



**Northern Lincolnshire
and Goole**
NHS Foundation Trust



Annual Report and Accounts 2025-2026

Northern Lincolnshire and Goole NHS Foundation Trust

Annual Report and Accounts 2025/26

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

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Chair's Foreword

Welcome to the annual report for Northern Lincolnshire and Goole NHS Foundation Trust.

Stepping into the role of Chair in April has been both a privilege and an education. In my first couple of months in post I have been fortunate to meet with many clinical teams and colleagues in support services, as well as hearing directly from patients and families about their experiences.

What has struck me most in these conversations is the contrast between the internal and external perception of the organisation and the pride people feel in the care they provide as well as the positive feedback from our patients. I accept that this isn't a scientific analysis of where we are as an organisation but I know that our people are proud of the care they provide and that it is rooted in compassion, professionalism, and a shared belief in the values that define our NHS.

Pride matters, because our Trusts are facing significant challenges. Like many organisations across the health service, we are contending with sustained demand, workforce pressures, financial constraints, and the ongoing need to recover performance against national standards.

These challenges are real, and we must be honest about our shortcomings and the scale of the work ahead. But I have been equally struck by the determination of our staff to meet these challenges head-on. Their willingness to innovate, to support one another, and to keep patients at the centre of every decision gives me genuine optimism about our future. We are seeing the signs of recovery in several areas, driven by a keen focus on patient safety, and I see it as vital that we share our successes as widely as possible.

These efforts are not abstract: they are already making a difference to patients, and they show what is possible when we harness the commitment and creativity of our people.

As we look ahead, our focus is clear: to improve performance, deliver consistently safe and high-quality care, and meet both national expectations and the priorities of the communities we serve. We will not achieve this overnight, but we will achieve it together. The conversations I have had across the group leave me in no doubt that we have the talent, the resilience and the shared purpose to succeed.

I would like to thank our staff for the warm welcome I have received and for their honesty in sharing their opinions. It is essential that colleagues feel able to speak up, raise concerns and identify problems, as well as sharing their positive experience of working in high-performing teams and delivering care which is both professional and compassionate.

I am proud to serve as Chair of this organisation, and I am confident in the direction we are heading. I look forward to working with my new colleagues, on your behalf, as we strive to make this a consistently good place to work and to receive care.



Alan Downey
Chair



The Performance Report

Overview

The aim of this overview section is to set out:

- A brief history of the trust and the regional context the trust operates in
- The purpose and activities of the trust
- The issues and risks within the year which could have affected the trust in delivering its objectives
- An explanation of the adoption of the going concern basis
- A summary of performance for 2025/26 against the national standards.

About the trust

Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) is a joint acute and community foundation trust serving a population of around 445,000 people across North Lincolnshire, North East Lincolnshire, the East Riding of Yorkshire and West and East Lindsey in Lincolnshire.

The trust has three hospital sites, with approximately 750 beds, offering a mix of acute and community services.

- Diana, Princess of Wales Hospital, Grimsby (Emergency Department)
- Scunthorpe General Hospital (Emergency Department)
- Goole District Hospital



We employ approximately 8,000 people and have an annual budget of circa £700m.

Together we serve a local population of more than 450,000 people and provide inpatient, day care and outpatient services.

Activity over the past three years has been as follows:

	2023/24	2024/25	2025/26
A&E attendances at Grimsby and Scunthorpe	174,008	187,436	198,766
Admissions into hospital	118,523	139,367	135,222
Number of discharges (patients leaving hospital)	118,174	139,348	135,232
Outpatient appointments (attendances)	339,021	323,850	336,018
Births	3,703	3,658	3,821
Patients who were admitted as an emergency	59,683	68,080	71,201
Total number of operations in theatre	19,743	20,464	17,930
Total number of planned operations in theatre	14,965	15,630	14,023

The trust was formed on 1 April 2001 following the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust. It has been a foundation trust since 1 May 2007. In April 2011 the trust became a combined trust providing both acute and community services for the communities of North Lincolnshire. As a result of this the name of the trust, whilst acknowledging the geographical spread of the organisation, was changed during 2013 to reflect the fact it does more than run hospitals.

In August 2023 NLaG partnered Hull University Teaching Hospitals NHS Trust (HUTH) - under a new group organisational structure (NHS Humber Health Partnership) with a Group Chief Executive and a group executive team, as well as a Group Chair. HUTH manages two hospitals: Hull Royal Infirmary and Castle Hill Hospital).

Under this structure NLaG continues to have its own board including, at present, two non-executive directors, and, as a foundation trust we retain our Council of Governors and foundation trust membership.

NHS Humber Health Partnership employs almost 19,000 staff, sees more than a million patients each year and has a combined budget of approximately £1.7bn.

In spring 2024 the group implemented a joint operational structure where clinical services across both trusts came together as 'care groups'. These groups bring together trust services with those of HUTH into a management structure split into north and south. They are

- The Site Management (North) which includes the following care groups: Cancer Network; Cardiovascular; Digestive Diseases; Head and Neck; Major Trauma Network; Specialist Cancer and Support Services; and Theatres, Anaesthetics and Critical Care – and also includes Patient Services
- Site Management (South) which includes the following care groups: Acute and Emergency Medicine; Community, Frailty and Therapy; Family Services; Neuroscience; Pathology Network; Specialist Medicine and Specialist Surgery and also includes the Discharge Teams

Corporate Directorates within the trust include the offices of the Chief Medical Officer and the Chief Nurse, Digital Services, Estates, Facilities and Development, Finance, People and Quality Governance.

Our values

Our values were co-designed with our people across both organisations to reflect our group identity. They shape how we work and how we interact with our colleagues, patients, loved ones and wider communities.

- Compassion – We care. We want the best for our patients, our people and our population.
- Honesty – We value integrity and are honest about our shortcomings.
- Respect – We recognise and respect everyone's unique contribution.
- Teamwork – We work together to achieve the best for our patients and communities.



Regional and health system context

The NHS Humber and North Yorkshire (HNY) Integrated Care Board (ICB) is the statutory organisation accountable for NHS spend and performance in the geographic area covered by the trust. The ICB works within the Integrated Care System (ICS) of HNY. This is an area of more than 1,500 square miles with a population of 1.7 million people, all with different health and care needs. It includes the cities of Hull and York and the large rural areas across East Yorkshire, North Yorkshire and Northern Lincolnshire.

The HNY ICB's vision is for people to 'Start well, live well, age well and when the time comes die well'. The ICB refreshed its strategy in the past couple of years and set out a renewed commitment to its partnership ambitions by:

- Introducing a new 'golden ambition' to drive a generational change in wellbeing, health and care for today's children
- Reaffirming its commitment to what is already working well, such as its person-centred and strengths-based approach
- Setting out areas for investment that will keep the voices of the people at the heart of everything it does and that will drive excellence, prevention and sustainability across the HNY health system.

Community Diagnostic Centres

During 2023/2024 the wider Partnership received approximately £45m of capital funding for the development of four community diagnostic centres. The funding provides an opportunity to significantly enhance our diagnostic capacity improving patient access and providing direct access for GPs to a community resource which will not only increase capacity and access but reduce waiting times and create local jobs.

The Community Diagnostic Centres are located in Scunthorpe, Hull, Grimsby and East Riding of Yorkshire.

The schemes have been developed in close partnership with our Local Authority partners and have a wider focus on town centre regeneration and the socio-economic development of our local communities.



Place Boards

The Trust continues to engage in the leadership and delivery of our four Place Boards – East Riding, Hull, North and North East Lincolnshire.

Trust leaders are widely engaged in multiple programmes of change which are primarily focussed on:

- workforce development – looking at new roles skills and academic partnerships
- new pathways of care – with a focus on what can be delivered outside the hospital environment in the patients home
- how we collaborate to ensure we fulfil our “Anchor Organisation” role

The Trust is committed to working collaboratively across multiple places, organisations and to fulfilling its Anchor role. An integral part of that is to recognise our significant role in collaborating to reduce health inequalities and to improve patient access and outcomes across multiple pathways of care.

Working in partnership

The trust delivers services by working in partnership with a wide range of partners in both health and social care. This includes (not an exhaustive list):

- National bodies:
 - NHS England (NHSE)
 - Care Quality Commission
 - Department of Health and Social Care
- Regional bodies like:
 - The HNY ICB, and the place boards and structures related to it
 - The Acute Collaborative, an association of the four acute trusts in the HNY ICB area
 - The HNY Cancer Alliance
- Two local authorities, and their health overview and scrutiny committees and health and wellbeing boards:
 - Hull City Council
 - East Riding of Yorkshire Council
- Other health services:
 - Mental health providers
 - Other acute trusts in neighbouring areas
 - GPs
 - Community providers
 - Voluntary sector and other third sector organisations
- Education institutions:
 - Hull York Medical School (HYMS)
 - Universities
 - Apprenticeship providers
 - Health Education England
- Professional bodies:
 - British Medical Association
 - Nursing and Midwifery Council
 - Royal Colleges
- Trade unions
- Other emergency services like the police and ambulance services

The Health Tree Foundation

The Health Tree Foundation (HTF) is the Trust's charitable arm, raising funds and managing donations across all three hospitals and in community services. Charity Manager, Lucy Skipworth reflects on the work of the charity in the 2025/26 financial year below.

We have supported a number of great causes across our hospitals including the Amethyst Garden at Grimsby hospital, which was officially opened by local actor Thomas Turgoose.



We have also granted a number of wishes for staff. These range from sprucing up waiting rooms to new equipment. The most important thing is everything we fund helps improve patient experience.

Our supporters and fundraisers continue to raise funds for the hospital. This includes events such as a sponsored walk from Castle Hill Hospital to Grimsby hospital, and a sponsored run between Louth County Hospital, Grimsby hospital and Castle Hill Hospital. Thanks to fundraising efforts, we were also able to purchase a therapy chair for patients on the Neuro Rehabilitation Centre at Goole hospital to use.



Scunny Bikers continue to put smiles on the faces of the children on Disney Ward at Scunthorpe hospital through their annual Easter and Christmas visits.



In the last financial year, we've received £150,000 from fundraising, £34,000 in donations from individuals, £13,000 from partner charities and £189,000 from legacy donations.

None of this would be possible without your support and the contributions of our local public in helping us to raise funds, so I would like to say a huge thank you to all of you who have helped us. There is always room for more, so if you have not already done so, may I urge you to acquaint yourself with The Health Tree Foundation, to find out what they may be able to do to support you and, of course, vice versa!

Group Chief Executive's Performance Statement

Welcome to the 2025–2026 Annual Report for Northern Lincolnshire and Goole NHS Foundation Trust.

Stepping into the role of Interim Chief Executive this year has given me the opportunity to see first-hand the extraordinary commitment, resilience and compassion that define our organisation. This report reflects a year of change, of challenges and of stabilisation as the Trust and our wider group - NHS Humber Health Partnership - seeks to improve the care we provide to the population of Hull, the East Riding and Northern Lincolnshire.

Over the past twelve months, our teams have focused on access to care, reducing waiting times, and strengthening the quality and safety of our services. We have continued to recover from the sustained pressures of recent years while laying the foundations for a more sustainable future.

A central achievement this year has been the development and launch of our clinically led improvement plan, a programme shaped directly by the insight and expertise of our clinical workforce. This plan sets out a clear, ambitious route to improving safety, strengthening performance, and embedding a culture of continuous learning. Crucially, it has been built not from the top down, but through genuine engagement with the clinicians who understand our services best. Their leadership has ensured that the priorities we have set are grounded in real experience and aligned with what matters most for patients.

Our focus on clinical engagement has been one of the most important drivers of progress. By creating more opportunities for clinicians to influence decision-making, redesign

pathways and shape strategic direction, we are building a more collaborative and responsive organisation. This approach has already begun to deliver tangible improvements in patient flow, elective recovery, patient safety and service quality, and it will remain a cornerstone of our work in the year ahead.

While national NHS league tables continue to highlight areas where our performance is not yet where we want or need it to be, we have approached this challenge with honesty, determination and a clear plan for change. We recognise the responsibility we hold as a major foundation trust, and we are committed to improving the experience and outcomes of every patient who relies on our services. The transparency of these comparisons has helped sharpen our focus and reinforce the urgency of the work already underway.

Importantly, the clinically led improvement plan launched this year is beginning to show early, positive signs; small but meaningful green shoots of recovery that reflect the hard work of teams across the organisation. We are seeing improvements in key pathways, stronger multidisciplinary collaboration, and a growing confidence among clinical leaders that the changes we are embedding will deliver sustained progress. These early indicators give us a solid foundation on which to build, and they reaffirm our belief that a clinically driven approach is the right one for our Trust.

Although there is still much to do, I am confident that we are moving in the right direction. With continued focus, strengthened clinical engagement, and the collective commitment of our workforce, we will deliver the safe, timely and high-quality care that our patients deserve. Our ambition is clear: to

become a Trust that not only meets national standards but consistently exceeds them, and to do so through a culture rooted in learning, accountability and compassion.

None of this would be possible without the dedication of our staff. Their professionalism, compassion and determination continue to inspire me. Whether working on the frontline or behind the scenes, every colleague has played a vital role in delivering safe, high-quality care during a period of significant operational pressure. I want to express my sincere thanks to them all.

As we look ahead, we remain focused on strengthening our services, supporting our workforce, and building a Trust that is innovative and responsive to the needs of our communities. I am confident that, together, we will continue to make progress and deliver the care our population deserves.



A handwritten signature in black ink that reads "Lyn Simpson". The signature is fluid and cursive.

Lyn Simpson
Chief Executive
18 June 2026

Performance measurement

The Well-led Framework used by NHSE identifies effective oversight by trust boards as essential to ensuring trusts consistently deliver safe, sustainable, and high-quality care for patients. This includes robust oversight of care quality, operations, and finance. At the trust an Integrated Performance Report (IPR), which sets out how the trust is performing against external and internal targets, is submitted monthly to the trust board for assurance. This consists of Key Performance Indicators (KPIs) for the areas of:

- Access and flow
- Workforce
- Quality and safety

2025/26 Trust Performance

This section of our Annual Report provides information about the Trust using measures from the Performance Oversight Framework.

Access to Services

Subject Area	Metric	Target	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Cancer Care	► SCORE: Cancer Care		1.00	1.00	1.00	1.00	1.25	1.00	1.00	1.50	1.25	1.00	1.00	1.25
	Cancer - 28 Day Faster Diagnosis Standard	≥ 80.0%	57.3%	60.2%	60.7%	65.0%	64.3%	66.7%	70.8%	75.6%	73.8%	62.2%	69.9%	66.4%
	Cancer - 62 Day All Referral Sources	≥ 75.0%	52.3%	48.2%	52.5%	58.8%	71.7%	59.1%	67.2%	70.4%	66.1%	62.1%	63.3%	74.2%
Elective Care	► SCORE: Elective Care		1.50	2.17	2.33	1.67	1.67	1.67	1.67	2.33	2.33	1.67	1.67	1.67
	RTT - Incomplete 18 Week Standard	≥ 46.7%	59.6%	60.8%	60.8%	59.9%	59.1%	59.3%	59.7%	59.5%	59.2%	58.3%	59.5%	61.4%
	RTT - Patients waiting 52+ weeks for Community Services					13.2%	13.8%	14.1%	14.4%	14.7%	15.0%	16.0%	15.6%	15.3%
	RTT - Percentage of 52+ Week Waits	≤ 1.1%	2.3%	2.4%	2.4%	2.3%	2.6%	2.6%	2.5%	2.5%	2.3%	2.4%	2.2%	2.1%
Urgent & Emergency Care	► SCORE: Urgent & Emergency Care		1.25	1.38	1.38	1.38	1.38	1.38	1.25	1.25	1.25	1.25	1.38	1.38
	A&E - 4 Hour Standard (All)	≥ 79.4%	69.3%	70.5%	71.0%	74.2%	74.1%	70.6%	69.8%	67.1%	65.3%	66.2%	71.4%	71.6%
	A&E - Patients Waiting > 12 hours in Department	≤ 15.0%	18.0%	17.3%	15.9%	13.7%	14.2%	15.7%	16.8%	17.6%	18.1%	22.2%	17.5%	14.1%
Primary Prevention	► SCORE: Primary Prevention		2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
	Diagnostics - 6 Week Standard	≤ 27.0%	35.2%	35.1%	33.6%	35.1%	38.8%	35.9%	38.4%	41.6%	46.5%	46.5%	37.2%	29.9%

The Trust has not met the diagnostic waiting standard (<5% over 6-weeks) throughout the year and continues to be an area of recovery focus for both cancer and elective care standards. All patients receive their necessary scans and tests but do not always receive these in a timely manner. Most metrics at NLaG increased activity levels over 24/25 and into 25/26. Whilst ahead of behind delivery of the recovery trajectory, aggregate diagnostic compliance has started to show improvement.

The 18-week referral to treatment (RTT) pathway is reported against the NHS Constitutional Standard of 92%, as in previous years the focus for the Trust was to end the year with a waiting list volume smaller than at the start of the year and achieve the nationally mandated long wait targets.

The Trust was able:

- Reduce the patients waiting +65 weeks
- There has been a marginal decrease in the number of patients waiting +52 weeks during 2025/26
- The total waiting list decreased during 2025/26 to 40,118 (-2,446)

The Trust has not delivered the Faster Diagnosis (FDS) standard, against the target of 79%, 2025/26 average of people receiving their diagnosis within 28-days of being referred on an Urgent Suspected Cancer (USC) pathway was 68%.

Whilst the Trust has undertaken detailed work on cancer pathways, specifically focussing on the 62-day cancer standard, this has not yet yielded a consistent performance against the standard; a Radiotherapy waiting times and Histology turnaround times recovery plans are in place.

In relation to the four-hour target in the Emergency Department, the Trust was measured against a target of 78% compliance. This was under-delivered at 71.6% at the end of March 2026. There continues to be focussed improvement activities.

Activity levels in the last three years

	2023/24	2024/25	2025/26
A&E attendance At Grimsby and Scunthorpe	174,008	187,436	198,766
Admissions into hospital	118,523	139,367	135,222
Number of discharges (patients leaving hospital)	118,174	139,346	135,232
Outpatients appointments (attendances)	339,021	323,850	336,018
Births	3,703	3,658	3,821
Patients who were admitted as an emergency	59,683	68,080	71,201
Total number of operations in theatre	19,743	20,464	17,930
Total number of elective operations in theatre	14,965	15,630	14,023

Patient Safety

Metric	Target	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
➤ SCORE: Patient Safety		2.50	2.50	2.50	2.50	2.50	2.50	2.50	2.00	2.50	2.50	2.50	2.50
CQC Safe Inspection Score		2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00	2.00
Infections – C. Difficile (per 1,000 bed days)		0.10	0.19	0.20	0.10	0.21	0.15	0.29	0.20	0.34	0.14	0.16	0.30
Infections – E. Coli (per 1,000 bed days)		0.85	1.12	1.32	1.35	1.03	1.44	1.55	0.99	0.86	0.66	1.35	0.74
Infections – MRSA (per 1,000 bed days)		0.00	0.00	0.00	0.00	0.05	0.00	0.05	0.00	0.05	0.05	0.05	0.10
Staff Survey – Rising Concerns sub-score		6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09	6.09
VTE Risk Assessment	≥ 95.0%	97.5%	96.7%	96.6%	96.0%	96.2%	96.6%	95.5%	92.2%	95.6%	96.1%	95.8%	95.7%
VTE Risk Assessment 14 Hour Standard	≥ 95.0%	94.6%	93.5%	93.8%	93.0%	93.0%	93.7%	93.1%	88.1%	92.6%	93.6%	93.2%	93.3%

C.difficile rates, MRSA, E-coli, Klebsiella and P Aeruginosa bacteraemia are over the annual target.
The VTE risk assessment at 14 hours is below the standard required. Work is underway to address this.

Effectiveness

Metric	Target	Apr 25	May 25	Jun 25	Jul 25	Aug 25	Sep 25	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	Mar 26
A&E – Urgent Community Response Attendances assessed < 2 hours		97.2%	95.0%	98.1%	96.3%	98.8%	97.4%	97.2%	98.3%	98.2%	95.2%	95.8%	97.8%
Inpatient – Annual Growth Under 18s Elective Activity		116.0%	110.0%	105.0%	101.0%	97.0%	91.0%	94.0%	92.0%	93.0%	93.0%	90.0%	94.0%
Inpatient – Average Length of Stay (Elective)		0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Inpatient – Average Length of Stay (Non-Elective)	≤ 8.0	3.0	2.9	2.9	2.8	2.8	2.8	2.7	2.8	3.1	3.0	2.9	2.9
Inpatient – Bed Occupancy (General & Acute)	93.0%	92.1%	91.3%	91.1%	90.4%	89.9%	87.6%	89.1%	88.5%	89.3%	90.9%	91.3%	91.0%
Inpatient – Bed occupancy classed as clinically ready for discharge						15.4%	18.7%	21.9%	19.5%	21.1%	18.9%	18.0%	18.2%
Inpatient – Day Case Rate	≥ 85.0%	93.3%	92.4%	92.7%	92.2%	92.1%	92.0%	90.8%	91.0%	91.4%	91.7%	91.8%	90.8%
Inpatient – Days between DRD and Discharge Date	≤ 4.4	4.1	4.2	5.3	4.6	4.1	4.9	3.9	5.0	4.5	4.1	5.8	4.9
Inpatient – Emergency Readmissions within 30 days		11.1%	10.6%	10.9%	11.1%	10.9%	11.7%	11.5%	10.9%	11.3%	11.2%	11.6%	11.0%
Mortality – Crude Mortality (Non-Elective)		1.9%	1.7%	1.9%	1.4%	1.6%	1.6%	1.6%	1.8%	2.4%	1.8%	1.9%	1.9%
Mortality – SHMI	≤ 1.0	1.01	1.00	1.02	1.03	1.02	1.01	1.00	1.00				

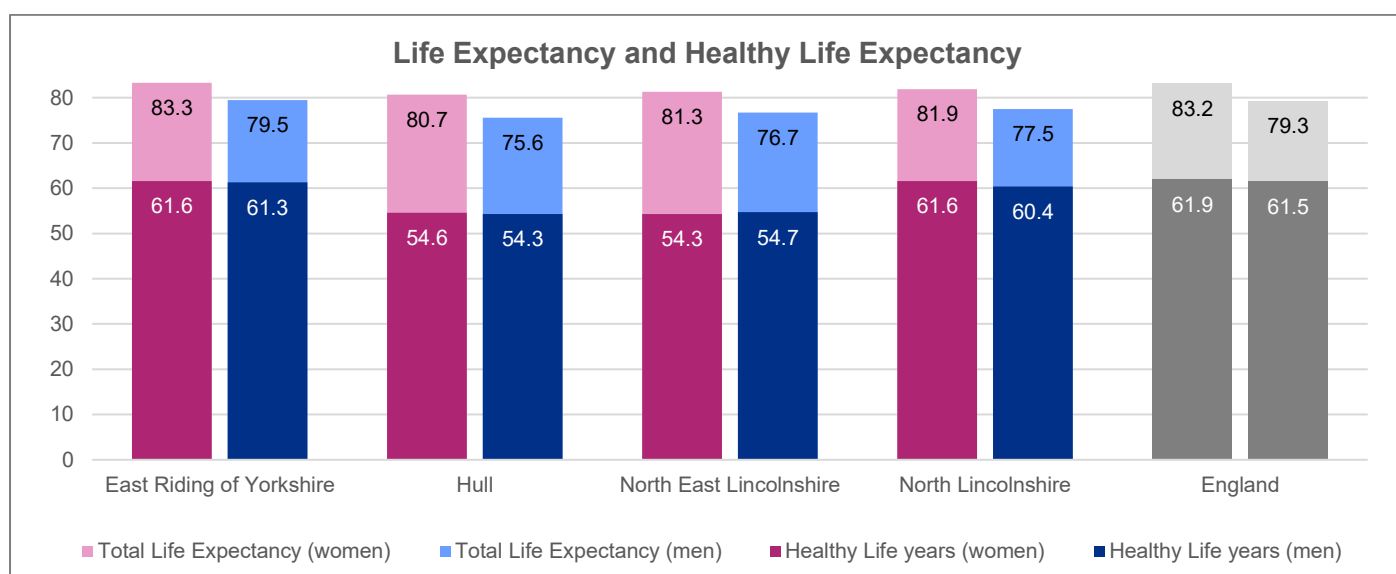
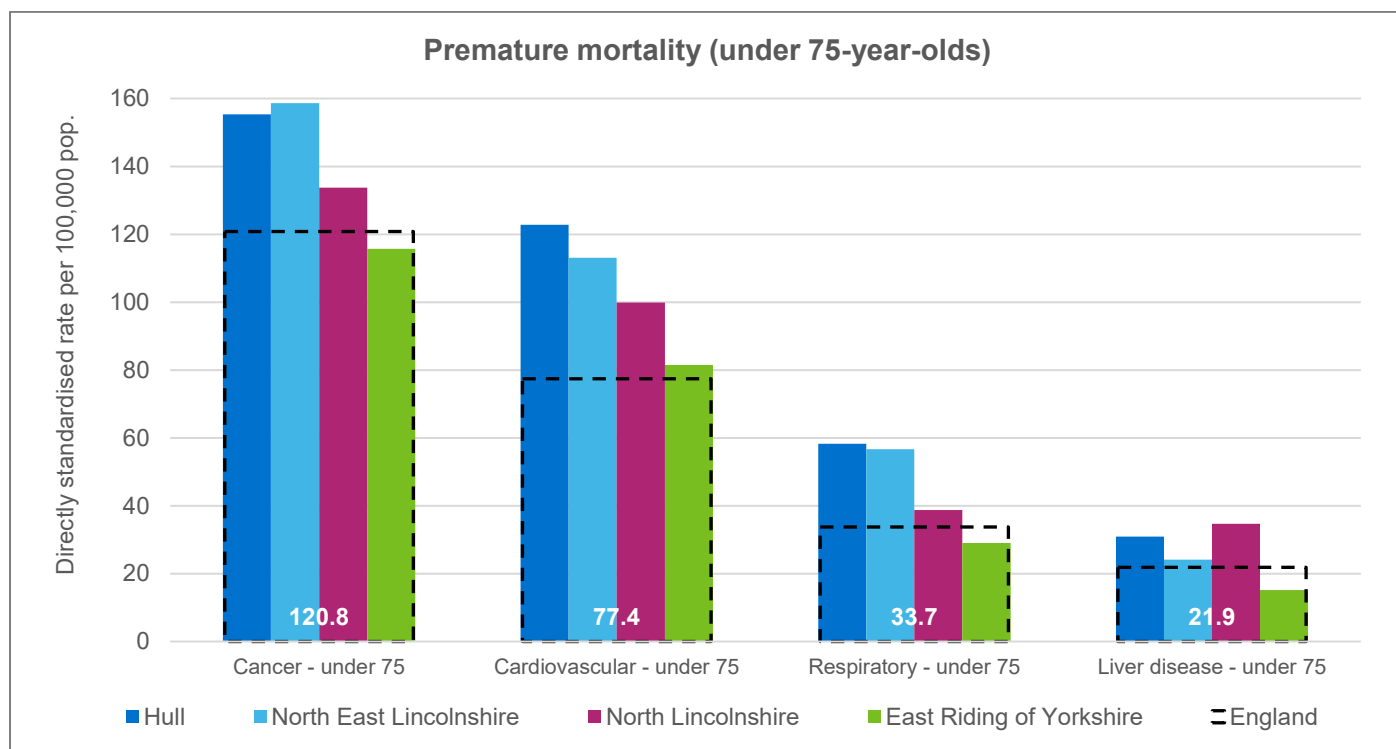
Tackling Health Inequalities

Background – understanding the health needs of our population

There are significant health inequalities in the population our hospitals serve.

For example, there is a staggering 17-year gap in the healthy life expectancy of baby girls born at Diana Princess of Wales Hospital in the 1 and a half miles between East Marsh in Grimsby and Haverstoe in Cleethorpes (Healthy Life Expectancy is 51.9 years and 69.0 years respectively).

Due to a complex range of factors and conditions of living, more people are dying early across the Humber from preventable diseases, as shown in the graph below.



Across the Humber, our population is living more years in poor health. The gap between overall life expectancy (LE) and healthy life expectancy (HLE) is particularly stark for women in our region who are typically living with chronic ill-health for 20-27 years.

