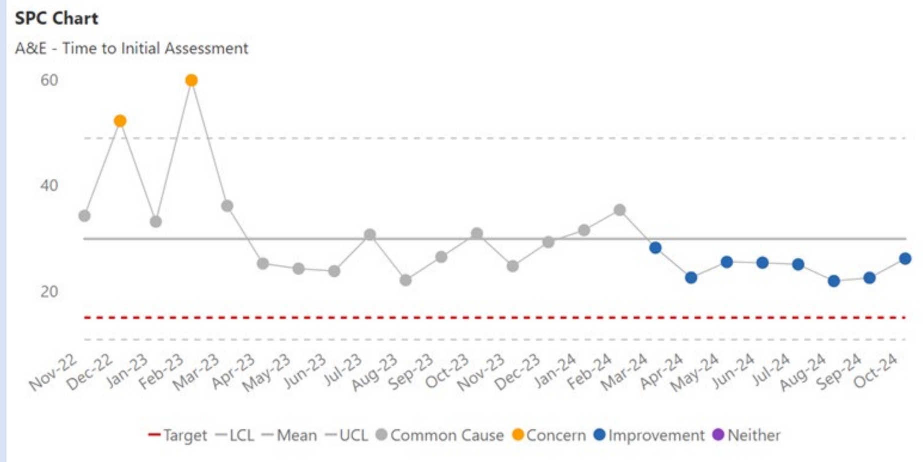
Compliance



Key Themes

- Performance in ambulance handovers >60 minutes increased marginally to 380 mins in September and to 698 in October, but remains within the normal operating range
- Time to initial assessment in October was 26 minutes against target of 15 minutes, a slight deterioration on the previous month

Critical Enabler



Actions

- Rapid Assessment and Treatment (RAT) model to be embedded to reduce waiting time to be seen.
- Audit of current practices planned to ensure handover principles are being adhered to. Working toward zero tolerance of >45-minute handover, aim to deliver 100% ambulance handovers under 45min and 80% under 30 minutes.
- Improvement of flow/ LOS through Discharge rounds in wards will reduce congestion.
- Impact and timelines for recovery programme being finalised with system partners.

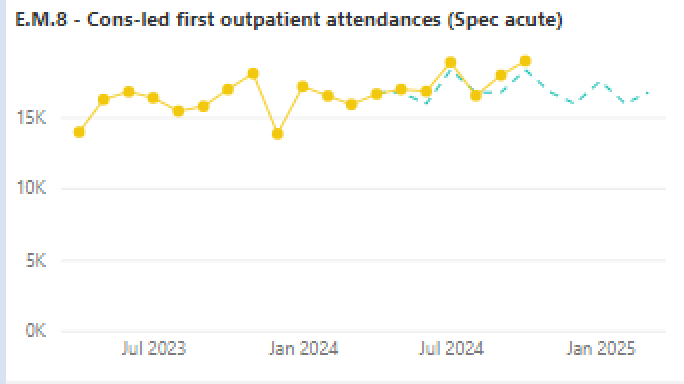
30. Activity

HUTH	NLAG (data shown to Month 6)

HUTH

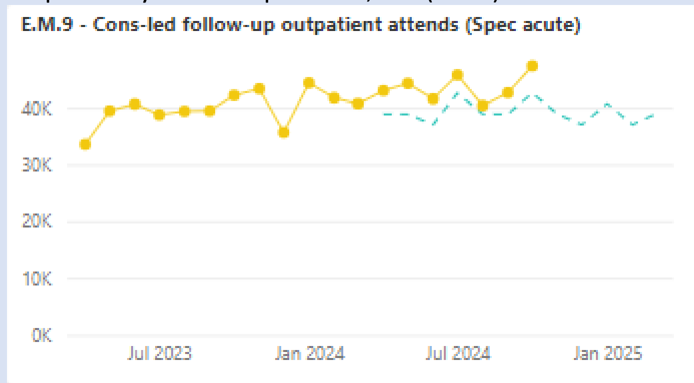
New Outpatient Attendances vs Plan

YTD New consultant-led activity is above plan at +3,131 (2.6%).