Our population face a range of barriers to accessing healthcare services including:

- Across the Humber, **nearly a third** (30.6%) of the population live within the most deprived communities nationally (CORE20)
- Nearly **two thirds** of all neighbourhoods in Hull are digitally excluded
- **Up to a third** of Humber residents have no access to a car
- Around **1 in 4** children in the Humber are living in poverty
- More than **1 in 12** adults in the Humber are out of work due to ill-health

Poor underlying health of the population drives increased demand for healthcare services and often lead to poorer outcomes for those from more deprived communities for a variety of complex reasons. The impact of deprivation on the underlying health of our population means that, compared to a hospital group serving an ‘England average’ population of the same size, every year Humber Health Partnership (HHP) provides for:

- **820** additional alcohol-related admissions (13.5% increase vs. the England average)
- **5,500** additional A&E attendances for children aged 0-4 (17.1%h)
- **4,430** additional admissions for respiratory disease (31.2%h)

Our Group Strategy, agreed in August 2025, sets out our commitment to doing more to tackle inequity and improve the health of our population.

For NLAG, RTT median incomplete waits show a relatively narrow variation across IMD deciles, suggesting that deprivation is not driving a strong consistent gradient in waiting times. Patients from the most deprived areas (Decile 1) wait 11.6 weeks, while those in the least deprived areas (Decile 10) wait 12.6 weeks, with most deciles clustered between 11.1 and 12.6 weeks. This pattern implies that access pressures are spread evenly across the provider’s population, although the very large pathway volumes in more deprived and mid-range deciles indicate that socioeconomic disadvantage still shapes demand and case mix. In practice, this may reflect the wider effects of deprivation on health need, comorbidities, transport barriers, and healthcare engagement, even if the median wait itself does not worsen steadily with deprivation.

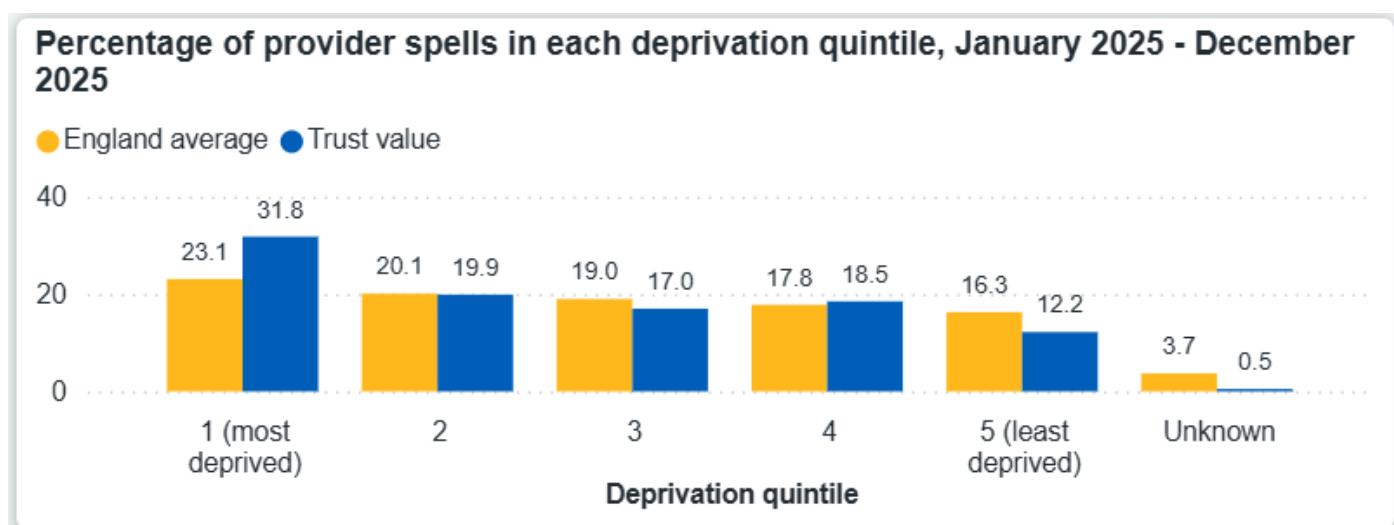
95th Percentile Incomplete Wait Times by IMD19 Decile

Metric	Period	Measure	1 (most depriv ed)	2	3	4	5	6	7	8	9	10 (least depriv ed)	Total
RTT Median Incomp lete Wait Time	Mar- 26	Wait Week s	11.6	12.6	12.1	11.9	11.9	12.3	11.1	11.4	11.1	12.6	11.7

		Path way Count	6,963	3,7 30	3,9 16	3,5 34	3,7 63	3,0 25	5,2 02	2,7 38	4,5 54	879	38,3 09
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This table shows the 95th percentile of waiting times based upon patients still waiting or elective treatment at the end of the financial year.

For NLAG, RTT Median Admitted Wait Time shows a clearer deprivation-related pattern than RTT Median Non-Admitted Wait Time. Admitted waits are highest for patients living in more deprived communities, with a median of 16.1 weeks in IMD decile 1 and remain relatively elevated through much of the deprivation range before falling to 13.5 weeks in decile 10.



While the pattern is not perfectly linear, the overall direction suggests that patients from more deprived areas may face a greater concentration of factors that can lengthen admitted pathways, including poorer baseline health, higher comorbidity, delayed presentation, and wider socioeconomic barriers such as transport difficulties, unstable employment, or competing caring and financial pressures.

In contrast, RTT Median Non-Admitted Wait Time is more even across the deciles, ranging from 10.0 weeks in decile 1 to 8.3 weeks in decile 10, with only modest variation overall. This suggests that non-admitted pathways at NLAG are comparatively more consistent across socioeconomic groups, whereas admitted care appears more affected by the additional complexity often associated with deprivation.

95th Percentile Wait Times by IMD19 Decile

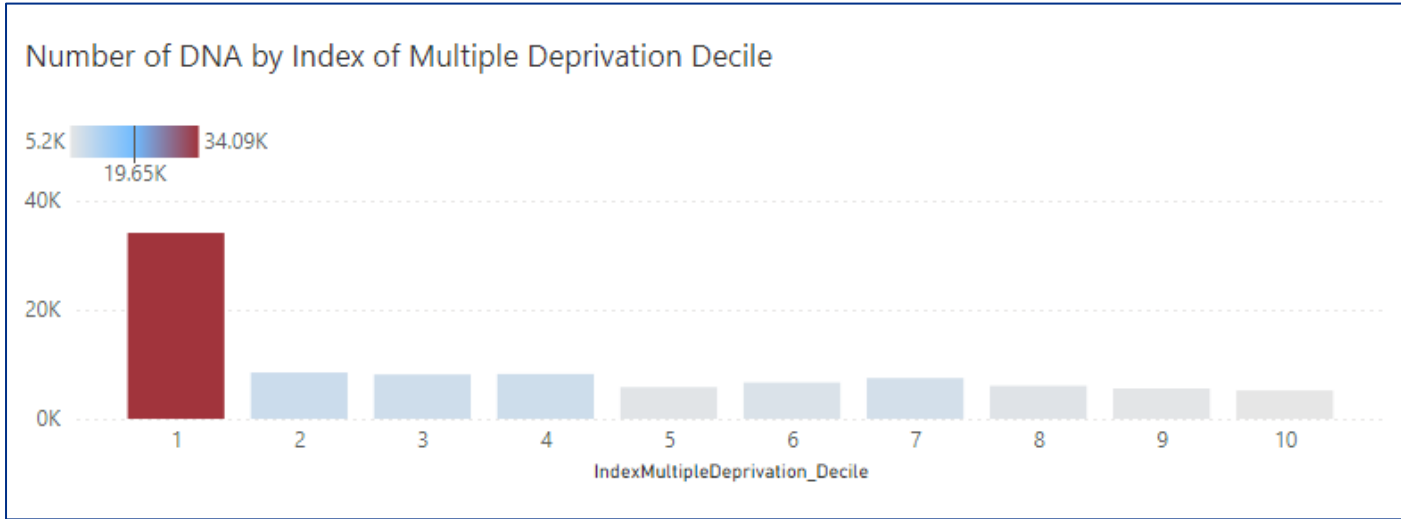
Decile 1 is the most deprived and Decile 10 the least deprived.

Metric	Measure	1 (most deprive d)	2	3	4	5	6	7	8	9	10 (least deprive d)	Total
RTT Median Admitt ed Wait Time Oct-25 to Mar- 26	Wait Weeks	16.1	16.6	15.9	16.7	14.6	15.4	15.2	13.6	14.2	13.5	15.4
	Pathw ay Count	1,548	838	945	873	942	806	1,320	763	1,232	286	9,567
RTT Median Non Admitt ed Wait Time Oct-25 to Mar- 26	Wait Weeks	10.0	9.1	8.9	9.5	9.1	9.0	8.7	8.6	8.9	8.3	9.1
	Pathw ay Count	7,008	3,803	4,274	3,898	3,955	3,219	5,604	3,000	4,999	1,003	40,766

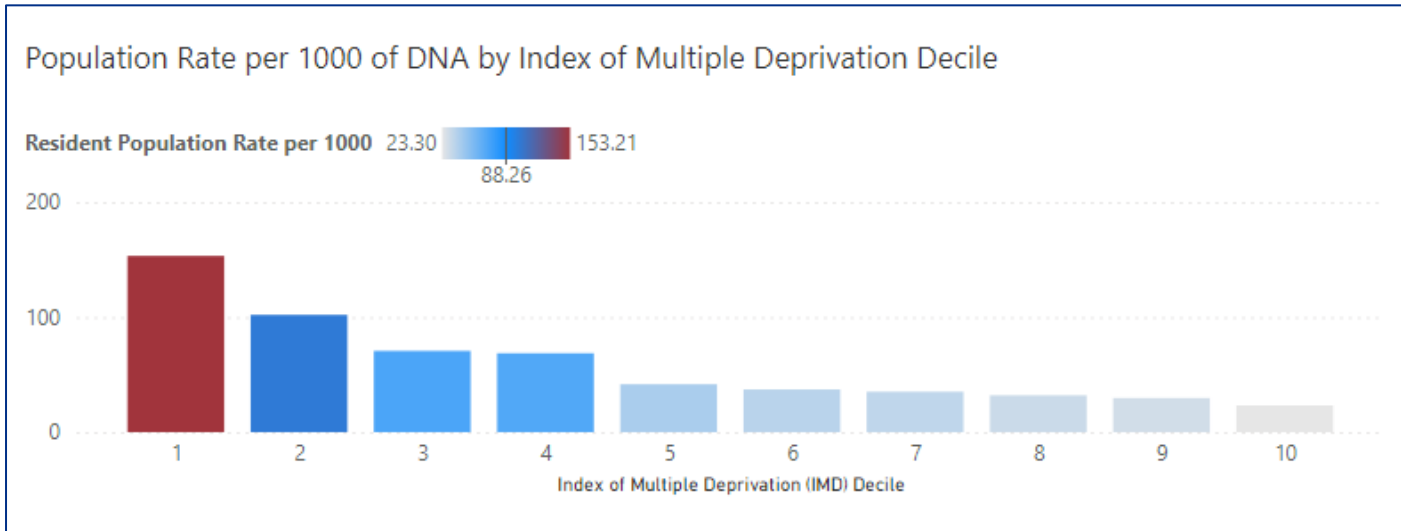
This Table shows the 95th percentile waiting times for treatment across the last 6 months of the Financial Year.

At Northern Lincolnshire and Goole NHS Foundation Trust (NLAG), the proportion of inpatient spells is substantially higher among patients from more deprived communities than would be expected when compared with the England average. Activity is most concentrated in the most deprived quintiles and falls progressively across the deprivation distribution, indicating that residents of disadvantaged areas make disproportionately greater use of inpatient services. This pattern is consistent with the wider impact of deprivation on health need, including higher levels of underlying ill health, multimorbidity, later presentation, and greater barriers to accessing timely preventive and community-based care. Taken together, the findings illustrate the extent to which deprivation is associated with increased demand for hospital-based treatment and reinforce the importance of targeted action to reduce health inequalities and support earlier intervention.

People living in deprived communities face more barriers to accessing their healthcare services and are more likely to miss healthcare appointments. Across Humber Health Partnership (HHP) a total of 95,696 appointments were lost to people not turning up on the day in 2024/25. More than a third of these (34,094, 36%) were from people living in the 10% most deprived communities (IMD Decile 1). Overall, this population cohort accounted for just 22% of all appointments in that period showing a disproportionate impact on the most deprived population.



When presented as a rate across the population, people living in IMD 1 are missing appointments at a rate **6.5 times** that of those from the least deprived areas (IMD Decile 10).



Improving data quality and using information to drive change

During this year, we have established a Data Quality Steering Group to maintain oversight and provide information and support to teams across the organisation to improve the capture of core demographic information. Our key challenge is in the collection of Ethnicity data at the Outpatient stage. This reflects a need to support staff to feel confident to ask and for patients to feel safe to answer. Looking forward into next year, we recognise that the increased focus upon avoiding physical hospital attendances changes the way in which we engage and see the development of our Single Point of Access pathways as a means to improve this.

Case Study examples

A deeper understanding of health inequalities impacting upon the population we serve is helping to shape how we offer services across the Group.

Improving uptake of AAA screening

One example of this is our AAA (Abdominal Aortic Aneurism) screening programme. The screening programme seeks to proactively identify cases of AAA amongst men at high risk of having the condition. A new pilot project began in December 2025 to seek to increase uptake of screening amongst men in lower-uptake areas.

The AAA screening team worked with a Primary Care Network which serves 50,000 patients across 5 practices, around 50% of whom do not have English as their first language. The team identify patients who have failed to attend a scheduled appointment on two occasions; the PCN's Health and Lifestyle Practitioner (HLP) then worked with those individuals to offer general health and wellbeing advice and identify any barriers for non-attendance at screening. Of the first cohort of patients identified, 35% took up the offer of screening following the intervention.

Data on impact will be collected throughout the pilot with the intention to scale the model across other PCNs in areas of high deprivation if effective.

MDT approach for frequent attenders in ED

Another example is our work to support people with high numbers of attendances in our Emergency Departments. In Hull Royal Infirmary, for example, the team receive a monthly report on the top 200 attendees (on a 12-month rolling basis) and a separate report with any patient who has had more than five attendances in the previous month.

Recognising the complexity and range of needs these patients face, the team work closely with partner organisations to put in place intensive support covering a range of needs such as mental health, housing, substance misuse and other safeguarding issues. This includes through a fortnightly intensive MDT with Clinicians, Safeguarding, Social work, Ambulance service and addiction services and other agencies where required. This process identifies unmet needs, oftentimes in marginalised groups that have difficulty being heard or seeking help elsewhere. As a result, a number of patients have been supported in both the immediate term and with longer term support for their unmet needs.



Performance analysis

The table on page 19 shows how activity levels in the hospitals have changed in the last three years. The figures show around 198,766 people attend the trust's two emergency departments (EDs) at Grimsby and Scunthorpe between April 2025 and March 2026, which is more than 11,330 over the same time frame in the previous year. The figures also show that the total number of patients admitted as an emergency has also increased. These two figures show as clearly as anything the levels of pressure and demand the trust is experiencing each day in unplanned (urgent and emergency) activity.

Urgent and emergency care

We have seen increased pressure on our two Emergency Departments (EDs). Greater numbers of patients have presented to our departments as well as an increase in ambulance conveyances, similar to other parts of the country. The target to see and admit or discharge patients within four hours in the EDs was 78% for March 2026. This was a target we were not able to meet, finishing the year with a figure of 71.6%. The trust has also not met its target relating to patients waiting longer than 12 hours in A&E to be admitted to a ward of 6.5% or less. Current performance is 14.1%. Improving urgent and emergency care performance will remain a key priority for the trust in 2026/27.

Elective care

This is where patients are waiting for treatment, a diagnostic test or an outpatient appointment. The trust did manage to reduce the number of patients waiting the longest times but still needs to focus on this as it is a priority, as is reducing the overall size of the waiting lists. The trust also did not meet its target to carry out diagnostic checks within six weeks with 37.2% of patients being seen after this time limit, which is better compared to the year before. The trust did not meet its Cancer targets in 2025/26 and remains in Tier 1 for NHS England scrutiny and enhanced oversight to support improvement of the position. Reducing waiting list sizes, cancer waiting times and also the time patients are waiting for other procedures and treatments are key priorities for the trust in 2026/27.

Workforce

The trust workforce position in March 2026 showed an overall vacancy rate of 6.1% with consultant vacancies remaining high at 16.7%. Nurse vacancies are stable and are expected to be maintained in 2026/27. Agency usage controls remain in place to minimise Agency spend.

Sickness rates were 4.8% against a target of 4% and the turnover rate was 7.8% against a target of 10%. The group is now focusing on reducing the number of senior medical gaps and this is a key priority for 2026/27.

Quality and safety

Recent (February 2026) CQC inspections undertaken at the trust include Urgent and Emergency Care and End of Life services at Diana Princess of Wales (Grimsby) and Scunthorpe General Hospital. Goole Hospital Outpatients service was also inspected by the CQC and the outcome of this inspection was a 'Good' rating across all five domains.

Areas of good practice and any potential risks will be highlighted and an action plan developed.

The Quality Priorities for 2025/26 have been monitored through the Quality and Safety Committees-in-Common. Risks to assurance include: workforce capacity, reliance on digital delivery and operational pressures reducing pace of improvement. The 2026/27 Quality Priorities will build on the progress made in 2025/26.

Health inequalities

The trust is required to publish information regarding health inequalities including:

- understanding Health needs,
- understanding healthcare access, experience and outcomes
- improving data quality, collection and analysis
- using information on health inequalities
- publishing information on health inequalities

This information is included in this report at pages 21 to 26.

Finance

The Group is reporting a year-end deficit of £36.5 million against a target of £35.5 million. This includes NLaG's year-end deficit is £14.5 million.

HUTH

£million	CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical income	78.4	87.1	8.7	915.2	923.7	8.5
Other income	7.7	41.6	33.9	89.0	125.8	36.9
Total operating income	86.0	128.6	42.6	1,004.2	1,049.6	45.4
Pay costs						
Clinical pay	(39.1)	(43.5)	(4.4)	(474.9)	(493.8)	(18.9)
Other pay	(8.2)	(43.1)	(35.0)	(100.3)	(135.0)	(34.7)
Total pay costs	(47.2)	(86.7)	(39.4)	(575.2)	(628.7)	(53.5)
Clinical non pay	(17.7)	(20.0)	(2.3)	(218.2)	(235.3)	(17.1)
Other non pay	(15.0)	(7.3)	7.7	(149.0)	(141.1)	7.8
Total non pay costs	(32.7)	(27.3)	5.4	(367.2)	(376.5)	(9.3)
Total operating expenditure	(80.0)	(114.0)	(34.0)	(942.4)	(1,005.2)	(62.8)
EBITDA	6.1	14.6	8.6	61.8	44.4	(17.4)
Depreciation	(2.5)	(2.5)	0.0	(29.8)	(29.4)	0.4
Non operating items	(1.4)	(1.5)	(0.1)	(16.8)	(16.6)	0.2
Surplus (deficit)	2.2	10.7	8.5	15.3	(1.6)	(16.9)
NHSE allowable adjustments	(0.3)	(5.8)	(5.5)	(15.3)	(20.4)	(5.1)
Adjusted surplus / (deficit)	1.9	4.9	3.0	(0.0)	(22.0)	(22.0)

NLaG

£million	CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical income	50.0	53.1	3.1	568.6	565.4	(3.2)
Other income	6.4	37.0	30.6	75.2	100.5	25.3
Total operating income	56.4	90.0	33.7	643.8	666.0	22.1
Pay costs						
Clinical pay	(27.9)	(30.1)	(2.2)	(336.5)	(344.2)	(7.8)
Other pay	(6.9)	(31.2)	(24.2)	(87.7)	(110.2)	(22.5)
Total pay costs	(34.9)	(61.2)	(26.4)	(424.1)	(454.4)	(30.3)
Clinical non pay	(6.2)	(8.2)	(2.0)	(83.1)	(93.5)	(10.5)
Other non pay	(8.6)	(44.2)	(35.6)	(85.0)	(117.3)	(32.3)
Total non pay costs	(14.8)	(52.4)	(37.7)	(168.1)	(210.8)	(42.7)
Total operating expenditure	(49.7)	(113.7)	(64.0)	(592.2)	(665.2)	(73.0)
EBITDA	6.7	(23.6)	(30.3)	51.7	0.8	(50.9)
Depreciation	(2.3)	(2.1)	0.2	(25.7)	(22.8)	3.0
Non operating items	(0.7)	(0.6)	0.1	(8.1)	(7.1)	0.9
Surplus (deficit)	3.8	(26.3)	(30.1)	17.9	(29.1)	(47.0)
NHSE allowable adjustments	(1.5)	25.4	26.9	(17.9)	14.6	32.5
Adjusted surplus / (deficit)	2.3	(0.9)	(3.2)	(0.0)	(14.5)	(14.5)

Humber Health Partnership

£million	CM			YTD		
	Plan	Actual	Variance	Plan	Actual	Variance
Income						
Clinical income	128.3	140.1	11.8	1,483.9	1,489.2	5.3
Other income	14.1	78.6	64.5	164.2	226.4	62.2
Total operating income	142.4	218.7	76.3	1,648.1	1,715.5	67.5
Pay costs						
Clinical pay	(67.0)	(73.6)	(6.6)	(811.4)	(838.0)	(26.6)
Other pay	(15.1)	(74.3)	(59.2)	(188.0)	(245.1)	(57.1)
Total pay costs	(82.1)	(147.9)	(65.8)	(999.3)	(1,083.1)	(83.8)
Clinical non pay	(23.9)	(28.2)	(4.3)	(301.3)	(328.8)	(27.6)
Other non pay	(23.6)	(51.6)	(28.0)	(234.0)	(258.4)	(24.4)
Total non pay costs	(47.5)	(79.8)	(32.3)	(535.3)	(587.2)	(52.0)
Total operating expenditure	(129.6)	(227.7)	(98.0)	(1,534.6)	(1,670.4)	(135.8)
EBITDA	12.8	(9.0)	(21.8)	113.5	45.2	(68.3)
Depreciation	(4.8)	(4.5)	0.3	(55.5)	(52.1)	3.4
Non operating items	(2.1)	(2.1)	(0.0)	(24.8)	(23.7)	1.1
Surplus (deficit)	5.9	(15.6)	(21.5)	33.1	(30.7)	(63.8)
NHSE allowable adjustments	(1.7)	19.6	21.3	(33.1)	(5.8)	27.3
Adjusted surplus / (deficit)	4.2	4.0	(0.2)	(0.0)	(36.5)	(36.5)

- The Group reported a £4.0m surplus in month, (£0.2m) adverse to plan with a year to date deficit of (£36.5m), (£36.5m) adverse to its break-even plan. £19.9m of balance sheet has been released year-to-date to support the Groups financial position.
- The Group delivered £94.8m in Cost Improvement Savings (CIP), (£35.2m) behind its £130m target.
- The Group cash balance increased by £6.4m in month to £73.1m (£33.1m HUTH / £39.9m NLaG). This includes the Group's £12.2m additional external cash support application for March 2026.
- The Groups financial deficit of £365m was marginally better than the £36.6m forecast outturn change protocol of £36.6m.

Emergency Preparedness, Resilience and Response

The Trust has in place robust emergency preparedness and business continuity arrangements, which are considered and signed off by the Trust Board annually. These arrangements have been tried and tested in response to multiple incidents over recent years and continue to be reviewed and exercised. During 2025/26 the Trust ensured critical services were maintained during several events, including industrial action, disruption to key clinical supply chains and digital system outages.

During 2025, the Trust completed its annual assurance cycle against the NHS England Core Standards for Emergency Preparedness, Resilience and Response (EPRR), reviewing evidence of compliance against a set of 62 national Core Standards. This assessment was peer reviewed and scrutinised through the Humber and North Yorkshire Local Health Resilience Partnership with full compliance against 58 core standards and partial compliance with 4 core standards, resulting in an overall compliance rating of Substantially Compliant. This is an improvement from the 2024/25 assurance cycle when the Trust was fully compliant with 56 core standards.

To ensure both organisational and individual resilience, these arrangements were continuously reviewed in line with NHS England EPRR guidance and instructions to meet our statutory obligations under the Civil Contingencies Act 2004. The EPRR work programme includes training and testing arrangements to ensure that leaders and staff across the organisation learn from previous events and build the resilience required to manage the ongoing challenges the Trust and our local community could face.

The Trust has participated in a range of regional and local exercises during the year aimed at testing the Trust's response to incidents such as mass casualty events, loss of facilities and severe operational pressures. These exercises have provided additional assurance and understanding of the Trust's resilience to such events and input into the multi-agency response.



Statements on the trust's wider impact

Equality, Diversity and Inclusion (EDI)

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

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

As such the Trust strives to ensure that in both employment and service provision no individual is discriminated against or treated less favourably by reason of age, disability, sex, pregnancy or maternity, marital status or civil partnership, race, religion or belief, sexual orientation or transgender (Equality Act 2010).

The Trust has an Equality, Diversity and Inclusion Strategy which was approved by the Trust Board (June 2023) and covers the period from 2023 to 2027. It sets out the Trust's equality objectives. These objectives are mapped against national and local EDI priorities but are only a starting point as they will evolve through the time period of the strategy as well as be informed by consultation to address health and workforce inequalities. The objectives are:

- To implement the NHS Equality Delivery System 22 (EDS22) within NLaG
- To improve the Trust's understanding of health inequalities data and how this impacts on the local health economy, to identify gaps and consider solutions
- To ensure that all staff have the skills and knowledge to treat patients, carers and colleagues with dignity and respect
- To report and deliver against Workforce Equality Standards and develop action plans for improvement
- To develop and grow staff equality networks

A Humber Health Partnership Group EDI steering group is now in place and this group is chaired by a group executive director. This steering group monitors progress against EDS actions and the EDI work plan. In addition, the Trust's Workforce Race Equality Standard, Workforce Disability Equality Standard, Equality Delivery System 22, Gender Pay Gap are reported as required to meet contractual and legal responsibilities.

Statement on the Modern Slavery Act

With reports of modern slavery victims increasing year on year and an estimate of more than 130,000 people being trapped in modern slavery, it is imperative the trust commits to the principles of the Modern Slavery Act 2015 and the abolition of modern slavery and human trafficking. The trust's statement sets out the steps it has taken to ensure slavery and human trafficking is not taking place in any part of its business or supply chains and covers the following:

- Organisational structure
- Policies in relation to slavery and human trafficking
- Due diligence and managing risks in the trust's business and supply chains
- Training and performance indicators

The trust's statement is available to view on its website here:

<https://www.nlg.nhs.uk/resources/modern-slavery-statement-2025/>

Involvement of employees

Staff at the Trust have a number of ways to get involved in the work and developments of the trust. All staff will be consulted or engaged with as part of any planned changes that have a direct impact. Some of these routes of engagement are:

- Staff networks, including BAME, Disability and LGBTQ+ Staff Equality Networks.
- Our Staff Equality Networks have supported new equality group focussed engagement events during the year.
- Our BAME Network has also supported our Internationally Educated Staff which has been recognised by the achievement of a national award.
- The HHP Group now has three established Zero Tolerance to Discrimination Frameworks, designed in partnership with the staff network, to enable colleagues to report discrimination in order to have an intervention by the Trust to tackle and hopefully eliminate discrimination.

The success of our Staff Equality Networks is measured through our Workforce Disability Standard and Workforce Race Equality Standard reporting and the NHS Staff Survey results.

Equality, Diversity, Inclusion and Human Rights

Control measures were in place to ensure that the organisation's obligations under equality, diversity, inclusion and human rights legislation were complied with. The trust has an Equality, Diversity and Inclusion Strategy which encompasses our Equality Objectives. Our Equality Objectives focus on achieving legal and contractual compliance and progress against them is reported to Trust Board and monitored via the EDI steering group. The organisation has an Equality Impact Assessment (EIA) process which ensured the integration of EIAs into trust core business and to support this training continued to be delivered across the trust.

The new Group People Strategy 2025-28 outlines that the Group will have allyship programmes that proactively educated all staff to reduce instances of discrimination and work with communities to ensure they understand that discrimination or abuse towards staff is unacceptable. The Group

will implement systems to ensure equal access to career opportunities for all staff, regardless of ethnicity, disability, or gender identity.

In 2025/26 the key points to note are:

- The expansion of anti-ableism frameworks across the Group, embedding policies into the governance arrangements
- Group formalisation of disability staff networks
- Zero Tolerance Frameworks are in place
- NLaG BAME Staff Network in place
- LGBTQ+ Staff Network in place
- Tailored support for internationally educated staff, including cultural competency training, extended onboarding and practical relocation assistance.

Task Force on Climate-related Financial Disclosures (TCFD) framework

Humber Health Partnership recognises that climate change presents both significant risks and opportunities for the delivery of NHS services across our population. This report sets out our climate-related financial disclosures in line with the Task Force on Climate-related Financial Disclosures (TCFD) framework.

We acknowledge that we are at an early stage of our TCFD journey and are committed to maturing our approach systematically over the coming years. This disclosure reflects our current position honestly and sets out the steps we are taking to strengthen our capabilities across all four pillars of the framework: Governance, Strategy, Risk Management, and Metrics and Targets.

We operate within a geography that faces distinct climate risks, and we recognise our responsibility both to manage those risks to service continuity and to play our part in the NHS commitment to reach net zero carbon emissions.

Pillar 1: Governance

The TCFD framework requires organisations to disclose how their governance structures oversee climate-related risks and opportunities.

Board Oversight of Climate-Related Risks and Opportunities

The Trust Board maintains ultimate accountability for climate-related risks and opportunities. The Chief Financial Officer (CFO) acts as the Board-level Senior Responsible Officer (SRO) for climate change and sustainability, ensuring that climate considerations are represented at the highest level of organisational leadership.

Operational responsibility for estates and buildings — which represent a significant source of direct emissions and physical climate risk exposure — sits with the Estates, Facilities and Development (EF&D) function.

Sustainability Committee

A Sustainability Committee is being established to provide a dedicated governance forum for climate and sustainability matters. Once operational, this committee will:

- Provide robust oversight of climate risk and sustainability performance
- Offer a formal escalation route to the Trust Board
- Monitor progress against Green Plan commitments
- Review climate risk assessments and adaptation plans
- Establishment of individual directorate project boards
- Report to the Board on an agreed cycle

ICS Engagement

Humber Health Partnership participates in the wider Humber and North Yorkshire Health and Care Partnership sustainability governance, engaging with the ICS-level Climate Change and Sustainability Group, which brings together sustainability leads from across the region on a monthly basis.

Current Gaps and Planned Actions

We recognise that our governance arrangements are still maturing. Business cases currently do not systematically incorporate climate change risk or adaptation considerations. We are committed to addressing this by:

- Establishing the Sustainability Committee with clear terms of reference
- Developing guidance to embed climate risk appraisal into the business case process
- Formalising reporting lines and escalation pathways from operational teams to the Board

Pillar 2: Strategy

The TCFD framework requires organisations to disclose the actual and potential impacts of climate-related risks and opportunities on their business, strategy and financial planning.

Physical Climate Risks

Humber Health Partnership operates within a geography that faces distinct and material physical climate risks. The Humber estuary and surrounding low-lying areas are among the most flood-exposed in England, with additional risks from:

- Surface water flooding from increased rainfall intensity
- Coastal erosion and long-term sea level rise
- Increased frequency and severity of heatwaves
- Extreme weather events disrupting service delivery and supply chains

Current Risk Identification Mechanisms

We have begun to identify climate-related risks through the following established mechanisms:

- **Green Plan:** Our published Green Plan sets out our sustainability objectives and provides the strategic framework within which climate-related risks and opportunities are being considered.
- **Corporate Risk Register:** Climate change is recorded on the corporate risk register, establishing it as a formal organisational risk.
- **Adverse Weather and Heatwave Plans:** A number of climate-related physical impacts — particularly extreme heat and adverse weather events — are already addressed through existing operational resilience plans.

Transition Risks and Opportunities

As the NHS pursues its net zero commitments, Humber Health Partnership faces transition risks associated with decarbonising its estate and clinical operations. These include:

- Capital investment requirements for low-carbon heating systems
- Fleet electrification costs and infrastructure requirements
- Supply chain transformation and sustainable procurement

At the same time, there are meaningful opportunities, including reduced long-term energy costs, improved estate efficiency, enhanced resilience and reputational benefit.

Planned Actions to Strengthen Strategy

We acknowledge that our understanding of the full range of climate-related risks and opportunities is at an early stage. We have not yet undertaken a systematic, quantified scenario analysis.

Planned actions include:

- Completing the NHS Climate Change Risk Assessment to build a structured, evidence-based understanding of physical and transition risk exposure
- Using the NHS Climate Adaptation Framework to translate risk assessment outputs into adaptation priorities and plans
- Developing scenario analysis using recognised climate pathways (including a below 2°C and a higher warming scenario) to stress-test strategy and financial planning assumptions
- Incorporating climate risk considerations into long-term financial and estates planning

Pillar 3: Risk Management

The TCFD framework requires organisations to disclose how they identify, assess and manage climate-related risks and how those processes are integrated into overall risk management.

How Climate-Related Risks Are Identified, Assessed and Managed

Humber Health Partnership manages climate-related risks through the Trust's established risk management processes. Climate change is formally recorded on the corporate risk register, providing a baseline for organisational awareness and oversight.

Physical climate risks — particularly those relating to extreme weather events and high temperatures — are currently managed through operational plans including the Adverse Weather Plan and the Heatwave Plan. The Trust has established processes for the identification, assessment, escalation and management of risks and impacts, and climate risk is subject to this same framework.

Integration with Overall Risk Management

At present, climate risk management is partially integrated into the wider risk framework:

- Physical, acute risks (such as flooding or heatwave impacts on services) are addressed operationally
- Longer-term chronic physical risks are not yet fully assessed within strategic risk management processes
- Transition risks are not yet formally incorporated into the risk register

The establishment of the Sustainability Committee will be a key enabler of stronger integration, providing the governance mechanism through which climate risks identified via the NHS Climate Change Risk Assessment can be formally incorporated into the corporate risk register.

Planned Actions

- Complete the NHS Climate Change Risk Assessment to identify and prioritise physical and transition risks systematically
- Develop a climate risk matrix aligned to TCFD categories (physical — acute and chronic; transition — policy, legal, technology, market and reputational)
- Strengthen the process by which climate risks are escalated from operational teams to the Board
- Embed climate risk consideration into the business case appraisal process
- Establish regular climate risk reporting to the Sustainability Committee and Trust Board

Pillar 4: Metrics and Targets

The TCFD framework requires organisations to disclose the metrics and targets used to assess and manage relevant climate-related risks and opportunities.

Metrics Currently Reported

Humber Health Partnership reports Scope 1 and Scope 2 greenhouse gas emissions through its Annual Report, in line with NHS and HM Treasury reporting requirements. This provides a foundational level of emissions transparency.

Emission Scope	Definition	Reporting Status
Scope 1	Direct emissions from owned or controlled sources (gas, fuel, fleet)	Reported in Annual Report and ERIC
Scope 2	Indirect emissions from the generation of purchased energy (electricity, heat)	Reported in Annual Report and ERIC
Scope 3	All other indirect emissions across the value chain (supply chain, travel, waste, etc.)	Not yet systematically reported

Targets

The Trust's Green Plan sets out our sustainability objectives, which are aligned with the Greener NHS net zero commitments. These include the national NHS targets of:

- Net zero for the NHS Carbon Footprint (Scopes 1, 2 and selected Scope 3) by 2040
- Net zero for the NHS Carbon Footprint Plus (full Scope 3) by 2045

Progress against these targets is reported through the Annual Report and monitored operationally by the EF&D function.

Development Priorities

We recognise that our current metrics are limited and do not yet encompass:

- Scope 3 emissions, which represent the largest share of NHS emissions nationally (estimated at approximately 60-80% of the total footprint)
- Physical climate risk metrics (e.g. proportion of estate in high flood-risk zones)
- Climate adaptation metrics and performance indicators
- Financial metrics quantifying climate-related financial exposure

As our TCFD capability matures, we will work to expand our metrics suite to include Scope 3 reporting and climate resilience indicators, drawing on the outputs of the NHS Climate Change Risk Assessment and Adaptation Framework.

Summary: Maturity and Forward Commitments

TCFD Pillar	Current Maturity	Key Next Steps
Governance	Foundational — CFO as SRO, EF&D operational lead, Sustainability Committee being established	Establish committee; embed climate impacts into business cases; formalise reporting cycle
Strategy	Early — Green Plan published, climate change on risk register, adverse weather and heat plans in place	Complete NHS Climate Risk Assessment; develop scenario analysis; embed into long term financial planning
Risk Management	Developing — climate risk management partially integrated into risk register; operational plans address acute physical risks	Integrate fully into risk framework; develop climate risk taxonomy; embed climate impacts into business cases
Metrics & Targets	Partial — Scope 1 & 2 reported in Annual Report; aligned to NHS net zero targets	Develop Scope 3 reporting; expand to adaptation and resilience metrics

Statement of Commitment

Humber Health Partnership is committed to progressive improvement in the quality and completeness of its TCFD disclosures. We recognise that climate change poses material risks to the continuity of NHS services, the health of our population, and the long-term financial sustainability of our organisation.

We will continue to build our capability, knowledge and governance in this area, completing the NHS Climate Change Risk Assessment and Climate Adaptation Framework as a priority, and will report transparently on our progress in future Annual Reports.

Leadership and trust performance

In line with the ongoing development of group service models, responsibility for sustainability has been formally assigned to the Group Capital Development Team. Baseline data on the trust's carbon emissions and energy consumption has been collected over several years for reporting purposes. This data has informed both previous Sustainability Reports and the mandatory Estates Returns Information Collection (ERIC) submissions. The trust's Green Plan formally established 2020/21 as the baseline year, building on the reliability and consistency of the existing data.

The Trust's Capital Investment Programme continues to progress at pace, with sustained momentum and no indication of slowing. Following successful funding approvals through the Public Sector Decarbonisation Scheme (PSDS), a series of carbon reduction projects are scheduled to commence in 2025. These include the development of a new energy centre at the Scunthorpe hospital site, installation of electric vehicle charging infrastructure, widespread LED lighting upgrades, and energy efficiency improvements across the trust's aging estate.

Sustainability

The report provides a comprehensive overview of the Trust's environmental performance, with a focus on estate operations, space utilisation, and energy consumption associated with natural resource use.

In addition, it examines wider carbon impacts, including emissions linked to travel by patients, visitors, and staff. The report also analyses the organisation's waste production, detailing how waste is managed and diverted in accordance with the principles of the waste hierarchy.

Following review and approval by the Estates & Facilities Governance Group, this report will be submitted for formal inclusion within the Trust's Annual Report.

This report is underpinned by the Humber Health Partnership Group Green Plan 2025. Oversight of sustainability initiatives and carbon emissions tracking is provided by the Trust's Sustainability Working Group.

Directorate Update

As part of the Humber Health Partnership (HHP), a Group Director has been appointed to lead Estates, Facilities, and Capital Services across both Hull University Teaching Hospitals NHS Trust (HuTH) and Northern Lincolnshire and Goole NHS Foundation Trust (NLaG). In line with the ongoing development of Group service models, responsibility for sustainability has been formally assigned to the Group Capital Development Team.

While these structural changes are being implemented, the report will continue to be developed and supported by the existing Sustainability Team, until formal reporting responsibilities are fully established under the Group model.

The North East & Yorkshire Greener NHS team continues to support delivery of the national Net Zero Challenge (2020) through its regional leads. As the Humber Health Partnership strengthens

its sustainability work, NLaG contributes to a wider system network focused on reducing carbon emissions across the healthcare sector.

The regional team coordinates collaborative meetings between system partners and supports a communications network to share best practice and learning. It also manages the distribution and collection of quarterly data submissions from NHS organisations.

The reporting framework includes all required deliverables commissioned nationally, supporting Trusts in tracking progress towards the Net Zero ambition. At NLaG, this reporting is completed by the Sustainability Team, who also represent the Trust on the North East & North Yorkshire Sustainability Group.

Trust Performance

Baseline data on the Trust's carbon emissions and energy consumption has been collected over several years for reporting purposes. This data has informed both previous Sustainability Reports and the mandatory Estates Returns Information Collection (ERIC) submissions.

The Trust's Green Plan formally established 2020–21 as the baseline year, building on the reliability and consistency of the existing data.

The Trust's Capital Investment Programme continues to progress at pace, with sustained momentum and no indication of slowing. Following successful funding approvals to a value of £27M through additional external funding, a series of carbon reduction projects commenced in 2025.

These include the PSDS3C programme of works at Scunthorpe Hospital site which has included fabric improvements (roofing and Glazing) to the entire SGH site, New BMS controls, completion of the LED lighting programme, Solar PV to the main Pitt car park and electrification of the heat source. In addition, the Trust has commissioned the Borehole previously installed under PSDS1 at SGH. Additional Solar PV is being installed at both DPOW and SGH adding an additional 4MWp which will provide substantial revenue savings in the years to come.

	2021-22	2022-23	2023-24	2024-25	2025-26
Floor Space (m2)	156,930	163,281	156,909	156,938	156,255
Number of Staff	6969	6637	5589	6676	8013

Energy Costs and Use

The Trust continues to monitor and report on its energy consumption and associated carbon emissions in line with the Green Plan and national Net Zero targets. The baseline year (2020–21) provides a point of reference for assessing progress.

As a result of the further fuel and energy price rises, the Trust has incurred energy & water costs totaling £7,433,960 during 2025-26. This spend is a year-on-year decrease of 9% on energy costs from the previous year, as detailed below.

Gas Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025-26
kWh	63,240,193	62,278,530	60,687,404	59,651,972	58,393,141
tCO ₂ e	11,583	11,347	11,079	10,910	10,683.6

Gas Oil Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
kWh	-	-	246,740	113,910	111,360
tCO ₂ e	-	-	63.3	29.2	28.6

Electricity Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
kWh	13,999,661	15,209,852	13,691,065	13,719,719	15,074,724
tCO ₂ e	0	0	0	3,092	2,947.6

Total Energy	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
CO ₂ e	11,917	11,347	11,142	14,031	13,659.8
Cost £	£4,036,886	£6,043,772	£7,362,486	£8,177,836	£7,433,960

Gas remains the largest contributor to the Trust's carbon emissions. Usage peaked in 2021–22 at 63.2 million kWh before gradually reducing to 58.3 million kWh in 2025-26. This has resulted in a corresponding decline in carbon emissions from 11,583 tCO₂e in 2021–22 to 10,683 tCO₂e in 2025-26 — an 8% reduction over four years.

Grid electricity use has increased 7.6% between 2020–21 and 2025–26 due to site expansion (MRIs and EDs) and more recently, the new community located Clinical Diagnostic Centres (CDCs). Despite this a year-on-year increase in consumption, our carbon emissions from grid by electricity still reduced due to continued decarbonisation of grid electricity.

Total year on year carbon emissions fell by nearly 3% in 2025-26, demonstrating continued progress despite the addition of the 2 two electricity only powered & heated CDC buildings.

Resource Use – Water

Whilst there has been a 2.8% rise in recorded water usage across the Trust in 2025/26, the increased consumption value is solely down to additional consumption from the two CDCs. Without this additional water requirement the Trust would have had an overall reduction in supplied water.

Total Water Use	2021 – 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
m ³	203,243	172,330	179,429	188,732	194,024
tCO ₂ e	30	60	52	50.5	56.1

Water and Sewerage Cost	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
£	£579,749	£519,121	£533,392	£671,061	£700,003

Resource Use – Photovoltaic (PV) Solar Systems

With the completion of the Gym refurbishment at Scunthorpe, the Trust now has roof mounted solar panel systems live at our 3 main hospital sites. The latest annual data is captured below:

PV Electric kWh	2022 - 23	2023 - 24	2024– 25	2025 - 26
DPoW - CDC	44,249	48,618	41,850	41,592
DPoW - Family Services	26,994	22,973	29,259	28,938
Goole – Main Building	159,067	133,919	170,339	188,945
SGH - GYM	0	0	9,885	14,859
Totals kWh	230,310	205,510	251,333	274,334

After being awarded grant funding under the PSDS and GB LEP Solar PV schemes, the Trust has been installing solar PV panels across SGH and DPoW sites. The SGH site is projected to increase from 18kWp to 2,308kWp. The DPOW site is projected to increase from 150kWp to 2,035 kWp. Arrays are being brought online systematically throughout the year as they complete providing a substantial saving contributing to the wider CIP target.

Medical Gases

The Trust continues to monitor its use of medical and anaesthetic gases, which are essential for patient care but contribute significantly to the NHS's overall carbon footprint. Under the NHS Net Zero strategy, anaesthetic practices are expected to contribute a 2% reduction toward overall targets, with acute providers accounting for approximately 5% of NHS carbon emissions from anaesthetic gases alone.

Total carbon emissions have decreased in 2025–26.

	2023 - 24		2024 - 25		2025 - 26	
	Vol (L)	tCO2e	Vol (L)	tCO2e	Vol (L)	tCO2e
Desflurane	9.84	25.77	9.84	25.77	0	0
Isoflurane	0.75	0	0.75	0	0	0
Sevoflurane	344.25	106.75	344.25	106.75	374	72.93
Nitrous Oxide	798.3	394.71	798.3	394.71	637	316
Total tCO2e	1,153.14	527.23	1,153.14	527.23	1,011	388.93

Desflurane use ceased in 2025-26 which reflects positive clinical engagement with Greener anaesthetic choices.

Sevoflurane usage rose by 8%, reflecting a shift toward lower-emission agents.

Nitrous oxide use continued its downward trend, decreasing by 21%. However, it remains the largest single contributor to anaesthetic-related emissions. As a potent greenhouse gas, further action is required to mitigate its impact.

Medical gas usage has decreased by 12.4% in year.

Travel

Travel remains a significant contributor to the Trust's overall carbon footprint and is a key focus within the Green Plan. Delivering healthcare services across three geographical areas presents both challenges and opportunities in reducing travel-related emissions.

The Trust's Travel Plan is subject to regular review and ongoing investment. It promotes the benefits of sustainable travel options for patients, staff, and visitors, and supports the wider objective of improving air quality in our communities and reducing traffic congestion.

The Trust is actively engaging with staff and local service providers to promote low-emission vehicle options, active travel, and improved public transport access. Fleet management is aligned with sustainability principles, aiming to model and share best practice both within the organisation and across the healthcare system.

As part of our "Movement Strategy," we continue to promote healthy, low-carbon travel options. The Trust provides information, services, and infrastructure to support sustainable travel, contributing to the health and wellbeing of staff, patients, and visitors while aligning with our Net Zero goals.

The Trust's business use only fleet continues to transition toward lower carbon emissions. As of 2025–26, the fleet includes 11 fully electric vehicles and 78 self-charging hybrids, representing 74% of the total business-use fleet.

Investment in charging infrastructure is ongoing and aligns with future plans to expand support for staff and visitor electric vehicle use, helping to embed sustainable transport options more widely across the Trust.

This trend highlights the need for further engagement with staff on sustainable travel options and for exploring additional strategies to reduce emissions associated with grey fleet use.

Cycling promotion and engagement from staff has been a welcomed interest, and all sites are equipped with excellent storage facilities, with 28 applications for bicycles via the cycle to work scheme in 2025/26.

Cross site travel is supported with inter-site transport aimed at reducing unnecessary mileage claims, single occupancy vehicle journeys and reducing emissions further. The table below details the miles travelled and associated metric tonnes of carbon dioxide.

[GHG Conversion Factors 2025](#)

Patient & Visitor own Travel	Mode	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
	Miles	17,737,436	18,831,805	21,219,104	16,067,630	21,219,104
	tCO2e	4,808	4,660	5,690	4,315	5,915

Staff Commute	Mode	2021 – 22	2022 - 23	2023 - 24	2024 – 25	2025 - 26
	Miles	6,690,240	6,378,157	5,368,892	6,936,364	7,700,493
	tCO2e	1,814	1,530	1,439	1,997	2,146

Business Travel & Fleet	Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
	Miles	1,868,015	1,995,880	2,227,343	2,842,696	2,019,852
	tCO2e	506.28	493.96	596.92	624.77	561.51

Owned EV and PHEV Mileage	Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
	Miles	29311	44,617	78,430	85051	76,820
	tCO2e	0	0	0	0	0

Total Cost Business Travel	Use	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
	£	£330,310	£1,005,000	£1,097,881	£944,841	£924,833

Waste

The Trust waste management services continues to work with our waste contractors to reduce single use plastics, increase recycling, single use metal instrument recycling, reduction, and removal of all waste to landfill, and new processing techniques to create energy from waste.

A significantly reduced emission factor of 4.68 kg used to calculate this year's tCo2e which was taken from the UK Government GHG Conversion Factors for Company Reporting 2025, this shows that the tCO2e from waste was decreased from 22.94 tCO2e to 4.16 tCO2e, which is mainly due to significant changes in the conversion factor

Recycling is actively encouraged, and staff members are invited to contribute and participate in the development of the waste strategy encouraging waste management via the waste hierarchy principles. The recycling percentage below is calculated on the total general waste tonnage and currently sits at 61%. Recycling hubs and the furniture/equipment re-use scheme contributes to our reduction in waste.

Clinical waste is sent to energy from waste plants which is used to provide power to the national grid. We have also introduced re-usable sharps containers which has eliminated the incineration of single use plastic containers, the new sharps containers can be cleaned and reused up to 500 times. The Trust continues to achieve zero waste to landfill status. Following the 60% offensive waste target set by NHS England the trust currently sits at 64%.

Recycling	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
Tonnes	278	341	348	325	549
tCO2e	5.9	7.25	7.47	6.91	2.57

Other Recovery	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
General Waste Tonnes	569.33	631	676	725	311
tCO2e	86.1	13.42	14.38	15.42	1.45

High Temp Disposal	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
Tonnes	68.8	38.33	39.5	28.3	29.9
tCO ₂ e	16.5	0.81	0.84	0.60	0.14

Landfill	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
Tonnes	0	0	0	0	0
tCO ₂ e	0	0	0	0	0

	2021 - 22	2022 - 23	2023 - 24	2024 - 25	2025 - 26
Total Waste Tonnes	916.13	1010.33	1063.5	1078.3	889.9
% Recycled	30%	33%	32%	30%	61%
Total Waste tCO₂e	108.5	21.48	22.69	22.94	4.16

Total Carbon Emissions Impact

The Trust's total carbon emissions are detailed below:

Annual NLaG Carbon Emissions (tCO ₂ e)	2023 - 24	2024 - 25	2025 - 26
Total Energy CO₂e	11,142	14,031	13,659
Total Water CO₂e	52	50.5	56.1
Total Medical Gas CO₂e	527	1,259	388.93
Patient & Visitor CO₂e	5,690	4,315	5,915
Staff Commute CO₂e	1439	1,997	2,146
Business Fleet CO₂e	596	625	561.51
Total Waste CO₂e	22	23	4.16
Total CO₂e	19,468	22,300.5	22,760.7

Conclusion and Recommendations

This report presents verified and consistent data that provides a reliable foundation for tracking the Trust's carbon emissions and shaping future sustainability actions. It supports the setting of ambitious but evidence based targets under the NHS Green Plan and informs the development of key innovation projects focused on decarbonising heating, power, and energy use across the Scunthorpe, Goole, and Grimsby sites.

Carbon emissions across several categories have shown mixed trends in 2025–26 with reductions in Energy, Medical Gas, and Staff/Fleet mileage there have been slight increases in Patient/Visitor mileage and Water. Overall emissions have slightly increased from 22,300.5 tCO₂e in 2024–25 to 22,760.7 tCO₂e in 2025–26 a 2.1% rise.

To maintain momentum and meet national Net Zero goals, the following actions are recommended:

- **Resource Expansion:** Allocate dedicated resources to strengthen data management, reporting, and performance analysis capacity within the Sustainability Team.
- **Targeted Emissions Reduction:** Prioritise high impact areas such as staff commuting and medical gas usage, supported by behavioural change programmes and technical interventions.
- **Capital Project Integration:** Ensure upcoming infrastructure projects incorporate low carbon design standards and embed sustainability metrics into business cases.
- **Fleet and Travel Reform:** Expand EV infrastructure and review travel policies to reduce reliance on higher emission employee owned vehicles.

The Trust remains committed to leadership in sustainable healthcare delivery. Continued data-driven planning, strong governance, and strategic investment are essential to realising our Net Zero ambition.

Key issues and risks that affected the trust in 2025/26

The boards-in-common papers set out the Board Assurance Framework at in place at the time of the report. Significant operational and clinical risks are identified, managed and monitored in accordance with the trust's Risk Management Policy and overseen by the Group Cabinet Risk and Assurance Committee. The committee reviews on a monthly basis the Board Assurance Framework and the high-level Risk Register. This process provides further assurance to the NEDs on the robustness of actions being taken. The risks highlighted in April 2025 are set out in the table below. More details of the key risks can be found in the Annual Governance Statement later in this section of the Annual Report.

Risk type	Nature of risk
People	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to address our working environments, then staff engagement scores (from staff surveys) will not improve and our staff retention and attendance rates will decline.
Patients - Access	We aim to achieve upper quartile performance. However, if we fail to develop the necessary skills and capabilities in our teams and have access to information to drive change, we will fail to give patients access to care they need, when they need it.
Patients - Safety	We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.
Pioneers	We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.

Partnerships	We aim to work well with others, build trust and develop ambitious partnerships for the future. However, if we lack credibility and fail to communicate our officer and where we need support, we will not become an outward-looking organisation that is genuinely collaborative in all that we do.
Public Purse	We will aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.

Going concern statement

After making enquiries, the directors have a reasonable expectation that the services provided by the NHS foundation trust will continue to be provided by the public sector for the foreseeable future. For this reason, the directors have adopted the going concern basis in preparing the accounts, following the definition of going concern in the public sector adopted by HM Treasury's Financial Reporting Manual.



**Northern Lincolnshire
and Goole**
NHS Foundation Trust

Blue Sky Imaging Suite



The Accountability Report

Directors' Report

This report sets out how the trust is run and the governance arrangements it has in place to ensure there is proper oversight and governance of the trust's activities. The trust boards-in-common meet in public and the meetings are open to anyone who wants to attend. Details, including the agenda and papers, are available on the trust's website.

The trust board is made up of eleven voting members. The eleven voting members comprise five Non-Executive Directors (NEDs) including the chair and vice chair, and six group executive directors. The board also has two other (non-voting) executive directors. Each board member brings a variety of individual skills and experience.

Brief biographical details of all the current NEDs and executive directors are available on the trust's website. NEDs are not employees of the trust and are appointed to provide independent support and challenge to the board. All board directors are required to comply with the trust's Standards of Business Conduct, including declaration of any actual or potential conflict of interest, and the requirements of the trust's constitution.

Signature:

A handwritten signature in black ink, reading 'Lyn Simpson'.

Lyn Simpson

Group Chief Executive

Date: 18 June 2026

Board of Directors on 1 June 2026

Non-Executive Directors
Alan Downey, Group Chair (Voting)
Murray Macdonald, Vice Chair (Voting)
Jane Hawkard (HUTH) (Voting)
David Sulch (HUTH) (Voting)
Julie Beilby (NLaG) (Voting)
Group Executive Directors
Lyn Simpson, Group Chief Executive (Voting)
Emma Sayner, Group Chief Finance Officer (Voting)
Heather McNair, Interim Group Chief Nurse (Voting)
Sam Peate, Group Chief Delivery Officer (Voting)
Kate Wood, Group Chief Medical Officer (Voting)
David Sharif, Group Director of Assurance (Non-voting)
Tom Myers, Group Director of Estates and Facilities (Non-voting)

Directors who left the trust in 2025/26

Non-Executive Directors
Sue Liburd (NLaG) (Voting)
Simon Parkes (NLaG) (Voting)
Helen Wright (HUTH) (Voting)
Laura Treadgold (HUTH) (Voting)
Tony Curry (HUTH) (Voting)
Gill Ponder (NLaG) (Voting)
Executive Directors
Clive Walsh, Interim Site Managing Director (North) (Voting)
Sarah Tedford, Interim Site Managing Director (South) (Voting)
Matt Powls, Interim Group Chief Delivery Officer (Voting)
Andy Haywood, Group Chief of Strategy, Partnerships and Digital (Non-voting)
Simon Nearney, Group Chief People Officer (Voting)

Registers of interest

All directors and governors are required to declare their interests, including company directorships: on taking up appointment; on an annual basis; and at Council of Governors and trust boards-in-common meetings.

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

In accordance with the Code of Governance, the board has reviewed Non-Executive Directors' continued service and their registered interests, and considers them to remain independent due to their consistent objectivity, lack of operational involvement, and continued constructive challenge.