Follow up Outpatient Attendances vs Plan

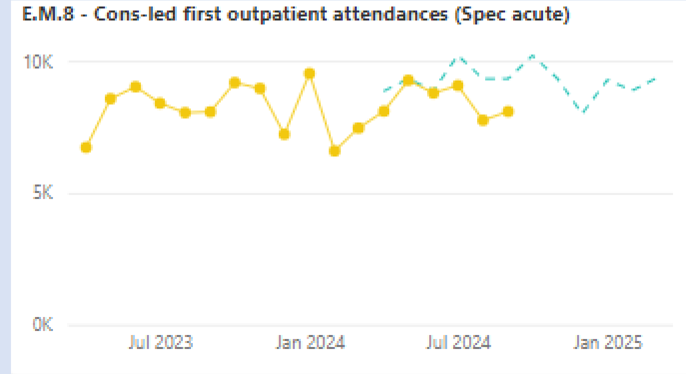
YTD Follow up activity is above plan +27,215 (9.8%).



NLAG (data shown to Month 6)

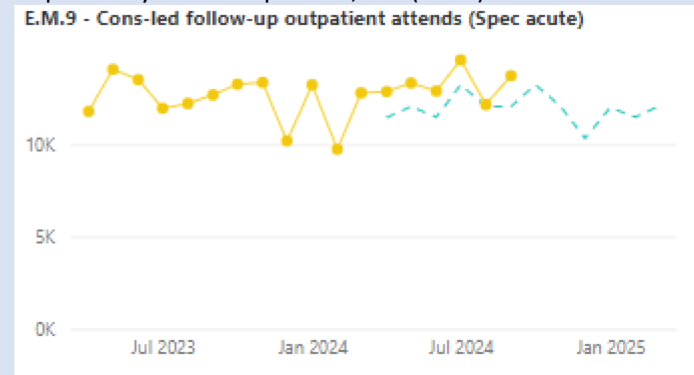
New Outpatient Attendances vs Plan

YTD New consultant-led activity is below plan at -4,881 (8.7%).



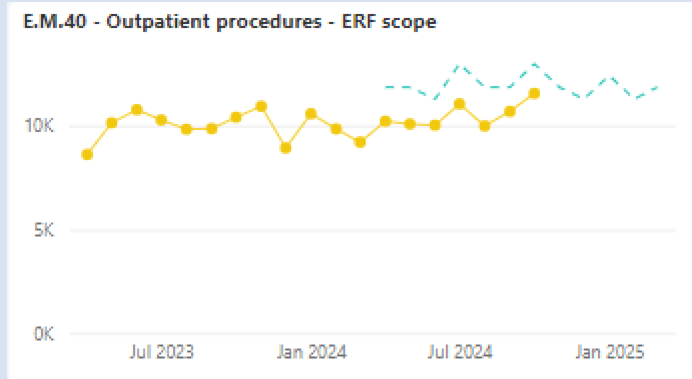
Follow up Outpatient Attendances vs Plan

YTD Follow up activity is above plan +7,117 (9.8%).



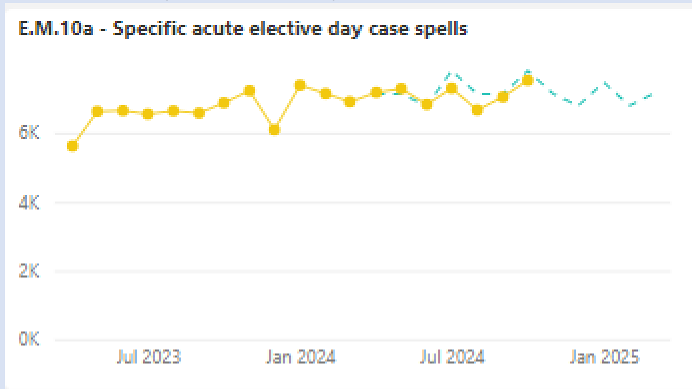
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -11,063 (13.1%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



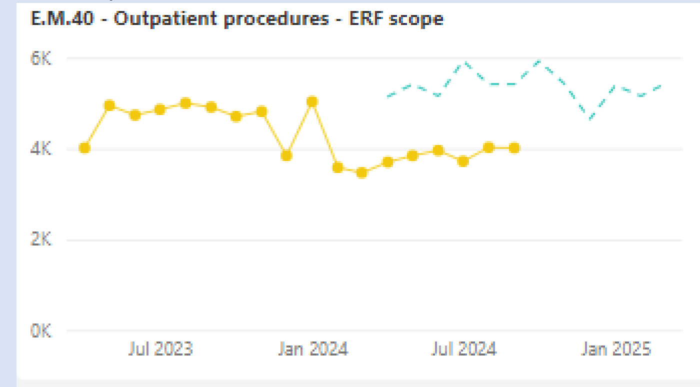
Day Case Admissions vs Plan

YTD Day case elective spells is below plan at -1,096 (2.2%).