The appointment and removal of the Group Director of Assurance is a matter reserved for the full board, ensuring appropriate oversight and alignment with the trust's governance framework.

Appointments to the trust board

The trust board considers the balance and breadth of skills and experience of its members to be appropriate with the needs of the trust. NEDs are appointed to bring particular skills to the board, ensuring the balance, completeness and appropriateness of the board membership. All NEDs are considered to be independent, meeting the criteria for independence as laid out in the national NHS Code of Governance guidance. NEDs are appointed and removed by the Council of Governors. A committee consisting of the Chair, the Group Chief Executive and the other NEDs appoints or removes the other executive directors. The trust's nominations and appointments processes are supported by external advice where appropriate. For senior appointments, including the Chair and Group Chief Executive, the selection panel includes an external assessor from NHS England and/or a representative from the Integrated Care Board (ICB), in line with best practice. The trust engages with NHS England to agree the approach to these appointments. Succession planning is reviewed annually to ensure the board maintains the skills and experience needed to meet future challenges and strategic priorities.

Operation of the trust board

The trust is run by a board of directors, comprising of a NED who is the chair, and four other NEDs and six executive directors. The Group Chief Executive leads the executive team and is accountable to the board for the operational delivery of all the trust's activities. The chair of the board is also the chair of the Council of Governors (CoG). The NEDs scrutinise the performance of the executive management team in meeting agreed goals and objectives, and they receive adequate information to monitor the performance of the organisation. The NEDs play a key role in taking a broad, strategic view, ensuring constructive challenge is made and supporting and scrutinising the performance of the executive directors while helping to develop proposals on strategy. The board sets the trust's strategic aims and provides active leadership of the trust.

The board is collectively responsible for the exercise of its powers and the performance of the trust, for ensuring compliance with the trust's Provider Licence, relevant statutory requirements, and contractual obligations, and for ensuring the quality and safety of services. It does this through the approval of key policies and procedures, the annual operational plan and budget for the year, and the scheme for investment or disinvestment above the level of delegation. The board meets every other month and its role is to determine the overall corporate and strategic direction of the trust and to ensure the delivery of the trust's goals and targets. The board has agreed a scheme of reservation and delegation which sets out those decisions which must be taken by the board and those which may be delegated to the executive or to board sub-committees. The trust board has reserved powers to itself covering:

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

The board is also responsible for promoting effective dialogue between the organisation and the local community on its plans and performance, ensuring that the plans are responsive to the community's needs. The board receives feedback from governors and members about the trust, through attendance at meetings of the CoG and its groups, direct face-to-face contact, surveys of members' opinions and consultations. The board is also responsible for ensuring proper standards of corporate governance are maintained.

The board accounts for the performance of the trust and consults on its future strategy with its members through the CoG. The board works closely with the trust's CoG. The trust chair is also chair of the CoG and works closely with the Lead Governor to review all relevant matters. The Chair, Group Chief Executive, Lead Governor, Group Director of Assurance and Deputy Director of Assurance meet before each meeting of the CoG to set the agenda and review key issues. The NEDs attend the CoG meetings and take part in open discussions for part of each meeting. The Chair is responsible for ensuring that all members of the Board of Directors and the Council of Governors receive accurate, timely, and clear information to support informed decision-making and effective fulfilment of their statutory responsibilities. This includes access to performance reports, strategic updates, and committee outputs, ensuring transparency and alignment across governance structures. The NEDs of the board attend the CoG meetings and take part in open discussions for part of each meeting. Key executive directors, and all NEDs, are assigned to, and are integral members of, the Governor Assurance Group, a CoG group, as per the Terms of Reference. Participation in each quarterly group ensures an understanding of the views of the governors and consequently members of the public. The group also received trust board committee highlight reports as shared at the trust board meetings.

The Trust Constitution and the CoG's Engagement Policy details how disagreements between the trust board and the CoG will be resolved. Should a disagreement arise which would impair the decision-making process or the successful operation of the trust then the Chair shall convene a joint meeting of the two bodies to consider the issue in dispute. Should this meeting not resolve the issue then the Chair has the authority to decide on behalf of the trust. This decision, and the reasons supporting it, will be communicated in writing to all members of both the trust board and the CoG. This has not been required during the period 1 April 2025 to 31 March 2026. The board ensures that adequate systems and processes are maintained to measure and monitor the trust's effectiveness, efficiency and economy as well as the quality of local healthcare delivery. The Standing Financial Instructions, including Reservation of Powers to the Board and Scheme of Delegation, details which types of decisions are to be taken by the board, and which decisions are to be delegated to the management by the board. The board also has powers to delegate and make arrangements to exercise any of its functions through a committee, sub-committee or joint committee. The board keeps the performance of its committees under regular review and requires that each committee considers its performance and effectiveness during the year.

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

Vice chair and senior independent director

Good practice suggests that the trust should have a deputy or vice chair to stand in during any periods of absence of the chair. National guidance states that this should be a CoG appointment, although it would be expected that the chair would make a recommendation to governors. Murray Macdonald, a NED, is the vice chair. The senior independent director has a key role in supporting the chair in leading the board and acting as a sounding board and source of advice for the chair and also leads the performance evaluation of the chair.

NEDs

NEDs are appointed for a period of two or three years, this can be extended for a further period. Any term beyond six years is subject to rigorous review. Arrangements for the appointment and termination of NEDs are set out in the Trust Constitution, which states the CoG has the power to appoint and remove the chair of the trust and other NEDs. Removal can only happen if three quarters of CoG members approve the motion. The board determines whether each NED is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could affect, the person's judgement. NEDs are considered to be independent by the trust board as per the Code of Governance for NHS Foundation Trusts. As chair of the board the chair is responsible for ensuring the board's effectiveness and for setting its agenda. As chair of the CoG the chair provides a pivotal link between governors and directors, especially the NEDs. Adequate time is allocated for the discussion of all agenda items, with particular emphasis on strategic matters, including organisational transformation, workforce, quality of care, financial sustainability, and system-level collaboration. The Chair ensures that board meetings are structured to support effective scrutiny and decision-making on these areas, in alignment with the trust's vision and the wider system strategy. The Chair plays a key role in promoting a culture of openness, honesty, respect and constructive challenge within the board. Through effective leadership and facilitation, the Chair ensures that all directors are able to contribute meaningfully to board debate and assurance processes. Listening to the governors is one of the ways the chair can hear the views of the local community. NEDs, including the chair, vice chair and senior independent director, are appointed by the CoG with the process being led by the Appointments and Remuneration Committee (ARC) for non-executive directors. The chair, other NEDs, and the Group Chief Executive are responsible for deciding the appointment of executive directors. NEDs routinely attend the trust board meetings, meetings of the CoG and also meet regularly with the chair without executives present.

Board meetings

Public board meetings are normally held every other month. However this has been increased to every month (from February) in 2026 due to the Group being placed in NOF 5 to ensure all performance is scrutinised. The Board follows a formal agenda which includes: an update from the Group Chief Executive; a patient story presented by the trust's patient experience lead nurse; updates on the trust's improvement plans; monthly capacity and capability on wards; and highlight reports and minutes from board committees-in-common.

Evaluation of the board/its committees/directors and the chair

Comprehensive arrangements are in place for reporting to the trust board on performance and key risks to future performance against a range of targets/contractual obligations and indicators. Risks in respect of compliance with other statutory requirements are escalated to the board via established governance and performance management frameworks including receipt by the board of the Board Assurance Framework (BAF) and Risk Register reports. More urgent risk issues are escalated directly to the executive team and the board via the relevant executive director. The Scheme of Delegation, which defines accountabilities for the delivery of performance, is monitored via the trust's performance management framework led by the Group Chief Executive. The board ensures that relevant metrics, measures, milestones and accountabilities are developed and agreed to understand and assess progress and delivery of performance.

The board receives assurance through a suite of financial and non-financial performance reports including the submission of an Integrated Performance Report (IPR), which includes reporting on the trust's annual priorities. The trust undertakes an annual evaluation of the board and its committees.

An assessment of whether services are 'Well Led' under the NHSE well led framework was undertaken as part of the trust's CQC inspection programme. Each member of the board completes an annual review of effectiveness, and the outcome including agreed actions, are reported to the trust board. A Well-led review will be conducted during 2026/27.

The board is also satisfied that the trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of healthcare services to the trust. In compliance with the Code of Governance for Foundation Trusts, no executive director holds more than one non-executive directorship of an NHS foundation trust or other organisation of comparable size and complexity.

Code of conduct for the board

All members of NHS boards should undertake and commit to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities. To support this there is the Code of Conduct for Board Members of Public Bodies (June 2019), which applies to all directors and has been adopted by all board members.

The Code of Conduct also aims to capture existing standards, codes and principles (the Nolan Principles) by which NHS board members are currently bound. In May 2013 the board formally signed up to these standards on an ongoing basis. All board directors meet the 'fit and proper persons' test as described in the provider license and confirmed annually by each individual director and collectively within the annual chair's declaration to the board. Included in the 'fit and proper persons' test is the Executive's requirement to declare any new significant external appointments. Such appointments require prior Board approval.

The board has maintained its support of the Nolan principles of public life and has continued to make the majority of its decisions at board meetings held in public. To support this there is the Directors' Code of Conduct, which applies to all directors and has been adopted by all board members.

Supporting NEDs

The board and CoG are both provided with high-quality information appropriate to their respective functions and relevant to the decisions they must make. They receive assurance through a suite of financial and non-financial performance metrics including the IPR and monthly finance report. The board ensures that directors, especially NEDs, have access to independent professional advice, at the trust's expense, where they judge it necessary to discharge their responsibilities or to provide additional assurance. New directors receive a full, formal, and tailored induction on joining the board. They also have access, at the trust's expense, to training courses and/or materials that are consistent with their individual and collective development. directors, Governors and members are all supported by the Group Director of Assurance and his team.

Where directors have concerns that cannot be resolved about the running of the trust or a proposed action, any concerns are recorded within the trust board minutes. Minutes of the board are comprehensive and are published in the public domain on the trust's website. The board, and in particular the NEDs, may reasonably wish to challenge assurances received from the executive management team. The executive directors ensure, wherever possible, that the NEDs receive sufficient information and understanding to enable challenge and to take decisions on an informed basis. The board minutes reflect any challenges of the executive management. Additionally, in the event that a non-executive director resigns and has unresolved concerns relating to the operation of the board or the conduct of the trust, they are invited to provide a written statement outlining their concerns. During the reporting period, no unresolved concerns or resignation-related statements were submitted by any member of the board.

Schedule of Attendance at Northern Lincolnshire and Goole NHS Foundation Trust Boards-in-Common meetings 2025/26

Member / Attendee	Apr-25	Jun-25	Aug-25	Oct-25	Dec-25	Feb-26	Mar 26
Murray Macdonald	✓	✓	✓	✓	X	✓	✓
Sean Lyons	-	✓	✓	✓	-	-	-
Jonathan Lofthouse	✓	X	-	-	-	-	-
Linda Jackson	✓	X	✓	-	-	-	-
Sue Liburd	✓	✓	✓	✓	✓	-	-
Julie Beilby	✓	✓	✓	✓	✓	✓	✓
Gill Ponder	✓	✓	✓	✓	✓	✓	✓
Simon Parkes	✓	✓	✓	✓	X	-	-
Lyn Simpson	-	-	X	✓	✓	✓	✓
Kate Wood	✓	✓	✓	✓	✓	✓	X
Heather McNair	-	✓	-	-	✓	✓	✓
Simon Nearney	✓	X	✓	✓	✓	✓	✓
Emma Sayner	✓	✓	✓	✓	✓	✓	✓
Amanda Stanford	✓	✓	✓	✓	-	-	-
Sarah Tedford	✓	✓	✓	✓	-	-	-
Clive Walsh	✓	✓	-	-	-	-	-
David Sharif	✓	✓	✓	✓	✓	✓	✓
Ivan McConnell	✓	✓	X	X	X	X	X

Board committees-in-common

Audit, Risk and Governance Committee-in-Common - NLaG

The Audit, Risk and Governance Committee-in-Common is a standing committee of the Trust's Board of Directors. Its remit is to:

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

The Committee meets five times each year. Its three members are appointed by the Board of Directors from among the Non-Executive Directors. Minutes of the Committee's meetings and highlight/escalation reports are submitted to the Board of Directors.

Following agreement by the Trust Boards of Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH) to move to a group model and aligned governance and decision making through a committees-in-common approach, the NLaG Audit, Risk and Governance Committee commenced meeting simultaneously with the HUTH Audit Committee from January 2024, but remain separately constituted committees. The two committees are known as the Audit, Risk and Governance Committees-in-Common. Aligned membership and terms of reference documents are in place which have been approved by the Trust Boards, as well as an aligned annual workplan.

Internal Audit services were provided during 2025/26 by KPMG who commenced on 1 April 2025 as the Group Internal Auditor, following a competitive procurement exercise in late 2024 and were appointed for a three year term with the option to extend for a further year. Internal Audit provides an independent and objective conclusion on the extent to which risk management, controls and governance arrangements support the effective operation of the Trust. The Head of Internal Audit produces an annual audit conclusion on the effectiveness of the system of internal control. The Head of Internal Audit and/or the Internal Audit Manager for the Trust will normally attend Audit, Risk and Governance Committee-in-Common meetings and has a right of access to all Audit, Risk and Governance Committee-in-Common members, the Chair and Group Chief Executive of the Trust. The Head of Internal Audit is accountable to the Group Chief Financial Officer.

Throughout 2025/26, the Committee received progress reports from Internal Audit on the agreed Group Internal Audit plan for the year, and the outcome of the individual reviews performed with associated management actions. The annual Head of Internal Audit Conclusion, which forms part of the Annual Governance Statement, contains details of high risk management actions made during the year. The Committee monitors the implementation of all internal audit recommendations and receives reports at each meeting to monitor progress on agreed actions. No reviews performed by Internal Audit during the reporting year resulted in a 'No assurance' rating (lowest rating).

The Trust's External Auditor is Sumer NI (formerly called ASM), appointed in June 2023 following a procurement process supported by NHS England (NHSE) due to difficulties in the NHS audit market. Representatives of the Audit, Risk and Governance Committee-in-Common act as

advisors to the Council of Governors in relation to the appointment of an External Auditor. Sumer NI were awarded a contract for three years plus an option to extend for a further two years (one plus one). The Audit, Risk and Governance Committee-in-Common assess the effectiveness of its External Auditor through the procurement exercise and thereafter via an annual review of effectiveness. As a result of the delayed appointment of an External Auditor, NHSE agreed to a revised annual accounts submission date for 2022/23 and 2023/24, resuming normal national submission deadlines for 2024/25. The Audit, Risk and Governance Committee-in-Common recommended the first extension year option (2025/26) and this was approved by the Council of Governors in February 2025. Additionally, the second and final extension year option (2026/27) was also approved by the Council of Governors in February 2026, along with approval to go out to tender for a Group External Auditor commencing with the 2027/28 financial statements audit. The value of external audit services is disclosed in the Trust's financial statements (note 7.1) and is circa £181k per annum.

The Committee received and reviewed the draft financial statements and the audited accounts, as well as the Annual Governance Statement. Like all NHS Trust's we are obliged to review the basic accounting policy of 'going concern'. The Audit, Risk and Governance Committee-in-Common, as part of the annual accounts preparation, reviewed this issue and agreed that this was not a matter to change. Note 1.2 of the financial statements refer to the accounts being prepared on a going concern basis and the Audit, Risk and Governance Committee-in-Common endorsed this as appropriate.

There is a policy for the engagement of the External Auditor for non-audit work to safeguard objectivity and independence. The value of any non-audit services is routinely disclosed in the Trust's financial statements at note 7.2. Sumer NI have not undertaken any non-audit work for the Trust during their tenure as the Trusts External Auditors to date.

Each year, the Committee reviews its own effectiveness in line with the latest NHS Audit Committee Handbook (Healthcare Financial Management Associated (HFMA), 2024). This was duly undertaken and reviewed at the January 2026 meeting, with the results provided to the Trust Board in February 2026.

In line with The Code of Governance for NHS Provider Trusts, the Committee also has a role in reviewing the organisation's arrangements for staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in any area of the organisation (financial, clinical, safety or workforce matters). In order to discharge this function the Audit, Risk and Governance Committee-in-Common has received periodic updates from the Trust's Freedom to Speak Up Guardian, most recently in January 2026.

Schedule of Attendance at Northern Lincolnshire and Goole NHS Foundation Trust Audit, Risk and Governance Committee-in-Common (ARG CiC) meetings 2025/26

Member / Attendee	Apr-25	Jun-25 Audited Accounts	Jul-25	Nov-25	Jan-26
NLaG Members:					
Simon Parkes – NLaG NED / NLaG ARG CiC Chair	Y	Y	Y	Y	Y
Gill Ponder – NLaG NED	Y	N	Y	Y	Y
Julie Beilby – NLaG NED	Y	Y	Y	Y	Y
Regular Attendees:					
Jane Hawcard – HUTH NED / HUTH ARG CiC Chair	Y	Y	Y	N	Y
Tony Curry – HUTH NED	Y	N	Y	Y	Y
Helen Wright – HUTH NED	Y	Y	Y	Y	N
Emma Sayner – Group Chief Financial Officer	Y	Y	Y	N	Y
David Sharif – Group Director of Assurance	Y	Y	Y	Y	Y
Rebecca Thompson – Deputy Director of Assurance - HUTH	Y	N	N ¹	-	-
Sally Stevenson - Asst. DoF – Compliance & Counter Fraud	Y	Y	Y	Y	N
Daryl Cheetham – Group Local Counter Fraud Specialist	-	-	-	-	Y ²
External Audit - NLaG (Sumer NI)	Y	Y	Y	Y	Y
External Audit – HUTH (Forvis Mazars)	Y	Y	Y	Y	Y
Internal Audit - NLaG (Audit Yorkshire)	Y	Y ³	-	-	-
Internal Audit – HUTH – (RSM)	Y	Y ³	-	-	-
Group Internal Audit (KPMG)	Y	Y	Y	Y	Y
Group Data Protection Officer / IG Lead (SM)	Y	N ⁴	Y	Y	Y
NLaG Governor Observer (MB)	Y	Y	Y	Y	Y
Member / Attendee	Apr-25	Jun-25	Jul-25	Nov-25	Jan-26
Ad-hoc Attendees:					
Asst. DoF – Planning & Control (NP)	Y	Y	-	-	-
HUTH Vice Chair (MM)	Y	-	-	-	-
Acting Group Chief Executive (AS)	Y	Y	-	-	-
Group Chief Strategy & Partnerships Officer (IM)	Y	-	-	-	-
Group Chair (SL)	-	Y ⁵	-	-	-
Group Deputy Director of Communications (AB)	-	Y	-	-	-
Associate Director of Quality Governance (RD)	-	-	Y	-	-
Operations Director – Group Emergency Planning (MO)	-	-	Y	Y	Y
Group Head of Legal (GC)	-	-	Y	-	-
Group Chief Technology Officer (TD)	-	-	Y	-	-
Group IT Security Manager (MK)	-	-	Y	-	-
Director of Procurement (EJ)	-	-	-	Y	-

Freedom to Speak Up Guardian – HUTH (FM)	-	-	-	-	Y
Freedom to Speak Up Guardian – NLaG (LH)	-	-	-	-	Y
Director of Patient Safety and Quality Governance (TC)	-	-	-	-	Y
NHS England Observer (JS)	-	-	-	Y	-
The Value Circle Observer (TB)	-	-	-	Y	-
NHS England Observers (SE, SH and LB)	-	-	-	-	Y

Notes:

- ¹ No longer required to attend at each meeting
- ² First meeting
- ³ Last meeting
- ⁴ Not required to attend, audited accounts meeting only
- ⁵ Attendance for part meeting

Capital and Major Projects Committees-in-Common

The Capital and Major Projects CIC changed its name and focus in October 2025 to the Strategic Programmes and Partnerships Committees-in-Common. The new CIC is responsible for providing assurance to the Trust Board that major programmes, significant project and major service changes (involving capital and / or revenue) align to the strategic objectives for the Group and that they are being effectively identified, resource, managed and delivered on time with the intended benefits.

The responsibilities of the CIC are:

- Oversight and scrutiny of significant capital investment and business cases
- Oversight and scrutiny of capital planning
- Oversight of the delivery of the Digital Strategy
- Oversight and scrutiny of any joint strategic capital development plans

Performance, Estates and Finance Committees-in-Common

This committees-in-common looks at the trust, and group, performance and finance metrics as well as any estate-related issues. Specifically its responsibilities are:

- Strategy
- Financial and operational performance (NHS Constitutional Standards)
- Business planning
- Procurement
- Estates, facilities and sustainability
- Cost Improvement Plans
- Risk and assurance

Quality and Safety Committees-in-Common

This committees-in-common looks at the trust, and group, approach to and monitoring of quality services and patient safety issues. Specifically its responsibilities include:

- To provide oversight of the development and monitor delivery of the trust's quality strategy, priorities and key performance indicators (KPIs)
- To provide oversight of the development of the trust's Annual Quality Report / Account in readiness for approval by the trust board and ensure that shared learning from the previous years' activities is disseminated throughout the trust and wider group
- To monitor and provide assurance to the trust board that quality and safety risks which threaten the achievement of the trust's strategic objectives are being identified and appropriately mitigated and / or to escalate concerns, as appropriate
- To assure the trust board that, where there are risks and issues that might jeopardise the trust's ability to deliver excellent quality care, these risks and issues are being managed in a controlled and timely way
- To assure the trust board that the trust continues to meet all relevant statutory, policy and best practice requirements in respect of quality and safety and is responding appropriately to and learning from national and national reviews and other sources e.g. CQC, NHSE, royal colleges, NHS resolution, internal and external audit, Coroner etc.
- To have oversight and receive assurance in respect of the implementation and embedding of CQC improvement actions and ensure that the trust continues to fulfil any requirements as determined by the CQC and other regulators

Remuneration Committees-in-Common

The Remuneration Committees-in-Common review the board's structure, size and composition. This includes an evaluation of the balance of skills, knowledge, experience and diversity. The findings inform succession planning and the development of role specifications for future appointments. The trust is committed to maintaining a board that reflects the communities it serves and is equipped to meet future strategic challenges. This committees-in-common is responsible for pay, other terms and conditions and the recruitment and retention of senior leaders with specific responsibilities for:

- Leadership and succession planning
- Nominations and selection of executive director roles
- Remuneration and terms and conditions
- Fit and proper persons

Workforce, Education and Culture Committees-in-Common

This committees-in-common is responsible for overseeing all element of the trust's, and group's, work in relation to its staff. Specifically its responsibilities include:

- To provide oversight of the development and monitor delivery of the trust's people strategy and priorities and ensure that the people strategy is aligned with the agreed strategic direction, culture, vision and values of the trust and wider group

- To provide input into and monitor delivery of the recruitment, retention, leadership, talent management and succession planning, training and organisational development and culture work programmes for the trust and wider group
- To monitor and provide assurance to the trust board that workforce risks which threaten the achievement of the strategic objectives of the trust and wider group and / or which may impact on the quality of care, are being identified and appropriately mitigated and / or to escalate concerns, as appropriate
- To monitor and seek assurance, as required, in respect of the delivery of national and local workforce indicators, standards and requirements including but not limited to: Workforce Key Performance Indicators (KPIs); staff survey (local and national); occupational health and wellbeing; staff vaccination; registered nurse and midwifery staffing; and equality, diversity and inclusion

Health Tree Foundation Trustees Committee

This committee is a formal sub-committee of the trust board, under the Trust Constitution Annex 7, Section 9.1.8. The membership is appointed by the board from among the non-executive and executive directors. The committee consists of these voting members: an Independent Chair, three NEDs, Group Chief Executive, Group Chief Medical Officer, Group Chief Nursing Officer, and Group Chief Financial Officer. It oversees and manages the affairs of the trust's charitable funds, the working name of which is the Health Tree Foundation. The committee ensures the charity acts within the terms of its declaration of trust, and all appropriate legislation on behalf of the trust board as the corporate trustee. This committee continues to meet as a separate committee and has not moved into a committees-in-common approach.

Board of Directors – Committees-in-Common attendance records 2025/26

Group (HUTH/NLaG)	Capital and major projects/ Strategic Programmes and Partnerships	Performance, estates and finance	Quality and safety	Workforce, education and culture
Number of meetings held	3	13	10	11
Murray Macdonald		1	2	
Sean Lyons				
Jonathan Lofthouse				
Lyn Simpson				
Julie Beilby			8	11
Tony Curry	2		9	9
Linda Jackson				
Jane Hawcard	3	10		
Laura Treadgold				7
Sue Liburd			8	8
Ivan McConnell	3			
Heather McNair			4	5
Simon Nearney				11
Simon Parkes	3	7		

Gill Ponder	3	12		
Matt Powls		5	4	
Emma Sayner	3	12		
David Sharif	3	11	8	11
Amanda Stanford			2	1
David Sulch			10	8
Sarah Tedford	2	6	1	
Clive Walsh		1		
Kate Wood			5	7
Helen Wright	3	11		
Tom Myers	3	12		

Notes to table:

- Not every board member is a member of every committee, although they do sometimes attend a committee for a specific item.
- Often when a committee member is unable to attend a meeting they will nominate another board member, or a deputy colleague, to attend on their behalf.

Cost allocation and charging

The trust has complied fully with the cost allocation and charging requirements as set out in HM Treasury and Office of Public Sector Information guidance.

Donations

As an NHS foundation trust, the trust makes no political or charitable donations. It has set up its own charity – the Health Tree Foundation (HTF) – and it continues to benefit from charitable donations received. HTF has continued to manage all the donations which the local public and businesses provided to help staff cope with the pandemic as well as other donations made to the trust.

Better Payment Practice Code

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

	2025/26		2024/25	
	Number	£000	Number	£000
Total Non -NHS trade invoices paid in the year	73,874	316,508	84,933	296,078
Total Non-NHS trade invoices paid within target	60,574	282,147	81,856	283,569
Percentage of Non-NHS trade invoices paid within target	82%	89%	96%	96%
Total NHS trade invoices paid in the year	2,285	41,033	2,361	33,931
Total NHS trade invoices paid within target	1,849	30,652	2,215	31,869
Percentage of NHS trade invoices paid within target	81%	75%	94%	94%

Income disclosures to auditors

The directors confirm that, as required by the Health and Social Care Act 2012, the income that the trust has received from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes. The trust has processes in place to ensure that this statutory requirement will be met in future years. The directors also confirm that the provision of goods and services for any other purposes are not materially impacted on our provision of goods and services for the purposes of the health service in England.

Statement as to disclosures to auditors

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

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

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

NHS England's well-led framework

The Trust's rating for well-led from the CQC was maintained as 'requires improvement' following the inspection report published in July 2022. The Annual Governance Statement later in this section of the report sets out in more detail how leadership and accountability is monitored by the trust and its directors. The trust is aware of the need to carry out externally facilitated developmental reviews of its leadership and governance and the value of that work in the context of the group development which started in 2023/24 and has continued into 2024/25.

Trust board approach to clinical governance

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

The effectiveness of the trust governance arrangements continued to be tested during 2024/25 via internal and external testing (including internally via the annual internal audit programme). An improvement plan is in place and ongoing in response to the findings and recommendations arising from those reviews, including agreed support.

Quality and patient safety are both monitored through assurance to the Quality and Safety Committees-in-Common and the Integrated Quality Improvement Group. The Group Patient

Safety and Learning Group and the Patient Experience Group, both operational, sit below the Board Committees.

Clinical governance comes under the remit of the Group Chief Nurse, in close collaboration with the Group Chief Medical Officer, and supported by Site Medical Directors, Site Directors of Nursing and Associate Directors of Quality Governance.

The trust is committed to improving patient safety and the Associate Director of Quality Governance is one of the trust Patient Safety Specialists as per the National Patient Safety Strategy, and continues to take forward the learning strategy to support the work on patient safety.

The trust ensures there is regular reporting to, and dialogue with NHS England, Integrated Care Board locality teams, and the Integrated Quality Improvement Group led by the Integrated Care Board. The trust's Quality Account annual report has been produced and consulted on with health and social care representatives in line with the national guidance, which sets out the progress made over the last year. The Quality Account is available on the Trust website. Work strengthening divisional governance continues, with an emphasis on specialty governance.

The Site Medical Directors, Site Directors of Nursing and the care group Chiefs of Service now have, authority and responsibility for quality, the use of resources (including staffing and finances), performance and governance, supported by the relevant nurse, midwife or allied health director and operational director roles. During the year, the role of Site Chief Executives has been introduced to lead the Site Triumvirate team with oversight of the care group teams. The Group Chief Executive, as the accounting officer for the trust, follows the procedures set out by NHS England in advising the board and the CoG and for recording and submitting objections to decisions.

Stakeholder relations

Collaborative working is continuing to be seen as crucial to delivering healthcare to local communities. The trust always tries to work in an open and honest way and it has a genuine desire to listen and act on feedback to improve services and our patients' experience. The trust works with numerous partners in the local 'health and care community' to continually progress services. These include GPs, community healthcare providers, social care providers, charities, ambulance services, mental health providers, local health Overview and Scrutiny Committees (OSCs) and the Place partnerships of the Humber and North Yorkshire Integrated Care Board (HNY ICB).

Stakeholders have been updated on this work through regular briefing sessions run in conjunction with local partners. Some of these sessions were held virtually and written updates have also been provided. Throughout the year representatives from the trust have regularly briefed local Members of Parliament (MPs) on what is happening within the trust. Members of the trust executive team also discussed other matters with local stakeholders including the trust's on-going response to the CQC action plan published in December 2022, the trust's performance in relation to ambulance handovers, reducing elective waiting lists, capital plans and updates on some possible service changes, particularly in relation to Goole and District Hospital.

Complaints

Both the PHSO and NHS England website outline that anyone has the right to make a complaint about any aspect of NHS care, treatment or service, and this is written into the NHS Constitution. The Group actively encourages feedback to enable it to understand our patient's journey, and the of receiving people's views and experiences, positive or negative is a cornerstone of our continued drive for improvement.

The Complaints team, based at Hull Royal Infirmary and Diana, Princess of Wales Hospital are a dedicated team of complaints facilitators and two complaints managers that support an individual to register their dissatisfaction and concern on a formal basis. This allow our Care Group, led by a Lead Investigator to undertake a thorough and systematic review of the issues that are raised. The aim is to achieve an early resolution addressing the concerns that the complaint that has registered.

The Patient Experience Team work as a single team with collaborative working between the two offices at both Trusts. In 2025-2026 the team have progressed to a single risk management system improving sharing of information between the two offices. The chart below shows comparative complaint data for the past displays five years complaint from April 2021 to March 2026.

Complaints Received HUTH/NLAG from 2021 to 2026

	Apr		May		Jun		Jul		Aug		Sep	
2021-2022	51	28	20	41	37	48	65	29	44	25	51	26
2022-2023	35	34	47	34	27	41	35	26	46	26	38	27
2023-2024	66	26	68	26	74	28	69	37	60	17	44	29
2024-2025	50	31	32	31	43	29	36	19	44	25	53	29
2025-2026	18	26	32	33	40	36	42	29	36	28	47	27
	220	145	199	165	221	182	247	140	230	121	233	138

	Oct		Nov		Dec		Jan		Feb		Mar		HUTH	NLaG	Total
2021-2022	36	37	49	41	37	20	37	40	31	27	43	34	501	396	897
2022-2023	41	20	22	29	41	21	55	29	50	29	67	24	504	340	844
2023-2024	76	36	52	31	29	21	27	25	32	28	38	29	635	333	968
2024-2025	40	30	29	40	37	22	33	29	30	39	27	28	454	352	806
2025-2026	51	20	56	26	36	19	31	47	35	45	26	43	450	379	829
	244	143	208	167	180	103	183	170	178	168	201	158	2544	1800	4344

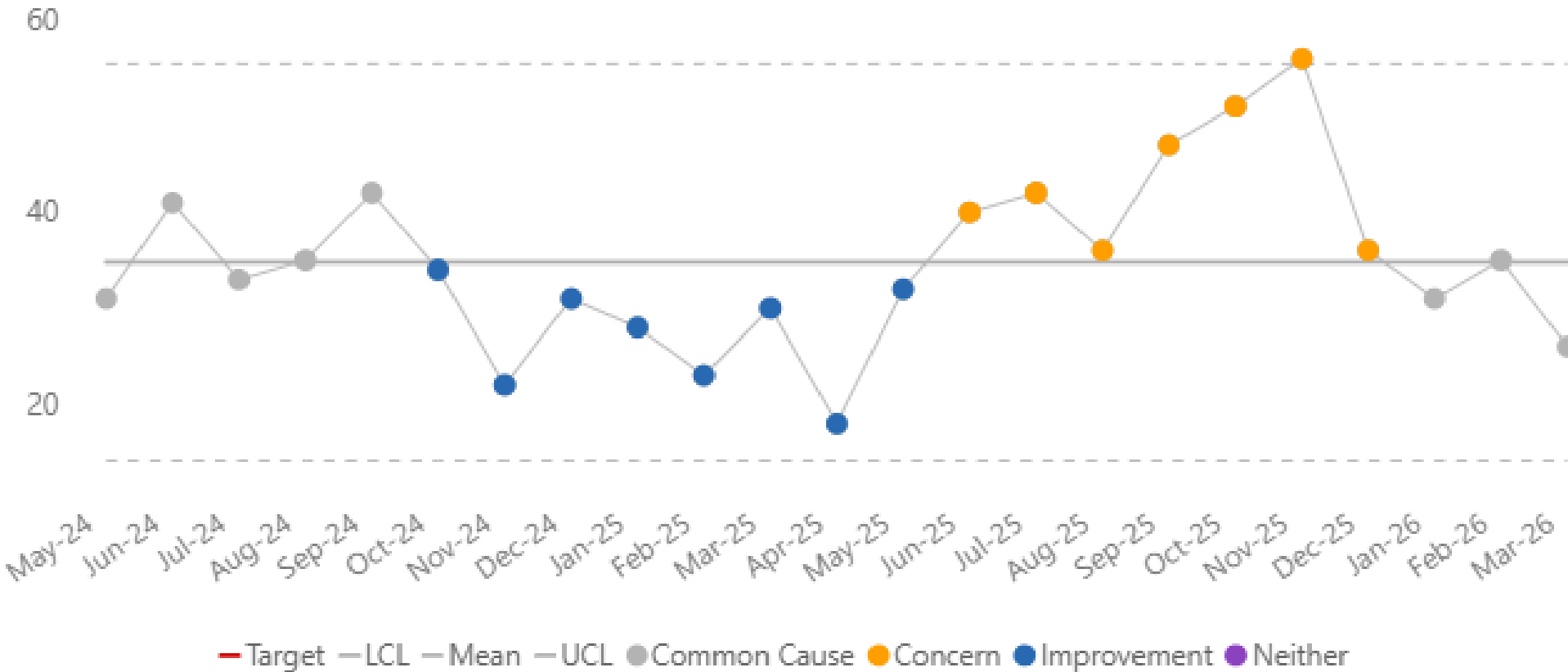
In 2025–2026, overall complaint volumes were broadly stable at Group level (829 vs 806; +2.9%), with a slight decrease in HUTH (450 vs 454; -0.9%) and a rise in NLaG (379 vs 352; +7.7%). The reduction in HUTH is consistent with strengthened early resolution, improved quality checking, and quicker implementation of actions, alongside the benefits of shared HUTH/NLaG approaches, including standardised templates and shared best practice, helping to limit escalation and repeat complaints.

The increase in NLaG is likely influenced by an increasingly complex caseloads and wider system pressures, particularly across community and integrated care pathways, with some services and elements of care delivered at alternative hospital sites compared with previous years.

HUTH Formal Complaints Received

SPC Chart

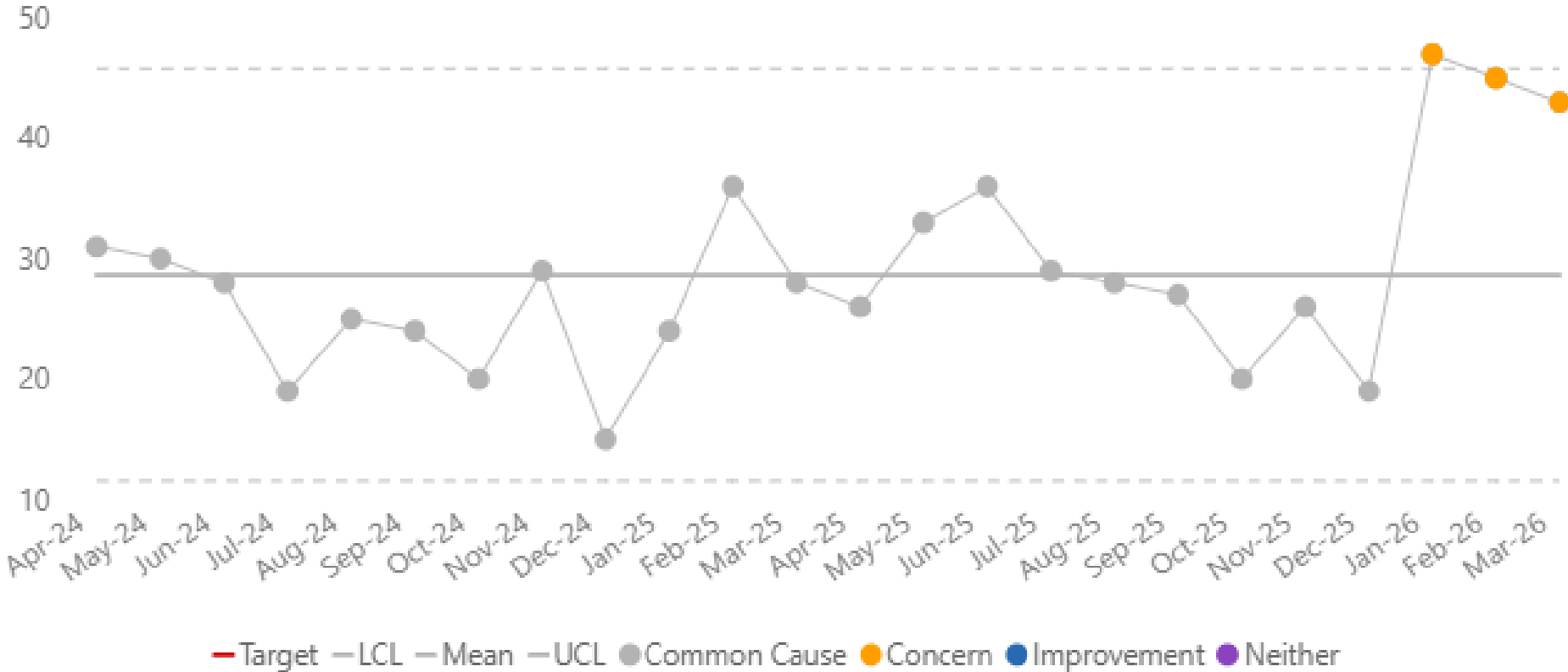
Complaints - Received



NLAG Formal Complaints Received

SPC Chart

Complaints - Received



HUTH – Formal Complaints (Annual)

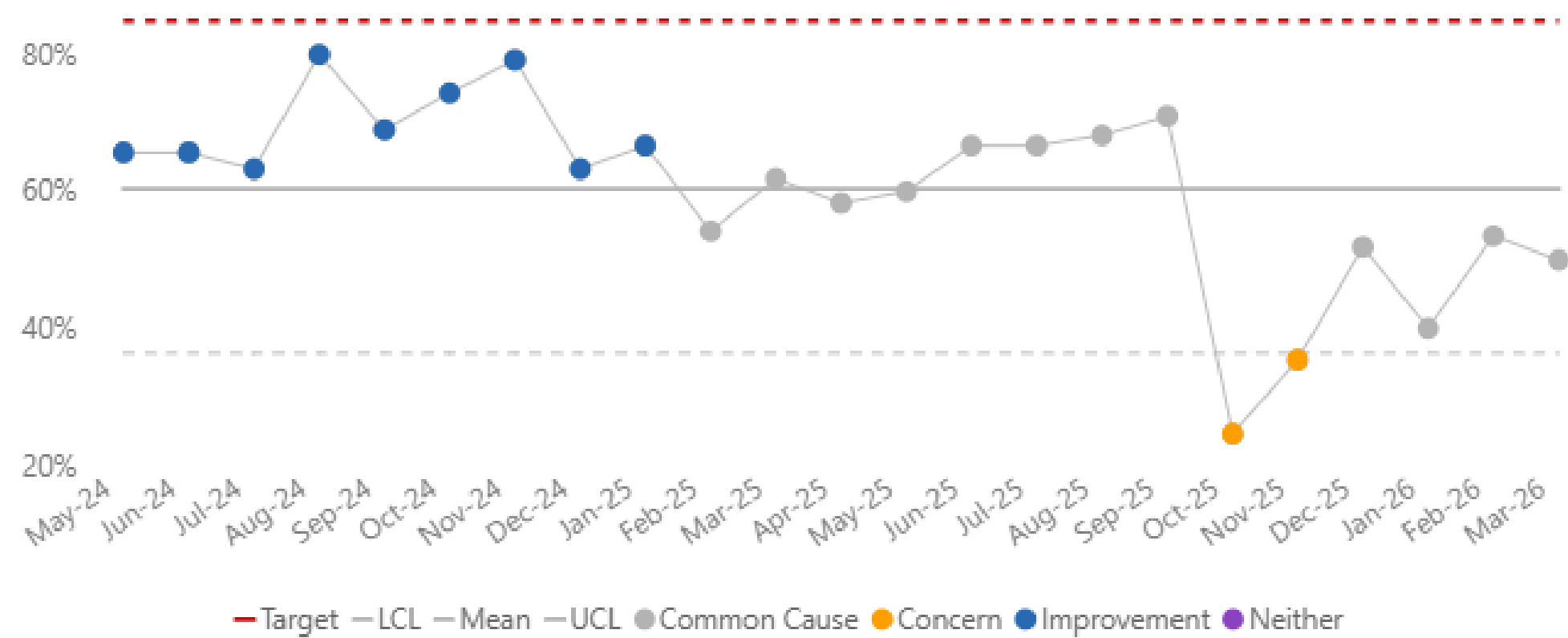
- HUTH received 450 formal complaints during 2025/26.
- Complaint volumes peaked in Quarter Three, aligning with increased PALS activity and winter operational pressures, before reducing in Quarter Four.
- Performance against the 60-working-day response KPI remained below the 85% target for much of the year but showed sustained improvement in the second half, reaching 50% compliance in Quarter Four.
- Quality checking processes and early resolution approaches contributed to reducing re-opened complaints and improving response quality.

Key Complaint Themes (HUTH – Annual):

- Treatment was the most frequent complaint theme overall.
- Delays and waiting times increased significantly over the year and represented over one-third of complaints by Quarter Four.
- Communication reduced markedly across the year, reflecting targeted improvement activity.
- Attitude emerged as a new complaint theme in the latter part of the year.
- Discharge-related concerns reduced proportionally over time.

SPC Chart

Complaints - 60 day compliance



NLaG – Formal Complaints (Annual Position)

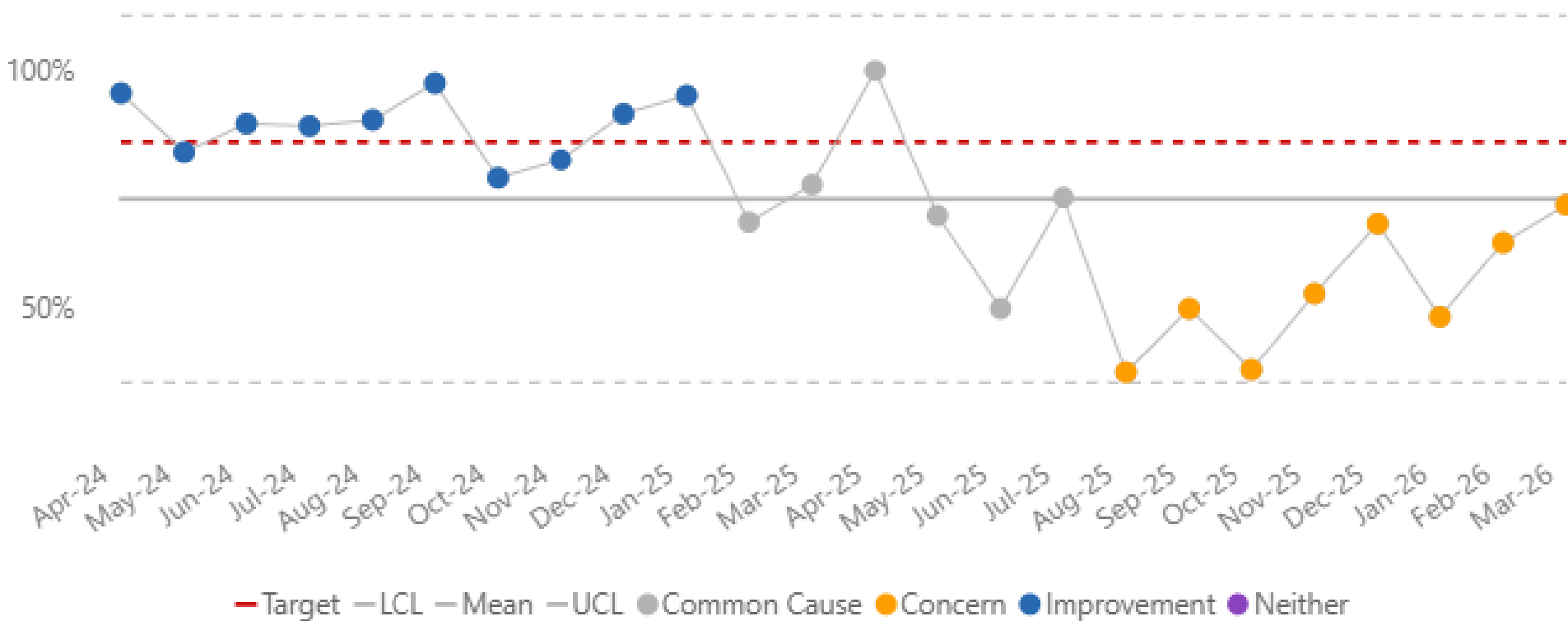
- NLaG received 379 formal complaints during 2025/26.
- Volumes reduced during Quarter Three before rising sharply in Quarter Four, coinciding with increased delay-related concerns.
- Performance against the 60-working-day response KPI improved steadily across the year, reaching 65% compliance in Quarter Four.
- Improvements in quality checking and response processes reduced re-opened complaints and strengthened overall complaint handling.

Key Complaint Themes (NLaG – Annual):

- Delays, waiting times and cancellations became the dominant theme by the end of the year, accounting for over 50% of complaints in Quarter Four.
- Treatment remained the second most common theme throughout the year.
- Communication and discharge reduced over time.
- Attitude emerged as a new but low-volume theme in the final quarter.

SPC Chart

Complaints - 60 day compliance



Patient Advice and Liaison Service (PALS)

HUTH – PALS (Annual)

- During 2025/26, HUTH received a total of 4,475 PALS contacts, of which 3,816 related to concerns.
- Demand for the service increased progressively across the year, with the highest volume in Quarter Four, reflecting sustained operational pressures and increased complexity of concerns.
- Performance against the 5-working-day response KPI remained below the 60% target across all quarters, with an annual average of approximately 48%. This reflects the increasing complexity of concerns, workforce vacancies and sickness within the Patient Experience team, and rising service demand.
- Average days to closure ranged between 9 and 13 days, with complexity (rather than volume alone) being the main driver for extended handling times.

Key PALS Themes (HUTH – Annual):

- **Delays, waiting times and cancellations** remained the dominant theme throughout the year.
- **Treatment** and **nursing care** consistently featured as the second most common theme.
- **Communication** fluctuated across the year, peaking during periods of heightened pressure and reducing later in the year following targeted improvement work.
- **Staff attitude** and **discharge** remained lower-level but recurring themes.

There has been a marked increase in activity into the PALS service which is not reflected in SPC below. This is due to reduced resource within the team with manager and staff vacancies and sickness. This has caused an inability to keep up with workload and contacts.

This has created a current significant backlog for which the Associate Director of Quality Governance and Patient Experience Lead Nurse have developed a recovery plan for.

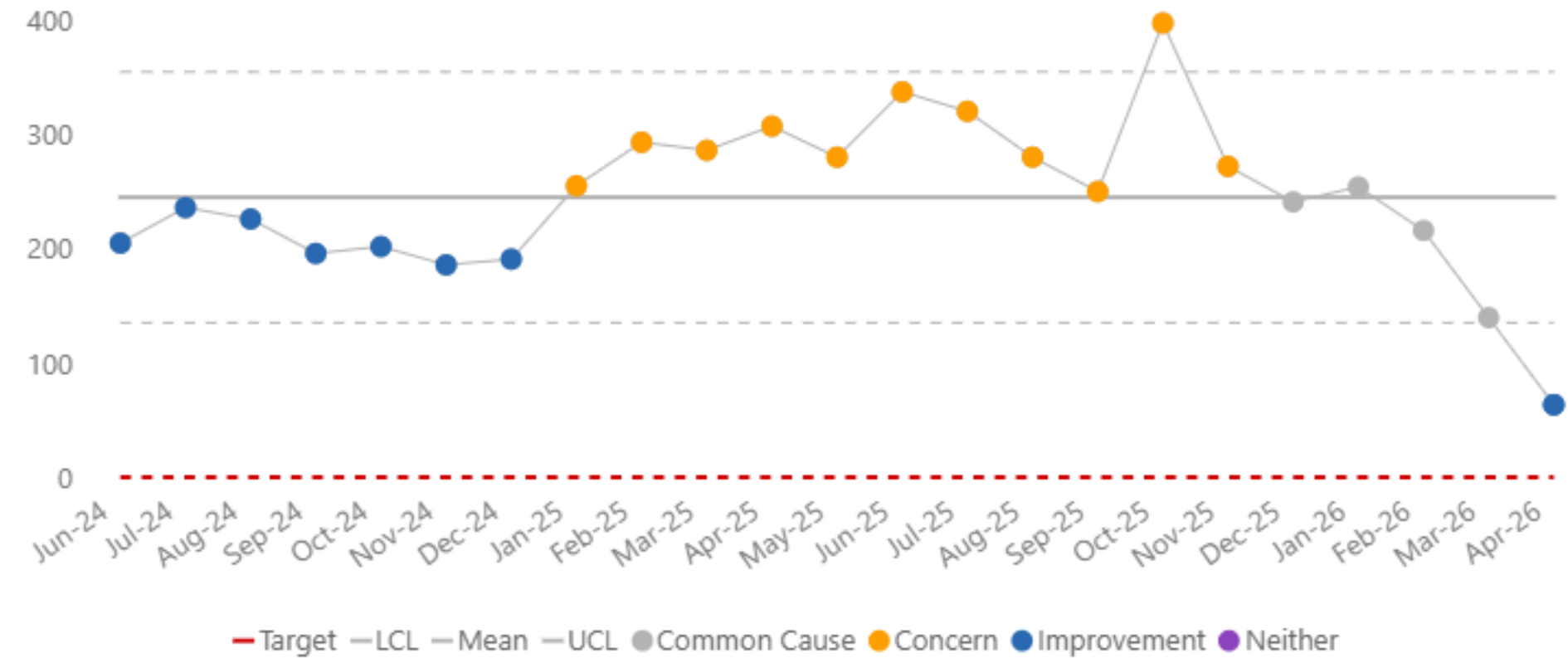
In addition, Patient Experience staffing vacancies are being recruited to and a replacement Patient Experience Manager is due to start early June.

This is likely to cause a significant rise in PALS numbers in the early part of FY2026-2027 as the recovery plan is implemented and the backlog addressed. The number of formal complaints may also increase as the recovery plan for PALS is completed, as a number of PALS concerns or enquires are usually converted to formal complaints following management review.

HUTH PALS Received (concerns only)

SPC Chart

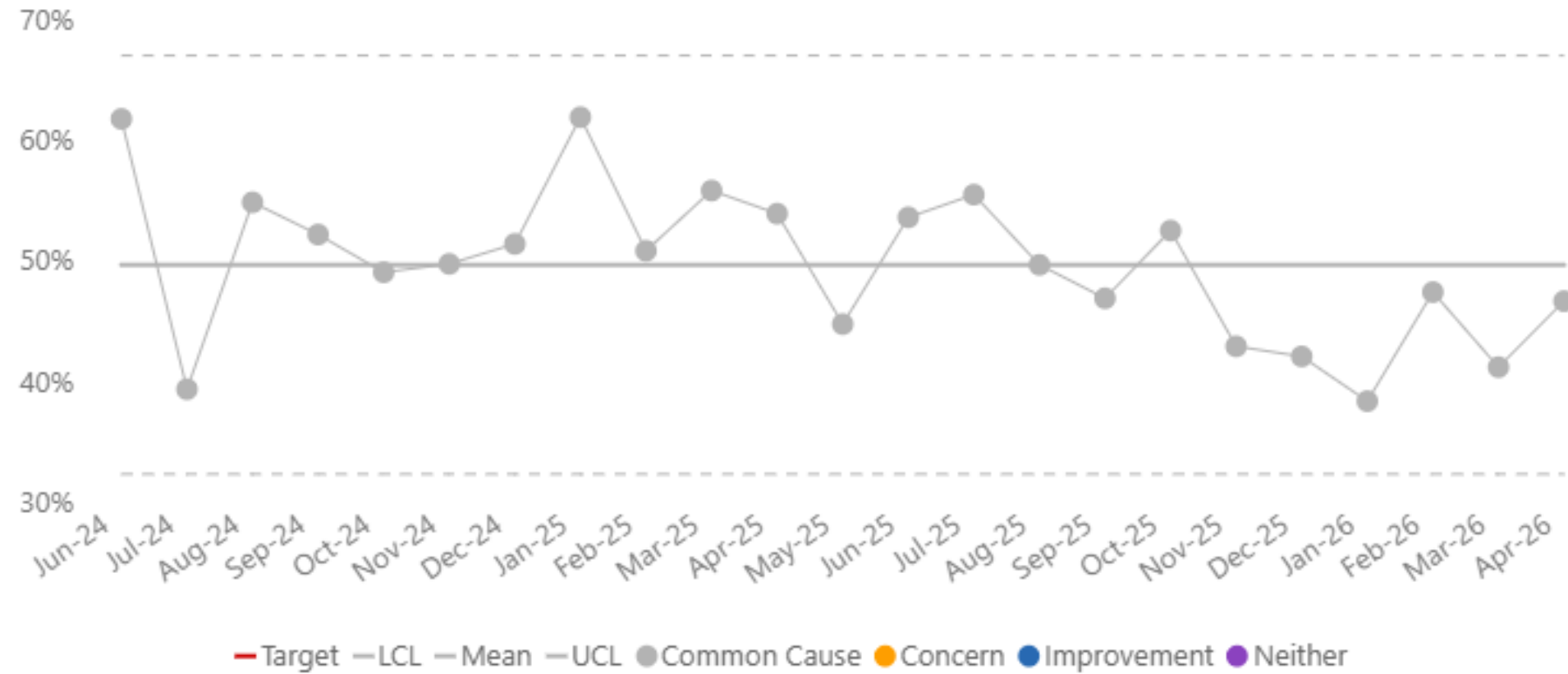
PALS - Complaints



HUTH PALS Closed (concerns only)

SPC Chart

PALS - Complaints compliance within 5 working days



NLaG – PALS (Annual)

- During 2025/26, NLaG received 4,267 PALS contacts, of which 2,898 were concerns.
- PALS activity remained high and consistent across the year, with improved resilience in Quarter Four.
- Performance against the 5-working-day response KPI averaged approximately 62%, meeting or exceeding the 60% target in several quarters, including Quarter Two and Quarter Four.
- Average days to closure ranged between 7 and 9 days, reflecting comparatively lower handling times despite increasing complexity.