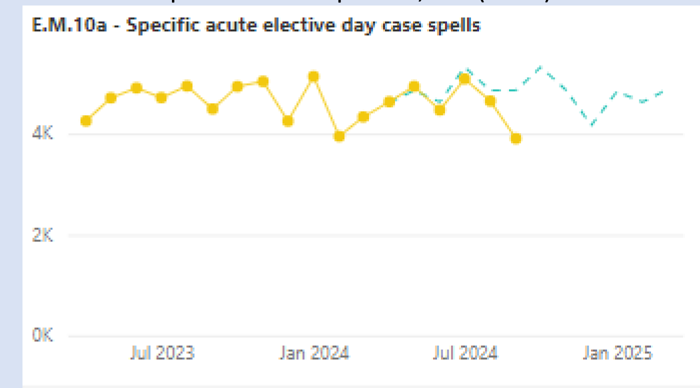
Outpatient Procedures vs Plan

YTD Outpatient procedure is under plan by -9,239 (28.5%). Action is being taken by the RTT Delivery Group to improve the recording of outpatient attendances with procedures.



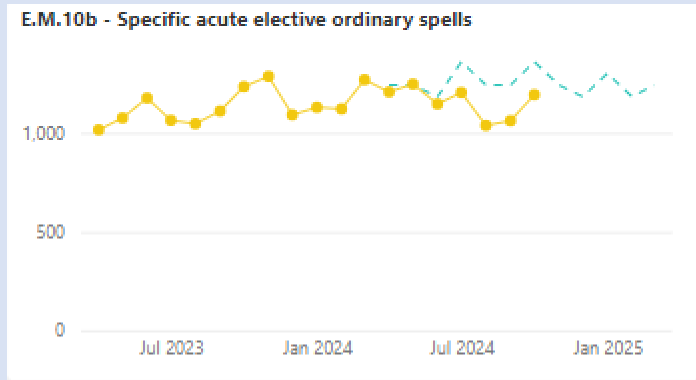
Day Case Admissions vs Plan

YTD Day case elective spells is below plan -1,460 (5.0%).



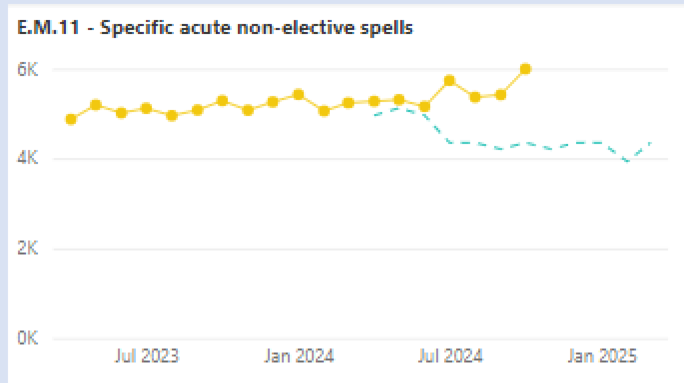
Elective Admissions vs Plan

YTD Inpatient spells is below plan at -776 (8.7%).



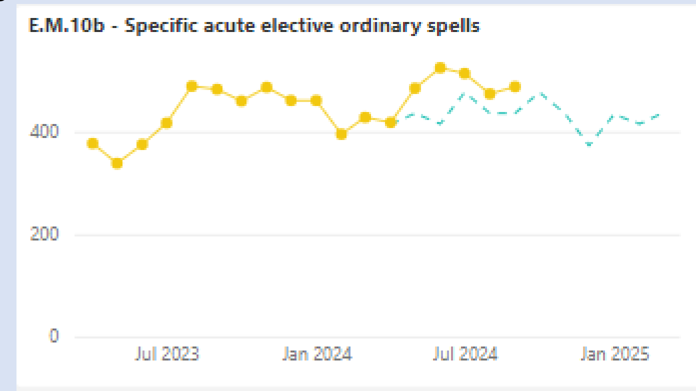
Non-Elective Admissions vs Plan

YTD non-elective spells +5,968 (18.5%) over plan.



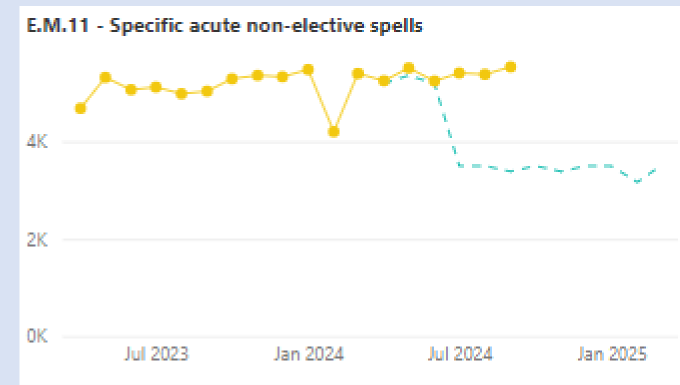
Elective Admissions vs Plan

YTD Inpatient spells is above plan +290 (11.1%), however data is subject to further evaluation of correct operational recording of intended management (Daycase versus zero LOS inpatient). A recent audit has evidenced this to be a recording issue.



Non-Elective Admissions vs Plan

Non-elective spells above plan YTD +6,223 (23.8%).



31. Elective Recovery Fund - HUTH

Hull University Teaching Hospitals	ERF Performance (%)							
	Apr	May	Jun	Jul	Aug	Sept	Oct	YTD
DAYCASE	115%	119%	118%	105%	102%	117%	114%	113%
ELECTIVE	107%	109%	104%	93%	97%	94%	93%	99%
OP FIRST ATTENDANCE	112%	116%	117%	116%	107%	118%	121%	115%
OP FIRST PROCEDURE	118%	114%	121%	117%	117%	128%	115%	119%
OP F/UP PROCEDURE	160%	158%	163%	152%	156%	163%	170%	160%
Total	**113%**	**116%**	**115%**	**105%**	**104%**	**111%**	**110%**	**111%**

Notes

This data is an early pull of data and as such this is not fully coded and may omit clinics/discharges that were cashed up late.

32. Elective Recovery Fund - NLAG

Northern Lincolnshire & Goole Hospitals	ERF Performance (%)							
	Apr	May	Jun	Jul	Aug	Sept	Oct	YTD
DAYCASE	115%	117%	115%	114%	113%	106%	108%	112%
ELECTIVE	97%	104%	122%	104%	108%	109%	104%	107%
OP FIRST ATTENDANCE	97%	112%	115%	102%	91%	97%	99%	102%
OP FIRST PROCEDURE	90%	96%	95%	84%	96%	90%	90%	91%
OP F/UP PROCEDURE	68%	66%	76%	66%	72%	76%	82%	72%
Total	**101%**	**108%**	**113%**	**103%**	**103%**	**102%**	**102%**	**104%**

Notes

This data is an early pull of data and as such is not fully coded and may omit some clinics/discharges that were cashed up late.

This data is from the new Insource Data Warehouse and contains some known DQ errors.

This data will not fully match to the SUS national position, as this the SUS position is being generated through the old Data Warehouse to avoid the known errors.

Known errors are:

- Length of stay is overstated where a second or subsequent critical care stay exists, this may overstate excess bed-day value.
- Nurse led activity is being treated as Consultant led due to some errors in clinic set up in implementation. A call has being logged to get this addressed.

Northern Lincolnshire and Goole
NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(25)016

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	9 January 2025
Director Lead	David Sharif, Group Director of Assurance
Contact Officer/Author	Alison Hurley, Deputy Director of Assurance
Title of the Report	**Acronyms and Glossary of Terms**
Executive Summary	A reference guide for any words, phrases or acronyms used during the meeting – updated December 2024. Document for information only.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

ACRONYMS & GLOSSARY OF TERMS

Dec 2024 – v8.9

2WW - Two week wait

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

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

ACE – A Commitment to Excellence – Accreditation scheme previously known as 15 Step Reviews

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

AAU – Acute Assessment Unit

Accounting Officer - The NHS Act 2006 designates the chief executive of an NHS foundation trust as the accounting officer.