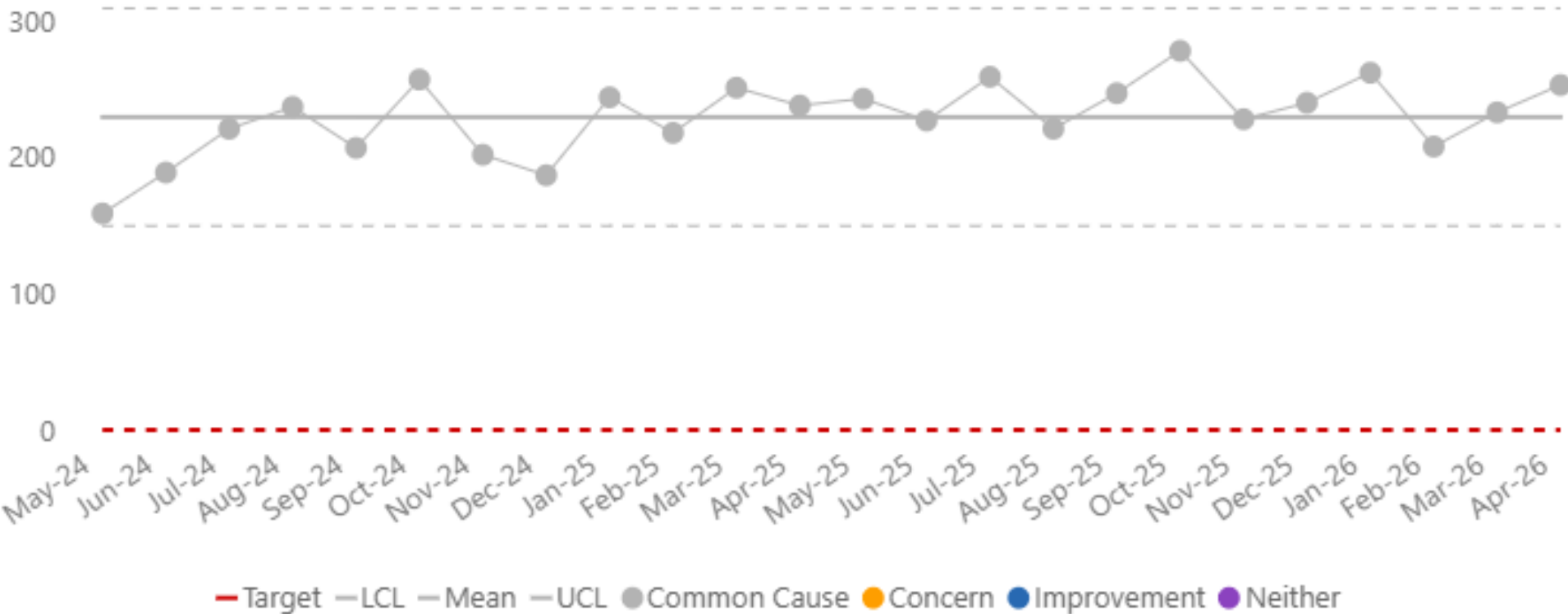
Key PALS Themes (NLaG – Annual):

- **Communication and nursing care & treatment** were dominant in the first half of the year.
- **Delays and waiting times** increased significantly in the latter half of the year, particularly during winter pressures.
- **Lost property** emerged as a new theme in Quarter Four.
- **Treatment-only concerns** reduced proportionally over the year.

NLAG PALS Received (concerns only)

SPC Chart

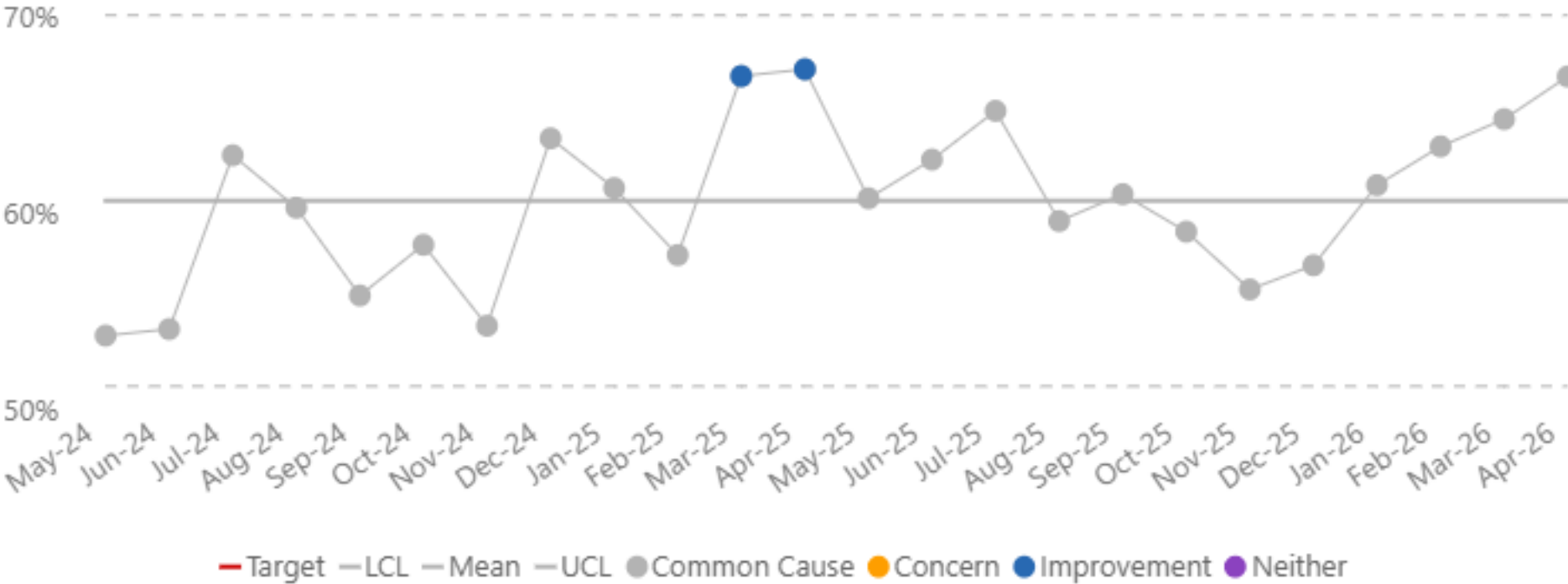
PALS - Complaints



NLAG PALS Closed (concerns only)

SPC Chart

PALS - Complaints compliance within 5 working days



Learning from Complaints and PALS

Across both Trusts, feedback from complaints and PALS consistently highlights delays and waiting times, treatment quality, and communication as the main drivers of patient and family concerns. These themes remain closely aligned, reflecting shared pressures across services and care pathways.

Learning from complaints and PALS continues to inform improvement activity across the Group, including:

- the use of early resolution approaches and proactive contact with patients and families
- targeted Care Group quality improvement (QI) initiatives focused on identified themes
- ongoing strengthening of complaint response quality, assurance and oversight processes

The Learning from Complaints and PALS Improvement Programme continues to be embedded across Care Groups, supporting the translation of patient feedback into measurable service improvements and sustained learning during periods of operational pressure.

Sharing Learning and Themes

Learning from complaints and PALS is shared through a structured and consistent governance framework to ensure visibility, accountability and action at all levels of the organisation. This includes:

- patient stories presented at Board and relevant governance forums to reinforce patient-centred learning
- monthly Patient Experience Group (PEG) meetings, beginning with a patient story to ground discussions in lived experience
- regular Directorate and Care Group meetings, supported by the Patient Experience Team, to track progress and review actions
- dissemination of learning through Directorate Clinical Governance and sub-specialty meetings
- quarterly reporting to the Quality and Safety Committee and the Quality Governance Group
- sharing themes and learning with external partners, including Integrated Care Boards, where appropriate

This approach ensures that learning from patient feedback is embedded from ward to Board level and continues to support service improvement, assurance and a culture of listening and learning across the Humber Health Partnership.

Patient Experience & Engagement

Following last year's annual report we agreed number of key actions for HUTH/ NLAG were agreed. The outcome of these is shown in Appendix 1.

There have been several initiatives and achievements which the Patient Experience team have been involved with, led by our Lead Nurse, Patient Experience Manager and the wider team, these are discussed below.

Collaborative Interpretation & Translation Project

During the year, Humber Health Partnership worked collaboratively on the provision of interpretation and translation services, recognising the critical role that effective communication plays in delivering safe, compassionate and equitable care. A joint procurement approach was undertaken on behalf of Northern Lincolnshire and Goole NHS Foundation Trust, Hull University Teaching Hospitals NHS Trust, and York and Scarborough Teaching Hospitals NHS Foundation Trust, with Humber Teaching NHS Foundation Trust participating. This approach aimed to ensure consistency of standards, quality and patient experience across participating organisations.

The project was designed to ensure that patients, carers and families who do not speak, read or write English, or who have communication needs including hearing, speech or learning impairments, receive appropriate support and reasonable adjustments. This includes access to face-to-face interpreting, written translation and information in accessible formats, supporting patients to understand information, participate in decisions and feel heard throughout their care journey.

A key objective of the collaborative approach was to work with a managed service provider to deliver a reliable, high-quality interpretation service that maintains a positive user experience while supporting service transformation and long-term sustainability. Quality requirements were embedded within the specification, including assurances around interpreter vetting, information governance, system compatibility and performance monitoring, reflecting a strong focus on safety, dignity and trust.

Social value and equality considerations were integral to the programme, aligning with organisational commitments to equal opportunity, wellbeing and tackling inequality. The tender placed explicit emphasis on quality assurance, recruitment, training and development of interpreters, alongside innovation and service improvement, helping to ensure that future delivery is responsive to patient feedback and evolving needs.

The project is expected to reach completion in early summer, with a new provider commencing service provision shortly thereafter. Next year's report will provide an update on the effectiveness and impact of the joint procurement approach.

Improving Access to Patient Feedback for Deaf and Hard of Hearing People

As part of our ongoing commitment to inclusive and accessible patient experience engagement, work is underway to pilot an online British Sign Language (BSL) patient feedback form, led by the ICB. This project has been developed in recognition that standard written feedback routes can

present barriers for Deaf and hard of hearing people, potentially limiting their ability to share experiences and influence service improvement.

The pilot aims to provide Deaf BSL users with a more accessible, appropriate route to give feedback directly about their care and experiences across our services. The form has been co-designed with a focus on clarity, confidentiality, and usability, and includes carefully considered demographic questions to support understanding of health inequalities while ensuring anonymity and compliance with data protection requirements. This will enable insight not only into individual experiences, but also into broader themes affecting Deaf communities.

At the time of reporting, the online form has been developed and is under review as part of a wider engagement programme. Next steps include incorporating feedback from local Deaf community partners, finalising supporting guidance and BSL video content, agreeing Equality, Diversity and Inclusion monitoring questions, and planning appropriate branding and communications ahead of launch. Work is also progressing to identify qualified BSL interpreters to support filmed content and to agree monitoring and reporting routes to ensure learning is shared and acted upon.

Once live, feedback received through this route will be monitored alongside existing complaints, PALS and Friends and Family Test data, with insights reported through established patient experience governance structures. Learning will be shared with services and fed back to Deaf patients wherever possible, supporting our ambition to improve accessibility, communication and equity of experience.

Enhancing Digital Feedback through Ulysses Integration

Alongside work to improve accessibility for specific communities, ongoing work is progressing with Ulysses, the Organisation's risk management system provider, to modernise and simplify how patient feedback is captured across our services. This programme of work focuses on developing an integrated feedback form embedded directly within the Trust's websites, enabling patients, families and carers to share feedback more easily and intuitively.

The integrated form is being designed to allow feedback submitted via our web pages to self-populate directly into the Ulysses system, removing the need for manual re-entry and reducing the risk of delays, duplication or transcription errors.

The form will support the full range of patient feedback, including complaints, PALS enquiries and compliments, and will include a clear consent facility so individuals can indicate how their feedback may be used and whether they are happy to be contacted. This represents a significant step forward in creating a more transparent, efficient and user-friendly feedback process for the general public.

By streamlining access and removing unnecessary barriers, this approach is expected to encourage greater use of compliments and positive feedback routes, ensuring that learning and recognition of good practice is captured more consistently alongside concerns. It also supports our wider digital and patient experience ambitions by aligning feedback capture with modern user expectations and improving system integration.

The next phase of work will focus on staff experience, specifically how colleagues can share patient compliments quickly and easily within Ulysses as part of their everyday workflow. This will

explore options for a simple, time-efficient process that enables staff to record compliments without additional administrative burden, ensuring that positive feedback is visible, valued and shared with teams while saving staff time.

Together, these developments will support a more balanced, accessible and efficient patient feedback system, strengthening how we listen, learn and celebrate good care across the organisation.

Interpretation Service

Hull University Teaching Hospitals (HUTH) continued its partnership with LanguageLine Solutions Ltd, whilst the collaboration project was undertaken. This has provided professional interpreter services since 2018. These services are available 24/7 and include:

- On-demand interpretation via telephone or video
- Face-to-face interpreter bookings
- Document translation services

To support video interpretation, the Trust uses Interpreter on Wheels (IOW)—mobile stands equipped with iPads running the InSight app. These devices allow clinical staff to connect directly with interpreters in the required language. A total of 64 IOW devices is currently deployed across Hull Royal Infirmary and Castle Hill Hospital.

Face-to-Face Interpretation

Between 1 April 2025 and 31 March 2026, HUTH staff made 3,437 face-to-face interpreter requests, including:

- 2,859 during office hours
- 578 out-of-hours

Top 5 Languages Requested:

1. Polish
2. Romanian
3. British Sign Language (BSL)
4. Arabic (Modern Standard)
5. Kurdish (Sorani)

Audio/Video Interpretation

A total of **23,057 interpretation calls** were made through LanguageLine, up from **21,269** the previous year:

- 18,299 audio calls
- 4,758 video calls (including 118 BSL sessions)

Top 5 Languages Requested:

1. Romanian

2. Polish
3. Kurdish (Sorani)
4. Arabic (Modern Standard)
5. Spanish

Northern Lincolnshire and Goole (NLAG) continued to support inclusive communication by offering both face-to-face and audio/video interpretation services.

Face-to-Face Interpretation

- 247 requests were made, up from 193 the previous year.
- Managed by the PALS Team, ensuring smooth coordination, including short-notice and special requests.
- Top 5 languages: 1. Romanian, 2. Polish, 3. Lithuanian, 4. Bengali, 5. Russian.
- 48 British Sign Language (BSL) requests were fulfilled, including hand-on-hand interpretation, up from 34 last year.
- Cancellations were efficiently managed to avoid unnecessary costs.

Audio/Video Interpretation (via LanguageLine)

- 7,695 calls made (up from 6,890), including:
 - 7,092 audio calls
 - 603 video calls (25 for BSL)

Accessed via phone, tablets (Insight App), or 42 Interpreter on Wheels (IOWs) across Grimsby, Scunthorpe, and community sites.

Top 5 languages:

1. Romanian
2. Polish
3. Bengali
4. Lithuanian
5. Sorani

These services continue to play a vital role in ensuring equitable access to healthcare for patients with language or communication needs and ensure patient safety.

National and Local Patient Surveys

Children & Young Persons 2024 (CYP24 - HUTH) – Published May 2025

Hull University Teaching Hospitals NHS Trust participated in the 2024 Children and Young People's Patient Experience Survey, commissioned by the Care Quality Commission and delivered by Picker. The survey gathered feedback from children, young people and their parents/carers, with 226 responses received, a rate broadly comparable with national benchmarks.

Overall findings showed that patient experience was largely in line with other NHS trusts. Strengths included clean, age-appropriate environments, quiet wards at night, overnight accommodation for parents, good food options, and clear written discharge information, supporting a positive inpatient experience.

Areas for improvement focused on communication, particularly explanations following procedures, information during waiting times, and clarity around discharge and next steps. Parents and carers also highlighted the importance of consistent information, emotional support, and greater play and engagement activities for children.

These findings have informed clear improvement priorities, including strengthening communication, enhancing discharge and aftercare, improving emotional support, reducing waiting times, and promoting child-centred engagement. An action plan will be developed with the Family Services Care Group to ensure feedback continues to drive compassionate, family-centred care.

Children & Young Persons 2024 (CYP24 - NLaG) – Published May 2025

Northern Lincolnshire and Goole NHS Foundation Trust participated in the 2024 Children and Young People's Patient Experience Survey, commissioned by the Care Quality Commission and delivered by Picker. The survey captured feedback from children, young people and their parents/carers, with 154 responses received (13% response rate).

Overall results showed that experience was largely in line with national expectations, with most questions scoring as expected when compared with other trusts. Strengths included friendly and approachable staff, positive ward environments, reasonable waiting times, good access to food, and children being kept occupied during waits, contributing to reassuring care experiences.

Areas for improvement focused on communication and discharge clarity, pain management, staff availability, Wi-Fi access, and greater play and engagement opportunities during hospital stays. Parents and carers also highlighted the need for clearer written information and improved access to staff when needed.

These findings have informed clear improvement priorities, including strengthening communication, improving discharge information, enhancing pain management and digital access, and increasing play and engagement provision. An action plan will be developed with the Family Services Care Group to ensure feedback continues to drive child-centred, supportive care.

Maternity 2025 (MAT25 - HUTH) – Published December 2025

Hull University Teaching Hospitals NHS Trust participated in the 2025 CQC NHS Maternity Survey, which gathered feedback from people who gave birth in early 2025. A total of 120 responses were received, representing a 40% response rate, in line with the national average.

Overall results showed that maternity experience at the Trust was predominantly in line with other NHS trusts, with most survey questions scoring as expected and no statistically significant year-on-year deterioration. Key strengths included staff availability and responsiveness, pain management following birth, concerns being taken seriously during labour, and timely discharge, reflecting positive staff engagement and supportive inpatient care.

Opportunities for improvement related mainly to communication and choice earlier in pregnancy, partner presence following birth, waiting times in triage, and staff awareness of antenatal history. These themes highlight areas for improvement in information, flow and family-inclusive care rather than clinical safety concerns.

These findings have informed targeted improvement priorities focusing on clearer antenatal information and decision-making, improved triage flow and expectation-setting, and reviewing barriers to partner involvement after birth. An action plan will be developed with the Care Group to ensure continued improvement in maternity experience and patient-centred care.

Maternity 2025 (MAT25 - NLaG) – Published December 2025

Northern Lincolnshire and Goole NHS Foundation Trust participated in the 2025 CQC NHS Maternity Survey, capturing feedback from people who gave birth in early 2025. A total of 132 responses were received, representing a 44% response rate, above the national average.

Overall findings showed that maternity experience was broadly in line with national performance, with stable and consistent results across maternity pathways. Key strengths included partner presence on the postnatal ward, positive triage experiences, continuity of postnatal care at home, access to infant feeding support, and useful antenatal information, all comparing favourably with national averages.

Areas for improvement related to discharge processes, continuity and communication during labour and birth, staff awareness of medical history, and teamworking when responding to concerns, highlighting opportunities to strengthen coordination and communication rather than clinical safety issues.

These findings have informed focused improvement priorities, including streamlining discharge planning, strengthening information-sharing and teamworking, and embedding consistent responses to service user concerns. An action plan will be developed with the Care Group, supported by staff feedback and engagement with Maternity Voices Partnership, to drive continued improvement in maternity experience and patient-centred care.

Local Surveys

Local surveys are conducted throughout the Hospitals by individual Wards and Departments; however, the Patient Experience Team and Patient Experience Learning Group provide a central supportive role. This is to ensure appropriate feedback and data is gathered in a uniformed and consistent approach, so all wards and departments are receiving valuable and relevant information about their areas.

A Standard Operating Procedure and supporting documents is available to all Care Groups and provide service guidance on who can support with their surveys – Audit, Care Group Governance or Patient Experience for example.

Friends and Family Test (FFT)

Across 2025/26, Friends and Family Test (FFT) feedback across Humber Health Partnership (Hull University Teaching Hospitals and Northern Lincolnshire and Goole NHS Foundation Trust)

remained consistently positive, with patients continuing to report good experiences of care across the majority of services.

Overall, FFT performance demonstrates strong patient satisfaction across inpatient, outpatient and community services, although response volumes reduced during the year due to a combination of operational pressures and changes to data collection methods. These reductions do not indicate a decline in care quality but reflect system and methodological changes.

Response Rates and Trends

Response volumes varied significantly across the year:

- At HUTH, Quarter 1 recorded a high volume of responses, followed by a marked reduction in Quarters 2 and 3 due to the end of the external FFT contract and transition to an internally managed system.
- Response rates began to recover in Quarter 4 following the introduction of QR codes, electronic data collection methods and revised engagement approaches.
- At NLAG, responses peaked in Quarter 1 and then reduced progressively across the year. This decrease was most evident during Quarter 3 and Quarter 4 and is primarily attributable to winter pressures, service demand and ongoing challenges with data collection systems, particularly within maternity services.

Patient Experience (Positivity Scores)

Despite fluctuations in response volumes, positivity scores remained strong:

- HUTH maintained consistently high positive feedback, with approximately 92–93% of patients reporting a positive experience across the year.
- NLAG reported strong performance at the start of the year (over 91% positive), with a gradual reduction to approximately 88–89% by Quarter 4, reflecting increased operational pressures during winter months.
- Overall, patient experience across both Trusts remained above national expectations in most service areas.

Performance by Service Area

Emergency Departments (A&E)

FFT feedback for Emergency Departments remained below the national target of 85% across both Trusts throughout the year. This reflects sustained system pressures, including high demand and flow challenges. However, there were some local improvements during the year, particularly within NLAG.

Inpatient Services - consistently achieved strong results

HUTH maintained approximately 93% positive feedback, slightly below the national target of 95%.

NLAG consistently exceeded the national standard, achieving 97–99% positive feedback throughout the year.

Outpatient Services - across both Trusts performed well

HUTH achieved approximately 95% positive feedback, with slight improvement over the year.

NLAG maintained high performance at 95–98%, consistently meeting or exceeding national expectations.

Community Services (NLAG only)

Community services maintained excellent performance, with 98–99% positive feedback reported consistently across all quarters.

Maternity Services

FFT data for maternity services remained limited and inconsistent across both Trusts. This reflects national challenges with FFT collection in maternity services, compounded locally by technical constraints, including the inability to collect SMS feedback through BadgerNet at NLAG. This remains a key area for improvement in data quality.

Thematic Analysis

FFT feedback themes remained consistent throughout the year.

Top Positive Themes

- Staff attitude and compassion
- Quality of care and treatment
- Communication with patients

Top Negative Themes

- Waiting times and delays, particularly in urgent and emergency care
- Communication gaps, particularly where delays occur
- Environment and facilities in some areas
- These themes align closely with those identified through PALS and complaints data, providing a consistent triangulated view of patient experience.

Key Developments During the Year

Significant changes to FFT collection and methodology were implemented:

- Transition from external providers to an in-house FFT model at HUTH
- Introduction of digital feedback methods including QR codes and handheld devices
- Continued use of external provider systems at NLAG, with plans for future transition
- Increased focus on improving accessibility and capturing feedback from harder-to-reach patient groups

These developments are expected to improve both response rates and data quality going forward.

Overall Annual Position

FFT data for 2025/26 demonstrates that patient experience across Humber Health Partnership remains consistently positive, with the majority of patients reporting good or very good experiences of care.

While response rates declined during the year due to operational pressures and changes in data collection processes, early signs of recovery are evident following the introduction of new digital approaches.

Key priorities for 2026/27 include:

- Increasing FFT response rates across all services
- Improving patient experience within Emergency Departments
- Addressing data collection challenges within maternity services
- Embedding consistent, Group-wide FFT collection and reporting processes

Governors' Report

Council of Governors

As a Foundation Trust, the Trust has a Council of Governors. The Board of the Trust is directly responsible for the performance and success of the Trust and satisfying the Council of Governors that the Board is achieving its aims and fulfilling its statutory obligations. Governors act as a link to the local community and report matters of concern raised with them, to the Board, via their quarterly Council of Governor business meetings.

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

The Health and Care Act 2022 expands, clarifies and adds to the Governor roles and responsibilities contained within the National Health Service Act 2006 and the Health and Social Care Act 2012 as detailed in the following sub-sections.

Role of Governors

The Council of Governors has a number of statutory roles and responsibilities, which are set out in a document called the Trust Constitution. These are:

- Appoint and, if appropriate, remove the Chair
- Appoint and if appropriate, remove the other Non-Executive Directors
- Decide the remuneration and other terms and conditions of office of the Chair and other Non-Executive Directors
- Approve (or not) the new appointment of a Chief Executive
- Approve and if appropriate, remove the Trust's auditor
- Receive the Trust's Annual Report and Accounts at a general meeting of the Council of Governors
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Trust's Board of Directors for Trust performance and its contribution to

the delivery of the objectives for the Humber and North Yorkshire Integrated Care Board (ICS) (with the implementation of the Health and Care Act 2022)

- Represent the interests of the members of the Trust, and public
- Approve Significant Transactions as defined by NHS England (NHSE) guidance
- Approve an application by the Trust to enter into a merger or acquisition
- Approve amendments to the Trust Constitution.

A key Governor responsibility is to represent the interests of the members of the Trust as a whole, and the interests of the public across the Trust's constituencies and now includes the 'public at large' across the ICS. As per the addendum to the 'Your Statutory Duties – Reference Guide for NHS Foundation Trust Governors - System Working and Collaboration: The Role of Foundation Trusts Council of Governors'.

The Council of Governors take the lead in agreeing with the Audit, Risk and Governance Committees-in-Common (NLaG specific), the criteria for appointing, re-appointing and removing external auditors. When an external auditor's appointment is ended in disputed circumstances, the Chair will write to NHSE informing it of the reasons behind the decision.

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

Members of the Council of Governors during 2025/26

Name	Initial date elected	Date re-elected	Term of office	Term of office ends	Date of retirement	Political party
Public Governors – East and West Lindsey						
Jenny Aspinwall	14.11.24		3 years	14.11.27	14.06.25	
Jeremy Baskett	19.04.16	17.05.22	3.5 years	17.11.25		
Dr Gorajala Vijayasimhulu	14.11.23		3 years	14.11.26		
Public Governors - Goole and Howdenshire						
Dietmar Harteveld	14.11.25		3 years	14.11.28		
Brent Huntington	14.11.24		3 years	14.11.27		
Rob Pickersgill	03.12.15	16.11.24	1 year	16.11.25		
Clare Woodard	14.11.24		3 years	14.11.27		
Public Governors – North East Lincolnshire						
Diana Barnes	22.10.19	22.10.22	3 years	22.10.25		
Mike Bateson	21.11.22	14.11.25	3 years	14.11.28		
Cheryl George	14.11.25		3 years	14.11.28		
David James	14.11.23		3 years	14.11.26		
Ian Reekie	16.11.18	14.11.24	3 years	16.11.27		
Vacancy						
Public Governors – North Lincolnshire						
Kevin Allen	13.10.20	14.11.23	3 years	14.10.26		
Paula Ashcroft	14.11.23		3 years	14.11.26		
Marian Davison	14.11.25		3 years	14.11.28		
Wendy Lawtey	14.11.24		3 years	14.11.27		
Caroline Ridgway	14.11.23		3 years	14.11.26		

Members of the Council of Governors during 2025/26 continued

Name	Initial date elected	Date re-elected	Term of office	Term of office ends	Date of retirement	Political party
Staff Governors						
Ahmed Aftab	13.10.20	14.11.23	3 years	14.11.26		
Corrin Manaley	14.11.23		3 years	14.11.26		
Dr Sandeep Saxena	14.11.24		2 years	14.11.26		
Jackie Weavill	14.11.24		3 years	14.11.27		
Stakeholder Governors						
Vacancy – Lincolnshire Council						
Vacancy – North East Lincolnshire Place						
Emma Munday – North Lincolnshire Place	30.09.22	30.09.25	3 years	30.09.28		
Cllr Paul Henderson – North East Lincolnshire Council	23.05.24	14.05.25	1 year	14.05.26	22.12.25	
Cllr David Howard – East Riding of Yorkshire Council	17.07.23		2 years	17.07.25	16.06.25	
Cllr Linda Bayram – East Riding of Yorkshire Council	24.06.25		1 year	24.06.26	08.03.26	Conservative
Cllr Anne Handley – East Riding of Yorkshire Council	09.03.26		1 year	09.03.27		Conservative
Vacancy – North Lincolnshire Council						

Composition of the Council of Governors and Council of Governors meetings

The Council of Governors comprises of the following constituencies:

Elected Public Governors

The Council of Governors now has 16 Governors elected from its public membership that represent the four main catchment areas of the Trust. This was amended following updates to the Trust Constitution in January 2023 to reflect general updates and changes resultant from the Health and Care Act 2022. Overall, there remains 26 Governor seats on the Council of Governors.

Public Governors are elected from within local authority areas. The number of Governors for each constituency is in proportion to the population within the area using NLaG services, as detailed below:

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

Elected Staff Governors

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

Appointed Stakeholder Governors

The Trust has a further six stakeholder Governors seats who are appointed by local partners or stakeholder organisations.

Annual elections ending November 2025

The Annual Governor elections were held in November 2025 as a result of four Governors reaching the end of their term of office and vacant seats. The election resulted in one public Governor re-elected and one new Governor elected for a term of three years for North East Lincolnshire. The public Governor elections were contested for Goole and Howdenshire and North Lincolnshire with one new public Governor for each constituency also elected for a term of three years. There were no vacant seats for staff Governors in this election.

Council of Governor meetings

The Council of Governors meets sufficiently regularly to discharge its duties. During the year April 1 2025 to March 31 2026 attendance at meetings was as follows:

Council of Governor meetings (held in person or virtually)

	Business	Business	Business	Annual Members Meeting	Business	Business	Annual Review Meeting	Extraordinary Business	TOTAL
Name	16.04	17.07	21.08	22.10	05.11	08.01	25.02	31.03	
Public Governors – East and West Lindsey									
Jenny Aspinwall	A								0/1
Jeremy Baskett	P	A	P	P	P				4/5
Dr Gorajala Vijay	P	P	A	P	A	P	P	P	6/8
Public Governors – Goole and Howdenshire									
Dietmar Harteveld						A	A	P	1/3
Brent Huntington	P	P	P	P	P	P	P	P	8/8
Rob Pickersgill	P	P	P	P	A				4/5
Clare Woodard	P	P	P	A	A	P	P	P	6/8
Public Governors – North East Lincolnshire									
Diana Barnes	P	P	P	P	A				4/5
Mike Bateson	P	P	P	P	P	P	P	P	8/8
Cheryl George						P	P	P	3/3
David James	P	P	P	P	A	P	A	P	6/8
Ian Reekie	P	P	P	P	P	P	P	P	8/8
Public Governors – North Lincolnshire									
Kevin Allen	P	P	P	P	P	P	P	A	7/8
Paula Ashcroft	A	A	A	P	A	A	A	A	1/8
Marian Davison						P	P	P	3/3
Wendy Lawtey	P	P	P	A	P	P	A	P	6/8
Caroline Ridgway	P	P	A	A	P	A	P	A	4/8
Staff Governors									
Ahmed Aftab	A	P	P	P	A	P	A	P	5/8
Corrin Manaley	P	P	P	P	P	A	A	A	5/8
Dr Sandeep Saxena	P	P	A	P	A	P	P	P	6/8
Jackie Weavill	P	P	P	P	A	P	P	P	7/8
Stakeholder Governors									
Emma Munday – NL Place	P	A	P	A	P	A	P	A	4/8
Cllr David Howard – ERY Council	P								1/1
Cllr Linda Bayram – ERY Council		P	P	A	A	A	A		2/6
Cllr Anne Handley – ERY Council								P	1/1
Cllr Paul Henderson – NEL Council	P	A	A	P	A				2/5

Key

- A – Absent
- P – Present
- NL – North Lincolnshire
- NEL – North East Lincolnshire
- ERY – East Riding of Yorkshire during the year April 1 2025 to March 31

2026 attendance by Executive and Non-Executive Directors at the Council of Governor meetings was as follows:

	Business	Business	Business	Annual Members Meeting	Business	Business	Annual Review Meeting	Extraordinary Business	TOTAL
Name	16.04	17.07	21.08	22.10	05.11	08.01	25.02	31.03	
Julie Beilby - NED	P	P	P	P	P	P	P	N/A	7/7
Andy Haywood - Group Chief Strategy, Partnerships & Digital Officer				P	A*	P	N/A		2/3
Linda Jackson - Vice Chair	P	A	P						2/3
Jonathan Lofthouse – Group Chief Executive	A*								0/1
Sue Liburd - NED	P	P	P	P	P	P			6/6
Sean Lyons - Group Chair	P	P	P						3/3
Murray Macdonald – Interim Group Chair				P	P	P	P	P	5/5
Murray Macdonald – Associate NED	A	P	P						2/3
Ivan McConnell - Group Chief Strategy and Partnerships Officer	P	P						N/A	2/2
Heather McNair – Interim Group Chief Nurse		A				P	N/A		1/2
Simon Nearney – Group Chief People Officer	P	P	N/A	P	P	A	N/A		4/5
Simon Parkes - NED	A	P	P	A	A	A			2/6
Gill Ponder – Senior Independent Director	P	P	P	P	P	P	P	N/A	7/7

Matt Powls – Interim Group Chief Delivery Officer					A	A	N/A	N/A	0/2
Emma Sayner - Group Chief Financial Officer	P	P	N/A	P	A*	P	N/A	N/A	4/5
David Sharif – Group Director of Assurance	P	P	P	P	P	A*	P	P	7/8
Lyn Simpson – Interim Group Chief Executive			P	P	P	P	N/A	N/A	4/4
Amanda Stanford – Acting Group Chief Executive	A*	P							1/2
Amanda Stanford – Group Chief Nurse			N/A	A	A				0/2
Sarah Tedford – Interim Group Chief Delivery Officer & Site Chief Executive - South	A	A	N/A	A					0/3
Clive Walsh – Site Chief Executive - North	A								0/1
Dr Kate Wood – Group Chief Medical Officer	P	P	N/A	P	A	P	N/A	N/A	4/5

Key

- P - Present
- A - Absent
- A* - Representative Attendance
- N/A - Attendance not required

Lead Governor

NHS England requires that each Council of Governors elects a Lead Governor to be the primary link with the Foundation Trust. A Lead Governor is elected by the full Council and would also be the formal link to NHSE if circumstances required direct communication between the Council of Governors and the regulator. Ian Reekie, a public Governor for North East Lincolnshire was re-elected as Lead Governor from 21 November, 2024.

Governor engagement

There are typically four Council of Governors business meetings and a Council of Governors Annual Members' Meeting held in public each year. Members of the Trust Board are invited to attend each meeting which includes reports from the Group Chair, the Group Chief Executive, the Lead Governor and from Non-Executive Director Chairs of the Trust Boards Committees-in-Common. A review of the collective performance of the Council of Governors is held annually and this year was held in February. The review is led by the Group Chair, supported by the Group Director of Assurance and the Deputy Director of Assurance, and utilises a framework document that incorporates NHS England's Code of Governance.

The Council of Governors has an active and vibrant working group called the Membership and Public Engagement & Assurance Group which has incorporated the Governor Assurance Group, the Membership & Patient Engagement Group, Quality Review Group and Staff Governor Working Group. In addition to this, Governors also have an Appointments and Remuneration Committee. NHS England requires foundation trusts to provide forward planning for each financial year, prepared by the Board of Directors. Governors are consulted on the development of these plans and are able to input views from the members they represent.

Governors are supported and involved in many aspects of the Trust including undertaking Patient Led Assessments of the Care Environment (PLACE) visits, along with ward accreditation programmes such as ACE – A Commitment to Excellence effective March to September 2025 and assist in the preparation of Care Quality Commission Inspections by undertaking ‘mock inspections’ with members of staff.

The Group Chair offers Governors one-to-one meetings and invites them to take up these opportunities, along with undertaking the Annual Developmental Governor Reviews, where they are encouraged to attend Trust Board meetings. During the course of the year Governors have also received Governor and Non-Executive Director briefings and training sessions, with or without the Executive Directors in attendance, where they receive detailed updates and are able to discuss matters amongst themselves.

Six such briefings were held during 2025/26 on topical health matters which included:

- Trust Priorities 2025-26 and Operational Plan 2025-26
- NHS Providers – GovernWell – NHS Finance & Business Skills
- Patient Communication
- National Oversight Framework
- Neighbourhood Health & Clinical Strategy
- NHS Provider Improvement Programme – Governor Focus Group

Additional briefings within the Council of Governor meetings were held during 2025/26 on topical matters which included:

- Transformation & Sustainability
- National Staff Survey Summary
- Patient Experience
- Community Diagnostic Centres
- Neighbourhood Healthcare Services Update
- Scunthorpe General Hospital Ward 5 Flow
- Improvement Plan and Learning from the Group Structure and Care Groups
- Group Strategy and Alignment with Associated Strategies
- Goole and District Hospital Update
- Digital Update
- Quality & Safety Priorities

Governors supported a series of communications with members and the public via drop-in sessions at each hospital site, the Trust website, social media platforms, news releases, posters and e-mails.

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

Governors have an important role in making an NHS Foundation Trust accountable for the services it provides. They bring valuable perspectives and contributions to its activities.

Governors are expected to hold Non-Executive Directors to account for the performance of the Trust Board of Directors and the following sets out the principles of how Governors discharge this responsibility:

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

The Council has established a policy for engagement with the Board of Directors for those circumstances when they have concerns. At no time during 2025/26 has the Council of Governors exercised its formal power to require a Non-Executive Director to attend a Council meeting and account for the performance of the Trust.

Non-Executive Directors are invited to attend all Council of Governors meetings based on the Trust Board Committees-in Common Chair role they hold. Governors can hold them to account at any of the sessions as required and appropriate. The Council of Governors is satisfied with its interaction and relationship with the board of directors and that it is appropriate and effective.

Appraisal and appointment

The Council of Governors has an Appointments and Remuneration Committee for the appointment of Non-Executive Directors (including the Chair, Vice Chair, Senior Independent Director and Associate Non-Executive Director (Vice Chair at HUTH)). The Committee has delegated authority to consider these appointments on behalf of the Council of Governors and provide advice and recommendations to the full Council in respect of these matters. The Committee periodically reviews the process to be followed for the appointment of the Chair, Vice Chair, Senior Independent Director and Non-Executive Directors, including the means by which views will be obtained from the Trust Board on the qualifications, skills and experiences required for each position when considering potential candidates.

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

It also considers and makes recommendations to the Council of Governors for the reappointment of the Lead Governor. The Council will only exercise its power to remove the Group Chair or any

Non-Executive Director after exhausting all means of engagement with the Board. The Group Chair and other Non-Executive Director appraisals for 2025/26 have been undertaken and reported to the full Council. The Chairman's appraisal is carried out by the Senior Independent Director.

Key items discussed in 2025/26 at the Council of Governor meetings

Various key items were discussed by the Council of Governors during the year and briefings detailed above were incorporated into the meetings. Additional items included:

- Feedback from:
 - Membership and Public Engagement & Assurance Group (MPEAG)
 - Appointments & Remuneration Committee (ARC)
- Reports from Board Committees-in-Common:
 - Audit, Risk and Governance Committee
 - Capital and Major Projects Committee
 - Performance, Estates and Finance Committee
 - Quality and Safety Committee
 - Workforce, Education and Culture Committee

Membership Report

As of 24 March 2026, the trust has 3,452 public members. These members must live within one of the four constituencies and be aged 16 or above. All staff are also offered the opportunity to be enrolled as members, when they start their employment with the trust.

From February 2024 to March 2024 a refresh of the membership numbers took place to remove all those members who did not respond to a postal survey about their membership or who had decided to opt out. This reduced the public membership numbers considerably compared to previous years but it does mean the trust is now clear it can communicate, and engage with, those members remaining on the database.

The Trust's public membership for 2025/26 is set out below.

	2025/26
Public members	3,452
Minimum of public members required under the Trust Constitution	1,400
Staff members	5,939

The tables below provide a detailed breakdown.

Age group – public members	Number	Percentage of members	Percentage of the total population served by the trust
0 to 16	0	0	
17 to 21	81	2.35%	
22 +	3206	92.97%	
DoB not stated	165	4.78%	
Total	3,452	100	

Breakdown by constituency

Constituency	Male	Female	Total
Goole and Howdenshire	136	277	217
North East Lincolnshire	414	1,102	1,495
North Lincolnshire	789	431	1,182
East and West Lindsey	84	217	297
Staff	1,122	4,817	5,939
Total	2,545	6,844	9,130

Breakdown by ethnicity

Ethnicity	Number	Percentage of members	Population	Percentage of population served by the trust
White	3,198	92.65%	372,737	97.63
Mixed	16	0.46%	1,854	0.49
Asian or Asian British	80	2.31%	5,529	1.45
Black or Black British	41	1.19%	882	0.23
Other	6	0.17%	786	0.21
Not stated	111	3.22%	0	0
Total	3452	100	381,788	100

Keeping in touch with members

Ensuring effective two-way communication with our members, via a combination of trust and governor managed formal and informal communications, is very important to our organisation. We issue a 'welcome' email or letter to all new members, which provides an outline of the trust and what we do.

During the 2025/26 year the trust sent a regular newsletter to those members who remained on the membership database. This email was distributed primarily through emails but was also sent through the post to those members who has expressed a preference for receiving it this way. In late 2025 this newsletter was sent out bi-monthly.

The trust's communications team manages the development and distribution of the newsletter and will be working with governors on the content throughout 2026/27 and beyond as part of the refreshed member and public engagement approach which is currently in development at the time of writing.

As well as the newsletter the trust will also be making information available to members and, by extension, the wider public through other means including:

- The trust website which includes a designated section for members and information for the public who may wish to become members in the future
- Face-to-face through informal governor drop-in sessions which give people the chance to speak to Governors in private about any issues they may have
- Face-to-face with local residents, groups and patients
- The trust's and group's social media accounts on Facebook.
- Engagement events which provide members with an opportunity to listen to presentations and debate the hot topics of the day
- A regular members' survey
- Governors continue to hold regular informal engagement sessions to meet with their constituents on-site at our hospitals (and off-site if pre-arranged). These sessions are used to survey the views of patients and visitors
- Other informal engagement mechanisms are also utilised by Governors in their local constituencies to gather public and patient views and provide updates as required.

Remuneration Report

Introduction

The Remuneration Committee-in-Common is jointly run between NLaG and HUTH and came into being from January 2024. The terms of reference focus on the remuneration of each member of the executive team individually, using principles set out in its internal document 'Principles for determining pay and conditions for CEO and Executives'. This included factors such as performance, NHS salary guidance, internal relativities, market consideration and comprehensive benchmarking. Remuneration levels of other staff groups within the trust, and in the wider NHS, were also taken into consideration. The key decisions made on senior managers' remuneration in 2025/26 were agreement of:

- Consideration of individual redundancy requests as part of isolated elements of organisational change.
- Agreement of a Group level Mutually Agreed Resignation Scheme (MARS)
- Agreement to extend Interim roles to cover structures gaps
- Review of pay uplift requests
- Amendments to the committee terms of reference

Non-Executive Directors' remuneration

The overarching policy for the remuneration of the NEDs is to award levels of remuneration in line with other comparable NHS foundation trusts, using benchmarked figures from a number of sources. The work of the committee is also in line with the requirement of paragraph 18(2) of Schedule 7 of the National Health and Social Care Act 2006. The Council of Governors' Appointment and Remuneration Committee decides on Non-Executive Director pay and terms and conditions.

Senior managers' remuneration policy

All Directors' performance is subject to an annual appraisal, the outcome of which was reported to the Remuneration Committees-in-Common by the Group Chief Executive. This is prior to any decision being made on executive remuneration. The Chief Executive's appraisal is usually reviewed by the Remuneration Committees-in-Common, but this has not been undertaken in 2025/26 due to the Chief Executive Officer starting with the Group mid-way through the financial year. The annual appraisal method is chosen as it is an effective way to assess performance against a range of performance targets and leadership responsibilities and includes feedback from NEDs. In coming to any decision on remuneration, the committees-in-common takes account of the circumstances of the group, the size and complexity of the role, any changes in the director's portfolio, the performance of the individual and any appropriate national guidance.

Senior managers are remunerated based on these decisions. In considering senior managers pay the committee has used the NHS Improvement Senior Managers benchmarking tool and guidance framework from 2018/19 onwards. Final decisions on any recommendation to uplift remuneration are taken by the committees-in-common. It also took note of the requirement to consider any pay above a threshold of £150,000. This is a requirement from the Secretary of State in respect of salaries higher than that of the national salary of the Prime Minister. All salaries above this threshold have been sanctioned in this way. Where applicable, director-level contracts of employment include provisions for payments in lieu of notice and claw-back in line with national guidance. Also, any severance payment that requires NHSE approval, obtains that approval prior to payment.

Policy tables

This section describes the policy narrative relating to the components of the remuneration packages for senior managers (Executive and Non-Executive Directors). Each of the components detailed in those tables supports the trust in terms of its long-term strategic objectives. Setting and reviewing pay is not a simple matter. It is vital to recruit and retain talent and to operate the pay system fairly; but it is also necessary to have a robust process for reviewing remuneration and to be able to demonstrate sensible use of public money. In the case of executive jobs the Remuneration Committees-in-Common made the decision that from 2018/19 job evaluation and remuneration of Senior and Very Senior Managers would be conducted using the NHS Improvement *‘Guidance on the pay for very senior managers in NHS trusts and foundation trusts’* tool. The hospital group is identified as a Supra Large Acute for the purpose of this tool. The trust also includes a performance discussion at the same time as the annual review of roles and salary but does not apply a performance related pay process.

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

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

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

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

Remuneration policy for Non-Executive Directors

Remuneration of the Chair and Non-Executive Directors for 2024/25 is as follows and is undertaken by the Council of Governors' Appointments and Remuneration Committee (ARC):

Name	Salary 2025/26	Salary 2024/25
Sean Lyons *	£37,500	£37,500
Murray Macdonald**	£37,500	£13,000
Linda Jackson	£19,354	£19,354
Stuart Hall	£13,000	£13,000
Susan Liburd	£13,735	£13,735
Julie Beilby	£13,735	£13,735
Simon Parkes	£16,133	£16,133
Gillian Ponder	£16,133	£16,133

*Joint Trust Chair with Hull University Teaching Hospitals (50%) until October 2025

**Joint Trust Interim Chair with Hull University Teaching Hospitals (50%) from November 2025

Future Policy Table for Non-Executive Directors

Element	Policy
Fee payable	They receive a base allowance for six days per month
Additional fees	They can claim a subsistence allowance
% uplift (cost of living increase)	This is reviewed, although not always applied
Travel	Appropriate travel expenses are paid for business miles
Uplift	Chair of the Audit, Risk and Governance Committees-in-Common receive an uplift for being chair
Uplift	An uplift is received for undertaking the role of Senior Independent NED

Performance and appraisal of the Executive Directors

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

Service contract obligations

HM Treasury has issued specific guidance on severance payments within 'Managing Public Money' and special severance payments when staff leave requires Treasury approval. Alongside this the trust observes NHS Improvement 'Guidance on pay for very senior managers in NHS Trusts and Foundation Trusts' which was published in March 2018. There are no contractual provisions for payments on termination of contract. This is the case on a substantive or interim basis.

Policy on payments for loss of office

There is currently no provision within the Remuneration Policy for payment for loss of office on senior managers contracts.

Statement of consideration of employment conditions elsewhere in the Trust

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

Policy on notice periods

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

Signature:



Alan Downey

Chair

Date: 18 June 2026

Annual report on remuneration

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

- The Remuneration Committee-in-Common
- The Appointments and Remuneration Committee

The Remuneration Committees-in-Common

The Remuneration Committees-in-Common was established in accordance with the Trust Constitution for the purpose of setting the remuneration of executive directors of the board and those reporting directly to the Group Chief Executive.

It is responsible for determining the pay and terms of service for executive directors and is accountable to, and reports directly to, the board. The key objective is to ensure that remuneration packages are sufficient to attract, retain and motivate executive directors of the quality required for the successful operation of the group, while avoiding paying excessively for this purpose. Remuneration includes pay, all contractual terms and conditions, pensions and redundancy or settlement entitlements.

The committees-in-common is comprised of all NEDs. Other directors attend meetings or parts of meetings by invitation as required for specialist advice including the Group Chief Executive and Group Chief People Officer.

In accordance with NHSI’s Code of Governance no director is involved in deciding their remuneration.

The Remuneration Committees-in-Common is independent of the executive arm of the board.

The tables overleaf illustrate the attendees and their attendance at the committee meetings held between 1 April 2025 and 31 March 2026.

The first table shows the programmed meetings of the Remuneration Committees-in-Common and the second table shows the additional meetings held between 1 April 2025 and 31 March 2026.

Name	Title	23 April (EO)	28 May (EO)	17 June	6 Aug	2 Oct (EO)	21 Oct (EO)	20 Nov Cancelled	4 Feb 2026 Cancelled
Sean Lyons	Group Chair	X	✓	✓	✓	X	-	-	-
Linda Jackson	Vice Chair - NLaG	✓	X	X	✓	X	-	-	-
Murray MacDonald	Vice Chair - HUTH	✓	✓	✓	✓	✓	✓	-	-
Lyn Simpson	Interim Group Chief Executive (from 28.7.25)	-	-	-	✓	✓	✓	-	-
Amanda Stanford	Acting Group Chief Executive (from 1.4.25 to 27.7.25)	✓	X	X	✓	X	-	-	-
Julie Beilby	Non-Executive Director – NLaG	✓	✓	✓	✓	✓	✓	-	-
Jane Hawkard	Non-Executive Director - HUTH	X	✓	X	✓	X	✓	-	-
Tony Curry	Non-Executive Director – HUTH	✓	✓	✓	✓	✓	✓	-	-
Sue Liburd	Non-Executive Director – NLaG	✓	✓	✓	X	✓	X	-	-
Simon Parkes	Non-Executive Director – NLaG	✓	✓	X	✓	✓	✓	-	-
Gill Ponder	Non-Executive Director – NLaG	✓	✓	✓	✓	✓	✓	-	-
David Sulch	Non-Executive Director - HUTH	X	✓	X	X	✓	X	-	-
Prof Laura Treadgold	Non-Executive Director - HUTH	X	✓	✓	X	✓	X	-	-
Helen Wright	Non-Executive Director - HUTH	X	✓	✓	X	✓	✓	-	-
Simon Nearney	Group Chief People Officer	✓	✓	✓	X	✓	✓	-	-
David Sharif	Group Director of Assurance	✓	✓	✓	✓	✓	✓	-	-

Remuneration CiC Attendance – Additional Meetings 2025/26

Name	06.11.25	18.12.25	14.01.26	04.02.26	04.03.26	24.03.26	26.03.26
Murray Macdonald	✓	✓	✓	✓	✓	✓	✓
Julie Beilby	✓	✓	✓	✓	✓	✓	✓
Tony Curry	✓	✓	✓	✓	✓	✓	✓
Jane Hawkard	x	✓	✓	✓	x	✓	x
Sue Liburd	✓	✓	✓	-	-	-	-
Helen Marks	✓	✓	✓	✓	✓	✓	✓
Simon Parkes	x	✓	x	-	-	-	-
Gill Ponder	✓	✓	✓	✓	✓	✓	✓
David Sharif	✓	✓	N/A	N/A	N/A	N/A	N/A
Lyn Simpson	N/A	N/A	N/A	✓	✓	✓	N/A
David Sulch	x	✓	✓	✓	✓	✓	✓
Laura Treadgold	x	✓	x	-	-	-	-
Helen Wright	x	✓	x	-	-	-	-

Key:

- ✓ Present
- X Apologies
- N/A Not required
- - Meeting cancelled or member left the Group

Advice to the committee

External advice to the committee is provided by the NHS Improvement benchmarking tool and guidance for Senior and Very Senior Managers. NHS Improvement guidance provides both job evaluation and remuneration benchmarking from comparison of the size of the Trust, based on annual budget, against comparator trusts and groups of an equivalent size (budget).

Directors' contracts

Details of the contract start date for the Group Chief Executive and other members of the executive team who served during 2025/26 are set out in the table below and overleaf.

Name	Title	Date of contract	Notice period from the Trust	Notice period to the Trust
Lyn Simpson	Interim Group Chief Executive Officer	15/08/2025	Six months	Six months
Simon Nearney	Group Chief People Officer	21/08/2023	Three months	Three months
Emma Sayner	Group Chief Financial Officer	2/12/2024	Three months	Three months
Dr Kate Wood	Group Chief Medical Officer	01/11/2023	Three months	Three months
Heather McNair	Interim Group Chief Nurse	17/11/2025	Three months	Three months
Amanda Stanford	Group Chief Nurse	01/04/2024	Three months	Three months
Matt Powls	Interim Group Chief Delivery Officer	22/10/2025	Three months	Three months

Sam Peate	Group Chief Delivery Officer	01/03/2026	Three months	Three months
Tom Myers	Group Director of Estates, Facilities and Development	01/11/2024	Three months	Three months
Clive Walsh	Interim Site Director North	01/12/2024	Three months	Three months
Sarah Tedford	Interim Site Director South	01/12/2024	Three months	Three months
Ivan McConnell	Group Chief Strategy and Partnerships Officer	01/11/2023	Three months	Three months
David Sharif	Group Director of Assurance	04/03/2024	Three months	Three months

Details of the NEDs who have served during the course of 2025/26 are shown in the table below, along with details of their current terms of appointments. The tenure (length) of employment for NEDs is set out in the Trust's Constitution and is for three years, and then subject to reappointment. Any terms beyond six years are subject to rigorous review by the Council of Governors (CoG) and NEDs serving beyond this are subject to an annual reappointment.

Name	Appointment date	Start of current term	End of current term
Sean Lyons	01/02/2022	01/02/2022	31/01/2025
Linda Jackson	30/09/2014	01/04/2022	30/09/2025
Julie Beilby	10/10/24	10/10/24	09/10/2027
Susan Liburd	03/10/2022	03/10/2022	02/10/2025
Murray Macdonald	01/01/25	01/01/25	31/12/2027
Simon Parkes	07/09/2021	07/09/2021	06/09/2027
Gillian Ponder	12/04/2021	31/05/2023	31/05/2026

The Appointments and Remuneration Committee

The Appointments and Remuneration Committee (ARC) is a committee of the Council of Governors. It sets the remuneration and terms of service for the Non-Executive Directors (NEDs), and it plays a role in the appointment of NEDs. The attendance at the ARC is set out in the table below. There was one existing NLaG Associate Non-Executive Director/HUTH Non-Executive Director appointed to the Interim Group Chair position in 2025/26.

ARC attendance 2025/2026

	18/06/25	25/09/25	22/12/25	19/02/26	31/03/26	Total
Public / Staff Governor Members						
Ian Reekie (ARC Chair)	P	P	P	P	P	5 out of 5
Ahmed Aftab	P	P	A	A	A	2 out of 5
Jeremy Baskett	P	P				2 out of 2
Mike Bateson	P	P	P	P	P	5 out of 5
Dietmar Hartevelde			P	A	P	2 out of 3
David James	P	P	P	A	P	4 out of 5
Wendy Lawtey			P	P	P	3 out of 3
Rob Pickersgill	P	P				2 out of 2
Dr Gorajala Vijay				P	P	2 out of 2
In attendance						
Paul Bunyan (Director of Planning, Recruitment, Wellbeing and Improvement)	P	P	P	N/A	A	3 out of 4
Tony Curry (NED & SID for HUTH)			P			1 out of 1
Alison Hurley (Group Deputy Director of Assurance)		P			P	2 out of 2
Linda Jackson (Trust Vice Chair)	A	A				0 out of 2
Sean Lyons (Group Chair)	P	P				2 out of 2
Gill Ponder (NED and SID for NLaG)	P		P			2 out of 2
David Sharif (Group Director of Assurance)	P	A*	P	P	P	4 out of 5

Key

- A – Absent
- A* - Absent with representative present
- P – present

Directors and Governors expenses

	2025/26			2024/25		
	Total in office	Total receiving expenses	Total expenses £'s	Total in office	Total receiving expenses	Total expenses £'s
Directors	22	9	£13,849	21	11	£12,817
Governors	19	6	£528	19	7	£1,218

Remuneration of all other staff

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

For all local pay arrangements not determined by AfC, pay increases were consisted with AfC increases. A robust system of appraisal and personal development planning has been adopted for all staff.

A different approach is adopted in relation to the trust executive because all other staff are on national terms and conditions and the executive team members' remuneration is determined locally. AfC staff have clear incremental progression as set out by the national terms and conditions. Medical and dental staff are on a separate contractual agreement which also allows for incremental progression and the award of substantial additional payments for clinical excellence. They are also able to benefit from an annual cost of living award if this is agreed nationally.

Salaries are inclusive and the trust follows national guidance from NHS England on the review of cost-of-living awards.

Expenditure on consultancy

The Trust during 2025/26 has spent £1,632k on consultancy fees compared to £1,375k in the previous financial year.