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

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

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

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

AGC – Audit & Governance Committee

AGM – Annual General Meeting

AHP – Allied Health Professional

ALoS – Average Length of Stay

AMM – Annual Members' Meeting

AO – Accounting Officer

AoMRC – Association of Medical Royal Colleges

AOP – Annual Operating Plan

ARC – the Governor Appointments & Remuneration Committee has delegated authority to consider the appointment and remuneration of the Group Chair, Vice Chair

and Non-Executive Directors on behalf of the Council of Governors, and provide advice and recommendations to the full Council in respect of these matters

ARM – Annual Review Meeting for CoG

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

ARGC – Audit Risk & Governance Committees-in-Committee

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

BAF - Board Assurance Framework

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

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

BLS – Basic Life Support

BMA – British Medical Association

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

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

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

CAP – Collaborative Acute Providers

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

CCG – Clinical commissioning groups (CCGs) were NHS organisations set up by the Health and Social Care Act 2012 to organise the delivery of NHS services in each of their local areas in England. On 1 July 2022 they were abolished and replaced by Integrated Care Systems as a result of the Health and Care Act 2022.

CDC – Community Diagnostic Centre

CFC – Charitable Funds Committee

CFO – Chief Financial Officer

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

CE/CEO – Chief Executive Officer

CF – Cash Flow

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

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

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

CMO – Chief Medical Officer

CMP or C&MP – Capital & Major Projects Committees-in-Common

Code of Governance – NHS England has issued this Code of Governance (the code) to help NHS providers deliver effective corporate governance, contribute to better organisational and system performance and improvement, and ultimately discharge their duties in the best interests of patients, service users and the public.

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

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

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

Committees-in-Common (CiC) - NLaG and HUTH are implementing a governance structure which will ensure that they have single focussed discussions on major areas of service change. These discussions would take place in the Committees in Common

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

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

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

CoP – Code of Practice

CPA – Care Programme Approach

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

CPIS - Child Protection Information Sharing

CPN – Community Psychiatric Nurse

CPO – Chief People Officer

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

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

CSPO – Chief Strategy and Partnerships Officer

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

Datix - is the patient safety web-based incident reporting and risk management software, widely used by NHS staff to report clinical incidents (Replaced by Ulysses in 2023)

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

DD – Due Diligence

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

DGH – District General Hospitals

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

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

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

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

DNR - Do not resuscitate

DoF – Director of Finance

DOI - Declarations of Interest

DOLS - Deprivation of Liberty Safeguards

DOSA – Day of Surgery Admission

DPA - Data Protection Act

DPH - Director of Public Health

DPoW - Diana, Princess of Wales Hospital, Grimsby

DTOCs – Delayed Transfers of Care

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

ECC - Emergency Care Centre

ED – Executive Directors or Emergency Department

EDI – Equality, Diversity and Inclusion

EHR – Electronic Health Record

EIA - Equality Impact Assessment

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

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

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

EoL – End of Life

EPR - Electronic Patient Record

ERF – Elective Recovery Fund

ERoY – East Riding of Yorkshire

ESR - Electronic Staff Record

Executive Directors - Board-level senior management employees of the NHS Foundation Trust who are accountable for carrying out the work of the organisation. For example the Chief Executive and Finance Director, of a NHS Foundation Trust who sit on the Board of Directors. Executive Directors have decision-making powers and a defined set of responsibilities, thus playing a key role in the day to day running of the Trust.

FD – Finance Director

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

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

FRC – Financial Risk Rating

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

FTE – Full Time Equivalent

FTGA – Foundation Trust Governors' Association

FTN – Foundation Trust Network

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

FY – Financial Year

GAG – the Governor Assurance Group has oversight of areas of Trust governance and assurance frameworks in order to provide added levels of assurance to the work of the Council of Governors (Replaced by Member and Public Engagement & Assurance Group (MPEAG) from April 2024)

GDH – Goole District Hospital

GDP – Gross Domestic Product

GDPR – General Data Protection Regulations

GIRFT – Getting It Right First Time

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

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

Governance - This refers to the “rules” that govern the internal conduct of an organisation by defining the roles and responsibilities of groups (e.g. Board of Directors, Council of Governors) and individuals (e.g. Chair, Chief Executive Officer, Finance Director) and the relationships between them. The governance arrangements of NHS Foundation Trusts are set out in the constitution and enshrined in the Licence

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

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

Group Model - Hull University Teaching Hospitals NHS Trust (HUTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) will still exist as separate legal entities but will operate within a singular Group model and one Group Executive Team

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

H1 - First Half (financial or calendar year)

H2 - Second Half (financial or calendar year)

HAS - Humber Acute Services

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

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

HCCP - Humber Clinical Collaboration Programme

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

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

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

HEE – Health Education England

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

HOBS - High Observations Beds

HOSC - Health Overview and Scrutiny Committee. Committee that looks at the work of the clinical commissioning groups, and National Health Service (NHS) trusts, and

the local area team of NHS England. It acts as a 'critical friend' by suggesting ways that health related services might be improve

HR – Human Resources

HSCA – Health & Social Care Act 2012

HSMR - Hospital Standardised Mortality Ratio

HTF - Health Tree Foundation (Trust charity)

HTFTC - Health Tree Foundation Trustees' Committee

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

Humber and North Yorkshire Health and Care Partnership - The Humber and North Yorkshire Health and Care Partnership is a collaboration of health, social care, community and charitable organisations

HW – Healthwatch

HWB/HWBB – Health & Wellbeing Board

HWNL - Healthwatch North Lincolnshire

HWNEL - Healthwatch North East Lincolnshire

HWER - Healthwatch East Riding

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

HUTH – Hull University Teaching Hospitals NHS Trust

IAAU – Integrated Acute Assessment Unit

IAPT – Improved Access to Psychological Therapies

IBP – Integrated Business Plan

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

ICB – Integrated Care Board

ICP – Integrated Care Partnership

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

ICU – Intensive Care Unit

IG – Information Governance

Integrated Care - Joined up care across local councils, the NHS, and other partners. It is about giving people the support they need, joined up across local councils, the

NHS, and other partners. It removes traditional divisions between hospitals and family doctors, between physical and mental health, and between NHS and council services. The aim is that people can live healthier lives and get the care and treatment they need, in the right place, at the right time.

IP – Inpatient

IPC - Infection Prevention & Control

IPR – Integrated Performance Report

IT – Information Technology

ITU – Intensive Therapy Unit

JAG – Joint Advisory Group accreditation

JHOSH - Joint Health Overview and Scrutiny Committee

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

JSNA – Joint Strategic Needs Assessment

KLOE – Key Line of Enquiry

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

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

LA – NHS Leadership Academy

LATs – Local Area Teams

LD – Learning Difficulties

Lead Governor - The Lead Governor has a role in facilitating direct communication between NHS England and the NHS foundation trust's council of governors. This will be in a limited number of circumstances and, in particular, where it may not be appropriate to communicate through the normal channels, which in most cases will be via the Chair or the Trust Secretary, if one is appointed.

LETB – Local Education and Training Board

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

LHE – Local Health Economy

LHW – Local Healthwatch

LiA – Listening into Action

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

continue to oversee the way that NHS Foundation Trusts are governed. It replaces the Terms of Authorisation

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

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

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

LTC - Long Term Condition

M&A – Mergers & Acquisitions

MCA - Mental Capacity Act

MDT - Multi-disciplinary Team

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

MHA – Mental Health Act

MI – Major Incident

MIU – Major Incident Unit

MLU - Midwifery led unit

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

MPEAG – Membership and Public Engagement & Assurance Group is responsible for overseeing the development, implementation and regular review of the Trust's Member and Public Engagement Strategy. This incorporates oversight of member recruitment and communication, public engagement initiatives and mechanisms to feed back the views of members and the public to the CoG, and Trust Board.

MRI – Magnetic Resonance Imaging

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

MSA – Mixed Sex Accommodation

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

NED – Non-Executive Director

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

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

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

Neurology - Study and treatment of nerve systems.

NEWS - National Early Warning Score

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

NEL - North East Lincolnshire

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

NHS - National Health Service

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

NHS Confederation - is the membership organisation that brings together, supports and speaks for the whole healthcare system in England, Wales and Northern Ireland.

NHS ICS Body - ICS NHS bodies will be established as new organisations that bind partner organisations together in a new way with common purpose. They will lead integration within the NHS, bringing together all those involved in planning and providing NHS services to take a collaborative approach to agreeing and delivering ambitions for the health of their population

NHSE - NHS England. NHS England provides national leadership for the NHS. Through the NHS Long Term Plan, we promote high quality health and care for all, and support NHS organisations to work in partnership to deliver better outcomes for our patients and communities, at the best possible value for taxpayers and to continuously improve the NHS. We are working to make the NHS an employer of excellence and to enable NHS patients to benefit from worldleading research, innovation and technology

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

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

NHSP - NHS Professionals

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

NHSTDA – NHS Trust Development Authority

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

NL - North Lincolnshire

NLaG - Northern Lincolnshire & Goole Hospitals NHS Foundation Trust

NMC - Nursing & Midwifery Council

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

NQB - National Quality Board

NSFs – National Service Frameworks

OBC - Outline Business Case

OFT – Office of Fair Trading

OLU - Obstetric led unit

OOH - Out of Hours

OP – Outpatients

OPA – Outpatient Appointment

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

OSCs – Overview and Scrutiny Committees

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

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

PAU – Paediatric assessment unit

PbR - Payment by Results

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

PCT – Primary Care Trust

PDC – Public Dividend Capital

PEWS - Paediatric Early Warning Score

PEF – Performance, Estates & Finance Committees-in-Common

PFI – Private Finance Initiative

PIDMAS – Patient Initiated Digital Mutual Aid System

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

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

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

Population Health Management (PHM) - A technique for using data to design new models of proactive care, delivering improvements in health and wellbeing which make best use of the collective resources. Population health aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population.

PPE - Personal Protective Equipment

PPG - Patient Participation Group. Patient Participation Group is a group of people who are patients of the surgery and want to help it work as well as it can for patients, doctors and staff

PPI – Patient and Public Involvement

PRIM - Performance Review Improvement Meeting

PROMS – Patient Recorded Outcome Measures

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

PSF - Provider Sustainability Fund

PST – Patient Suitability for Transfer

PTL – Patient Transfer List

PTS – Patient Transport Services

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

QGAF – Quality governance assurance framework

QI – Quality Improvement

QIA – Quality Impact Assessment

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

QOF – Quality and Outcomes Framework. The Quality and Outcomes Framework is a system designed to remunerate general practices for providing good quality care to their patients, and to help fund work to further improve the quality of health care delivered. It is a fundamental part of the General Medical Services (GMS) Contract, introduced in 2004.

QRP – Quality & Risk Profile

Q&SC – Quality & Safety Committees-in-Common

QSIR – Quality & Service Improvement Report

R&D – Research & Development

RAG – Red, Amber, Green classifications

RCA – Root Cause Analysis

RCGP – Royal College of General Practitioners

RCN – Royal College of Nursing

RCP – Royal College of Physicians

RCPSYCH – Royal College of Psychiatrists

RCS – Royal College of Surgeons

RGN – Registered General Nurse

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

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

RoI – Register of Interests

RoI – Return on Investment

RTT – Referrals to Treatment

SaLT - Speech and Language Therapy

SDEC – Same day emergency care

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

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

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

SGH – Scunthorpe General Hospital

SHCA – Senior Health Care Assistant

SHMI - Summary Hospital-level Mortality Indicator

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

SIB - System Improvement Board

SID - Senior Independent Director - One of the non-executive directors should be appointed as the SID by the Board of Directors, in consultation with the Council of Governors. The SID should act as the point of contact with the Board of Directors if Governors have concerns which approaches through normal channels have failed to resolve or for which such normal approaches are inappropriate. The SID may also act as the point of contact with the Board of Directors for Governors when they discuss, for example, the chair's performance appraisal and his or her remuneration and other allowances. More detail can be found in the Code of Governance

SJR - Structured Judgement Review

SLA – Service Level Agreement

SLM/R – Service Line Management/Reporting

SNCT - Safer Nursing Care Tool

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

SPA – Single Point of Access

SoS – Secretary of State

SSA – Same Sex Accommodation

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

Statutory Requirement - A requirement prescribed by legislation

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

T&C – Terms and Conditions

TCI – To Come In

Terms of Authorisation - Previously, when an NHS Foundation Trust was authorised, Monitor set out a number of terms with which the trust had to comply.

The terms of authorisation have now been replaced by the NHS provider licence, and NHS Foundation Trusts must comply with the conditions of the licence

TMB - Trust Management Board

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

ToR – Terms of Reference

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

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

TTO – To Take Out

ULHT – United Lincolnshire Hospital NHS Trust

ULYSSES - Risk Management System to report Incidents and Risk (Replaced DATIX in 2023)

UTC - Urgent Treatment Centre

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

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

VTE – Venous Thromboembolism

WEC – Workforce, Education & Culture Committee-in-Common

WRES - Workforce Race Equality Standards

WDES - Workforce Disability Equality Standards

WTE - Whole time equivalent

YTD - Year to date