Audited Directors' Remuneration 2025/26

Name	Title	Note	2025/26				2024/25			
			Salary (bands of 5,000) £000's	Benefits in Kind (£s to the nearest £100) £s	Pension related benefit (bands of £2,500) £000's	Total	Salary (bands of 5,000) £000's	Benefits in Kind (£s to the nearest £100) £s	Pension related benefit (bands of £2,500) £000's	Total
Mr M Macdonald	Interim Group Chair (from October 2025) and Non-Executive Director	2	£25-£30	-	-	£25-£30	£0-£5	-	-	£0-£5
Mr S Lyons	Group Chair (resigned October 2025)	2	£20-£25	-	-	£20-£25	£40-£45			£40-£45
Mrs L Simpson	Interim Group Chief Executive Officer (Appointed July 2025)	2	£90-£95	-	-	£90-£95	-	-	-	-
Mr JM Lofthouse	Group Chief Executive Officer (until January 2026)	2,3	£130-£135	-	-	£130-£135	£140-£145	-	-	£140-£145
Mrs A Stanford	Interim Group Chief Executive Officer and Group Chief Nurse (until November 2025)	2,4	£65-£70	-	-	£65-£70	-	-	-	-
Mr S Peate	Group Chief Delivery Officer	2	£5-£10	-	-	£5-£10	-	-	-	-

	(appointed March 2026)									
Mr M Powls	Group Chief Delivery Officer	2	£30-£35	-	-	£30-£35	-	-	-	-
Mrs S Tedford	Group Chief Delivery Officer	2,5	£85-£90	-	-	£85-£90	£60-65	-	-	£60-65
Mr P Bytheway	Group Chief Delivery Officer	2	-	-	-	-				
Mr S Stacey	Group Chief Delivery Officer (resigned May 2024)	2	-	-	-	-	£30-£35	-	-	£30-£35
Mr S Nearney	Group People Officer (resigned March 2026)	2	£85-£90	-	-	£85-£90	£85-£90	-	-	£85-£90
Mrs H McNair	Interim Group Chief Nurse (May to July 2025 and November 2025 to March 2026)	2	£60-£65	-	-	£60-£65	£90-£95	-	-	£90-£95
Dr KA Wood	Group Chief Medical Officer	1,2	£115 - £120	5985	-	£120-£125	£145-£150	4800	£125-£127.5	£280-£285
Mrs E Sayner	Group Chief Financial Officer	2	£100-£105	-	-	£100-£105	£30-£35	-	-	£30-£35
Mr M Brearley	Interim Group Chief Financial Officer (September 2024 to December 2024)	2	-	-	-	-	£30-£35	-	-	£30-£35
Mr L Bond	Group Chief Financial Officer (resigned September 2024)	2	-	-	-	-	£50-£55	-	-	£50-£55

Mr A Haywood	Interim Group Chief Strategy, Partnerships and Digital Officer (July 2025 to March 2026)	2	£55-£60	-	-	£55-£60	-	-	-	-
Mr IP McConnell	Group Chief Strategy, Partnerships and Digital Officer (resigned June 2025)	2	£15-£20	-	£5-£7.5	£25-£30	£80-£85	-	£47.5-£50	£130-£135
Mr D Sharif	Group Director of Assurance	2	£65-£70	-	-	£65-£70	£65-£70	-	-	£65-£70
Mrs H Gwilliams	Interim Group Chief Patient Safety Governance Officer	2	£10-£15	-	-	£10-£15	-	-	-	-
Mr S Hall	Associate Non Executive Director (resigned December 2024)		-	-	-	-	£5-£10	-	-	£5-£10
Mrs L Jackson	Group Vice Chair and Associate Non Executive Director (resigned September 2025)	2	£5-£10	-	-	£5-£10	£15-£20	-	-	£15-£20
Mrs J Bielby	Non Executive Director		£10-£15	-	-	£10-£15	£10-£15			£10-£15
Ms SP Liburd	Non Executive Director (Resigned January 2026)		£10-£15	-	-	£10-£15	£10-£15			£10-£15

Mr S Parkes	Non Executive Director (Resigned January 2026)		£10-£15	-	-	£10-£15	£15-£20	-	-	£15-£20
Mrs G Ponder	Non Executive Director (Resigned March 2026)		£15-£20	-	-	£15-£20	£15-£20			£15-£20
Mrs K Truscott	Non Executive Director (Resigned September 2024)		-	-	-	£5-£10	-	-	-	£5-£10
Gross Remuneration Including National Insurance and Pension Contribution			1,301	5,985	5	1,312	1,235	4,800	-	-

Note	2025/26	£000					
23	Banded remuneration of the highest paid director	£275 - £280					
	Change between years	(0.7%)					
		25 th percentile	Median	75 th percentile	25 th percentile	Median	75 th percentile
23	Pay and benefits excluding pension	26,600	33,500	46,600	24,200	30,000	45,000
23	Pay and benefits excluding pension: pay ratio for highest paid director	10.4	8.3	6.0	11.6	9.4	6.2
		Lowest	Highest		Lowest	Highest	
23	Range of remuneration for employees of the Trust as a whole	14,800	232,700		12,500	278,000	
		Average			Average		
24	Percentage change in average employee remuneration	4.1%			4.2%		
		Number			Number		
25	Number of employees that receive remuneration in excess of the highest paid director	0			0		

Key

1. benefit in kind relates to Lease Cars
2. Group roles as a joint appointment with Hull University Teaching Hospitals NHS Trust. The table above relates to remuneration for Northern Lincolnshire and Goole NHS Foundation Trust only, apart from the pension benefit which is the benefit of the group role.
3. Mr JM Lofthouse was Group Chief Executive until January 2026. He now works for NHS England but continues to be paid by the Group. The figures above include a payment for accrued leave.
4. Mrs A Stanford was Interim Group Chief Executive from April to July 2025 when she returned to her role of Group Chief Nurse until November 2025. Mrs A Stanford is currently on secondment with Humber and North Yorkshire Integrated Care Board.
5. Mrs S Tedford was Chief Executive South to July 2025 when she took up the Interim Group Chief Delivery Officer until October 2025
6. These Directors are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and March 2022 was moved back into the 1998/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.
7. NHS Foundation Trusts are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the lower quartile, median and upper quartile remuneration of the organisation's workforce.
The remuneration of the employee at the 25th percentile, media and 75th percentile is set out above. Total remuneration includes salary, benefits in kind, but not severance payments.
The pay ratio shows the relationship between the total pay and benefits of the highest paid director (excluding pension benefits) and each point in the remuneration range for the organisation's workforce.
The ratio is obtained by dividing the highest paid directors salary by the median salary, the 25th percentile salary and the 75th percentile salary.
The median remuneration is the middle item salary when the annualised salaries of all members of staff including agency and seconded staff (excluding bank staff and the highest paid director) are arranged in descending order.
The pay and benefits of the highest paid Director decreased by 0.7% in the year.
8. The percentage change in average employee remuneration is based on total for all employees on an annualised basis divided by full time equivalent number of employees.
9. The number of employees that received remuneration in excess of the highest paid director is based on the full time equivalent cost.

Audited Pension Benefits 2025/26

Name	Title	Real increase/ (decrease) in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2026 (bands of £5000) £000	Lump sum at pension age related to accrued pension at 31 March 2026 (bands of £5000) £000	Cash Equivalent Transfer Value at 1 April 2025	Real increase/ (decrease) in cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2026	Employer's contribution to stakeholder pension
Mrs L Simpson	Interim Group Chief Executive Officer	5.0 -7.5	-	15-20	-	-	-	-	-
Mrs A Stanford	Interim Group Chief Executive Officer and Group Chief Nurse	0-2.5	-	0-5	-	9	7	38	-
Mr JM Lofthouse	Group Chief Executive Officer	5.0-7.5	2.5-5.0	85-90	205-210	1,661	65	1,807	-
Dr KA Wood	Group Chief Medical Officer	-	-	85-90	210-215	2,090	-	2,006	-
Mrs E Sayner	Group Chief Financial Officer	5.0-7.5	17.5-20.0	45-50	120-125	877	149	1,050	-
Mr A Haywood	Interim Group Chief Strategy Partnership & Digital Officer	2.5-5.0	-	10-15	-	141	7	183	-
Mr IP McConnell	Interim Group Chief Strategy Partnership & Digital Officer	0-2.5	-	25-30	-	470	1	505	-
Mr S Nearney	Group Director of People	2.5-5	-	40-45	-	584	45	660	-
Mr D Sharif	Group Director of Assurance	2.5-5.0	-	20-25	20-25	327	30	378	-
Mr S Peate	Group Chief Delivery Officer	0-2.5	-	40-45	-	495	3	583	-
Mr M Powls	Interim Group Chief Delivery Officer	0-2.5	-	5-10	-	45	1	80	-
Mrs H McNair	Interim Group Chief Nurse	2.5-5.0	-	5-10	-	109	38	164	-

The Chair, Vice Chair and Non-Executive Directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for the Chairman and Non -Executives Directors.

Notes

The table above represents joint roles with Hull University Teaching Hospitals NHS Trust and is the total benefits for this role.

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by the pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves the scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their services in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

CETV figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2023/34 CETV figures.

Real increase in CETV

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

Pay Multiples – Fair-Pay Disclosures

(subject to audit)

Reporting bodies are required to disclose the relationship between the total remuneration of the highest-paid director / member in their organisation against the 25th percentile, median and 75th percentile of total remuneration of the organisation's workforce.

Total remuneration of the employee at the 25th percentile, median and 75th percentile is further broken down to disclose the salary component.

The banded remuneration of the highest paid director / member in Hull University Teaching Hospitals NHS Trust in the financial year 2025-26 was the Group Chief Executive Officer at £277,500 (2024-25: £282,500). This is a reduction of 1.77%. The relationship to the remuneration of the organisation's workforce is disclosed in the below tables.

Pay multiple table 2024/25 (subject to audit)

	2025/26 (£)	2024/25 (£)	2023/24 (£)
Median Pay	37,796	36,483	34,581
Pay Multiple	7.34	7.74	7.74
Average Pay	47,837	45,845	42,620
Average Pay (excluding highest paid Board member)	47,815	45,822	42,598
Highest paid Director – actual remuneration	279,156	281,138	267,750
Highest paid Director - (mid-point of the £5k band)	277,500	282,500	267,500
Highest paid employee – actual remuneration	377,758	277,371	297,930
Highest paid employee - (mid-point of the £5k band)	377,500	277,500	297,500
Change in median pay	3.60%	5.50%	-1.04%
Change in pay multiple	-5.18%	0.10%	24.27%
Change in average pay	4.34%	7.57%	2.02%
Change in average pay (excluding highest paid Board member)	4.35%	7.57%	2.01%
Change in highest paid Director pay	-1.77%	5.61%	22.99%
Range of staff remuneration	14,763-377,758	12,514-281,138	12,514 - 297,930

Pay ratio information table	2025/2026			2024/2025		
	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio	25th percentile pay ratio	Median pay ratio	75th percentile pay ratio
Total remuneration (£)	27,250	37,796	51,711	25,819	36,483	49,385
Salary component of total remuneration (£)	27,250	37,796	51,711	25,819	36,483	49,385
Performance pay and bonuses (£)	-	-	-	-	-	-
Pay ratio information (multiple)	10.2	7.3	5.4	10.9	7.7	5.7

The Trust's highest paid director's remuneration is 7.34 times the median remuneration of the workforce (2024/25: 7.74 times), which is £37,796 (2024/25: £36,483), 10.2 times greater than the 25th percentile remuneration (2024/25: 10.9 times) and 5.4 times greater than the 75th percentile remuneration (2024/25: 5.7 times).

The median level of remuneration has increased by 3.6% and the remuneration of the highest paid Director has decreased by 1.77%.

In 2024/25, 7 employees (2024/25: 0) received remuneration in excess of the highest paid director/member.

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

During 2025/26 the Trust spent £748k on consultancy fees (2024/25: £1,528k).

Cash Equivalent Transfer Values

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which disclosure applies. The CETV figures and the other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme.

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

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

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

Cash equivalent transfer value (CETV) figures are calculated using the guidance on discount rates for calculating unfunded public service contribution rates that was extant on 31 March 2023. HM Treasury published updated guidance on 27 April 2023; this guidance will be used in the calculation of 2025/26 CETV figures.

Real Increase in CETV

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

Signature:

A handwritten signature in black ink that reads "Lyn Simpson". The signature is written in a cursive, flowing style.

Lyn Simpson
Group Chief Executive
Date: 18 June 2026

Staff Report

Overview

Workforce highlights

Learning and Development

Over the past year, Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) has continued to strengthen its approach to learning, education and workforce development, supported by increasing collaboration across the NHS Humber Health Partnership. The Trust has focused on improving the quality, accessibility and consistency of education and training, ensuring staff are equipped with the skills required to deliver safe, high-quality care.

Collaborative Group Learning and Development Service

A key focus during 2025/26 has been the continued development of a collaborative Group Learning and Development service, bringing together education, simulation, organisational development, library and knowledge services across the Partnership.

This collaborative model has strengthened access to shared expertise, reduced duplication, and supported more consistent delivery of education and training.

Working together at Group level enables services to respond more effectively to workforce challenges, align learning to clinical risk and service priorities, and maximise the impact of available resources.

Learning Environment and Infrastructure

Significant progress has been made in improving the learning environment across NLaG sites. At Goole Hospital, refurbishment work has continued to enhance local learning and training facilities, improving access to

education closer to staff workplaces and reducing the need for travel to other sites. This investment supports equitable access to training and strengthens local workforce development.

At Scunthorpe General Hospital, simulation facilities have been identified to support education and patient safety. This development will see a 2 bed ward area available for training, enhancing the realism for our health care professionals.

Simulation and Skills Development

Simulation continues to be an important component of education across the partnership, supporting clinical skills development, service transformation and workforce capability. Simulation activity has been incorporated into a range of services, supporting clinical decision-making, human factors awareness and escalation, while enabling teams to learn in realistic, supportive environments.

Through collaboration with colleagues across the Partnership, NLaG has benefited from shared expertise, faculty development and alignment of simulation approaches, ensuring consistency and quality across sites.

Improving Access to Learning – HHP Learning Hub

From 1 April 2026, NLaG staff will begin transitioning to a single Learning Management System, the HHP Learning Hub, as part of a Partnership-wide move to standardise access to learning across the Group. The Learning Hub provides a unified platform for statutory and mandatory training, role-specific learning and continuing professional development, improving equity, consistency and oversight across services.

The introduction of the HHP Learning Hub strengthens data quality, improves visibility of

learning activity and supports clearer reporting, while enabling staff to access learning more easily across organisational boundaries.

Learning Governance and Mandatory Learning Oversight Group

During the year, NLaG has been an active contributor to strengthened learning governance through the Mandatory Learning Oversight Group (MLOG). Working at Group level, MLOG provides executive oversight of statutory and mandatory learning, ensuring learning requirements are proportionate, risk-based and aligned with national and regulatory expectations.

This approach supports a reduction in unnecessary training burden, clarity around accountability, and improved assurance that learning adds genuine value to staff roles and patient safety.

Apprenticeships, Careers and Work Experience

Apprenticeships, careers and work experience activity across HHP are supported through the Group Learning and Development service, enabling closer collaboration with colleagues across the Partnership.

This approach has strengthened:

- Consistency of learner experience and support
- Sharing of best practice and expertise
- Alignment of apprenticeship and career activity with strategic workforce priorities

During 2025/26, as a Group service, HHP continued to strengthen its approach to apprenticeships, careers and work experience, supporting both entry routes into the NHS and progression opportunities for

existing staff. The partnership has ensured consistency, equity and scale while retaining a strong local focus.

Apprenticeships

Apprenticeships remain a central element of the Trust's workforce strategy, supporting recruitment, retention and talent development across clinical and non-clinical roles.



In 2025/26, apprenticeship activity at NLaG increased its starts from 107 to 135 (26% growth), with a continued emphasis on:

- Supporting existing staff to progress through structured apprenticeship pathways
- Developing clinical apprenticeship routes aligned to service need
- Using the apprenticeship levy to build sustainable workforce pipelines

Apprenticeships continue to be used to support a broad range of roles, enabling staff to earn, learn and progress while contributing directly to service delivery. This approach supports succession planning, skill development and internal progression at all levels of the organisation.

Ongoing collaboration across the Partnership has strengthened oversight of apprenticeship quality, support for learners and alignment of provision with workforce priorities.

Careers and Progression

As a Group HHP has continued to focus on creating clear, accessible career pathways for staff, recognising the role of development and progression in retention and engagement.

Career activity supports:

- Progression from entry-level and support roles into registered and specialist roles
- Development of leadership and management capability
- Opportunities for staff to retrain, upskill or transition into new roles as services evolve

This work is increasingly aligned with Group-level approaches to workforce development, ensuring staff have equitable access to opportunities regardless of site or role.

Work Experience and Early Careers Engagement

Work experience and early careers activity remain a priority for HHP, supporting inclusive routes into NHS careers and helping young people and career-changers gain insight into healthcare roles.

The Trust continues to:

- Offer structured work experience placements across a range of services
- Engage with local schools, colleges and education providers
- Support widening participation initiatives to improve access to NHS careers

These opportunities play an important role in building future workforce supply, increasing awareness of NHS careers and supporting social mobility across the local population.

Next Steps

In 2026/27, we will continue to focus on:

- Embedding and optimising the use of the HHP Learning Hub
- Further developing simulation activity and local learning provision
- Strengthening assurance and proportionality through MLOG
- Building on the Group Learning and Development service to further improve consistency, quality and access

Together, these developments support recruitment, retention and professional development, ensuring the NLaG workforce is skilled, supported and prepared to meet current and future service demands.

Equality, Diversity, Inclusion and Human Rights

Control measures were in place to ensure that the organisation's obligations under equality, diversity, inclusion and human rights legislation were complied with. The trust has an Equality, Diversity and Inclusion Strategy which encompasses our Equality Objectives. Our Equality Objectives focus on achieving legal and contractual compliance and progress against them is reported to Trust Board and monitored via the EDI steering group. The organisation has an Equality Impact Assessment (EIA) policy and procedure which ensured the integration of EIAs into trust core business and to support this training continued to be delivered across the trust.

Information on health and safety performance

The areas of occupational safety, security strategy and fire safety are managed within the safety and statutory compliance team. The Health, Fire and Safety Group has oversight of these areas and this group comprises of staff representatives, union appointed safety representatives and management from all care groups and corporate groups across the Trust.

This group reports to the Performance, Estates & Finance Committee-in-Common (PEF) in general, with some elements being reported via the Audit, Risk and Governance

Care Groups and Corporate Divisions have established governance groups and these incorporate the safety and health aspects covering their areas. There are also established links with the Security Group and the Joint Negotiating Consultative Committee (JNCC). Regular update reports are submitted to PEF with annual reports for areas such as fire safety and security being submitted to the Trust Board

The safety and statutory compliance team work across all Care Groups and Divisions within the Trust as well as the Estates, Facilities and Development Directorate (in which the team is located). This means that it can facilitate close working with the clinical care groups, infection control, emergency planning, preparedness and resilience teams so appropriate controls and measures are in place covering emergency situations as well as operational pressures.

The team also administrate the electronic risk assessment system containing risk assessments, COSHH assessment, fire risk assessments and other specialist assessments. In addition, the team report incidents externally that meet the RIDDOR reporting threshold and during the 25/26 period it reported

In addition, the work includes overseeing the update of risk assessments and reviewing incidents which could be reportable to external authorities. In relation to the incidents which met the threshold of the RIDDOR requirements the Trust reported 9 incidents during the 2025/26 period. This was decrease from previous years.

The period also saw the completion of the replacement of the fire alarm system at SGH and funding secured for the replacement of the fire alarm system at GDH to commence in the 26/27 period. This will means that by the end of the 27/28 period all fire systems at the main sites will have been replaced and brought up to current standards.

Staff policies and actions

Policy	Action
Policies for giving full and fair consideration to applications for employment made by disabled persons, having regard to their aptitudes and abilities	The group is in the process of implementing revised group-wide recruitment documentation and materials to ensure they are inclusive of information which encourages future applications of disabled candidates and sets out expectations and support available at a recruitment stage and during employment.
Policies applied for continuing the employment of, and for arranging appropriate training for, employees who become disabled during the period	The Trust has a number of staff equality networks, including a Disability Equality Staff network. We have incorporated feedback from the staff network to enable the development of a Disabilities and Long-Term Health Conditions (D and LTHC) policy and procedure, which has been implemented alongside a number of support mechanisms around guidance and managers toolkit aligned to this policy. The aim of this policy was to align and centralise information and guidance currently contained within several HR policies; this will provide a clear and consistent approach in one document. The aim of this policy is to support new employees coming into the Trust, employees with existing disabilities and employees who may develop a disability. In respect of reasonable adjustments required to retain employment and wellbeing, a centralised budget has been created to support quick and efficient ordering of resources and equipment to ensure a fair and equitable process, also utilising support and guidance available via Access to Work where appropriate. The Trust has also developed a Dyslexia Guidance (including dyspraxia and dyscalculia), this provides a clear process for employees and managers to follow to gain appropriate assessments required, incorporating suggested reasonable adjustments and support available. The Trust has further developed the HR HUB site to bring together all information and resources for employees and managers in one place to ensure this is easily accessible. Managers are now being asked to complete an 'Individually Tailored Adjustment Agreement' with their employees to capture all reasonable adjustments required, this includes any requirements for disability leave, ensuring expectations are mutually agreed and any future changes in management does not affect the agreed arrangements in place. Work will continue to be developed with ongoing and future workstreams being driven by the Staff Disability Network as part of the NHS People Promise.

Staff policies and actions continued

Policy	Action
Policies applied for continuing the employment of, and for arranging appropriate training for, employees who become disabled during the period.	Redeployment Policy and Procedure has also been introduced to protect the employment of individuals whose employment may be at risk, including where this is related to a disability, affording priority access to vacancies. This includes the provision of reasonable training and/or support in order to secure suitable alternative employment.
Policies applied during the year for the training, career development and promotion of disabled employees.	The Disabilities and Long-Term Health Conditions Policy and Procedure and Dyslexia Guidance (including dyspraxia and dyscalculia) both include suggested adjustments and support available, the aim being to ensure the removal of any barriers to development opportunities wherever possible.

Staff engagement and communications

In August 2023 the new Group Chief Executive joined the trust and looked to reinvigorate how the trust communicated and engaged with staff at both NLaG and across the NHS Humber Health Partnership's other trust Hull University Teaching Hospitals (HUTH). The Group CEO writes a weekly email to all staff across the group which is sent every Friday. A monthly opportunity for staff to hear from the executive team directly through an online Microsoft Teams environment. Called 'Ask the Executives' the sessions are an opportunity for staff to ask questions, either live or in advance by completing a form. Each session is recorded and transcribed so staff who cannot attend have the opportunity to see or read what was communicated.

All the questions and answers, including those which are not answered in the live slot, are published on the group's intranet which is called 'Bridget'. Senior leaders in the trust are invited to quarterly briefing sessions with all the executive to be briefed on upcoming issues and to take part in workshops and team building activities.

The trust and the group continued to use existing methods to communicate information to staff including:

- A weekly Thursday email called 'Building our future' which focuses on the building works and digital changes taking place across the trust, which was extended to HUTH at the start of 2024
- Publishing regular content on the Trust's social media channels – particularly Facebook and X (formerly Twitter) – as well as new group channels which were set up in spring 2024. The trust continued to offer staff access to a private Facebook group, and this was extended to HUTH in spring 2024
- Publishing content on the trust's intranet – The Hub – ahead of the launch of a new joint intranet with HUTH called 'Bridget'.

Fraud, bribery and corruption statement

It is estimated that the NHS is vulnerable to £1.3 billion pounds worth of fraud each year, monies that could be spent on vital patient care, therefore everyone has a duty to help prevent it. NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS.

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

The NHS Counter Fraud Authority (NHSCFA) provides the national framework through which NHS organisations seek to minimise losses through fraud. The Group follows the guidance contained in the NHS Counter Fraud Functional Standard and ensures our contractual obligations with our local Integrated Care Board (ICB) is adhered to.

The Group Chief Financial Officer is nominated to lead counter fraud work and is supported by the Trust's Local Counter Fraud Specialist (LCFS).

We have an in-house collaborative counter fraud arrangement with Hull University Teaching Hospitals NHS Trust and four other local NHS trusts, which allows us to have a LCFS permanently on site, supported by a small team of counter fraud specialists dedicated to combatting fraud within both community and secondary care settings.

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

The Trust also has a Standards of Business Conduct Policy which sets out the expectations we have of all our staff where probity is concerned. The policy also contains a statement from the Group Chief Executive in relation to ensuring that our organisation is free from bribery and corruption. There are references to counter fraud measures and reporting processes in various other Trust policies and procedures.

An annual work plan, approved by the Group Chief Financial Officer with oversight from the Trust's Audit, Risk and Governance Committee-in-Common, has been in place over the last year. The key aims are to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and ensure that allegations of fraud are appropriately and professionally investigated to a criminal standard. Progress reports on all aspects of counter fraud work and details of investigations are received at each meeting of the Trust's Audit, Risk and Governance Committee-in-Common.

The Trust has a well-publicised system in place for staff to raise concerns if they identify or suspect fraud. They can do this via our LCFS, the Group Chief Financial Officer, the Trust's electronic anonymous reporting system 'Bad Apple', via the NHS fraud and corruption reporting line on 0800 028 40 60 or online at <https://cfa.nhs.uk/report-fraud>. Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels with the exception of the 'Bad Apple' reporting system which is an internal staff system.

Occupational health

Occupational Health (OH) is a specialist area of medicine that focuses on staff health in the workplace and carries specific responsibilities under Section 3(1) of the Health and Safety at Work Act 1974.

The Occupational Health team aims to assess the potential impact of work on staff wellbeing and to confirm that employees are physically and emotionally capable of performing their duties. OH provides independent support and guidance to staff, managers, and recruitment teams, helping the organisation maintain a healthy and effective workforce when employees are affected by temporary or ongoing health challenges. In line with the Humber Partnership Group, the Occupational Health teams operate under central leadership and continue to work toward a standardised OH service across the group in terms of processes, policies, and service delivery.

In line with the *Growing Occupational Health and Wellbeing Together* strategy, Occupational Health will work in unified partnership with key stakeholders including Organisational Development, the Health and Wellbeing Team, Staff Psychology and Counselling, Staff Physiotherapy and Occupational Therapy services, Pastoral and Spiritual Care, and HR.

As part of our three year 'Health and Wellbeing plan' we aim to have a central point of access and support for the wellbeing of all the staff across the Humber Health Partnership Group.

Trade union facility time

The Trade Union (Facility Time Publication Requirements) Regulations 2017 requires employer, including NHS Trusts, to report annually a range of data in relation to their usage and spend on trade union facility time. The Trust's Trade Union Facility Time Report can be found on the Trust's website: <https://www.nlg.nhs.uk/resources/trade-union-facility-hours/>

Staff sickness absence data (subject to audit)

Figures converted by DH to best estimates of required data			Statistics published by NHS Digital	
Average Full Time Equivalent (FTE) for 2025/26	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE - Days Available	FTE - Days recorded Sickness Absence
6,714	81,139	11.3	2,421,236	131,626

Key to table

- Source – NHS Digital: Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse
- Period covered – April 2025 - March 2026
- Data items – ESR does not hold details of the planned working/non-working days for employees so days lost and days available are reported based upon a 365-day year
- For the Annual Report and Accounts the following figures are used:
 - The number of FTE-days available has been taken directly from ESR. This has been converted to FTE years in the first column by dividing by 365.
 - The number of FTE-days lost to sickness absence has been taken directly from ESR. The adjusted FTE days lost has been calculated by multiplying by 225/365 to give the Cabinet Office measure

The average number of sick days per FTE has been estimated by dividing the FTE Days by the FTE days lost and multiplying by 225/365 to give the Cabinet Office measure. This figure is replicated on returns by dividing the adjusted FTE days lost by Average FTE.

NLaG NHS Staff Survey

The National Staff Survey 2025 ran between September and November 2025. Overall it generated a higher response than last year based on the number of respondents - 3281 in 2025 versus 3230 in 2024.

7856 invited to complete the survey	7793 eligible at the end of survey	42% completed the survey (3281)	48% average response rate for similar organisations	42% your previous response rate
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We have seen a slight improvement of our overall scores and against most key themes but overall staff engagement has dipped, following a peak in 2021, with Advocacy the weakest dimension. Perceptions relating to Advocacy ("would recommend the organisation as a place to work", "care is top priority", "staff feel happy with care") remain below the national average.



We are
compassionate
and inclusive



We are recognised
and rewarded



We each have a
voice that counts



We are safe and
healthy



We are always
learning



We work flexibly



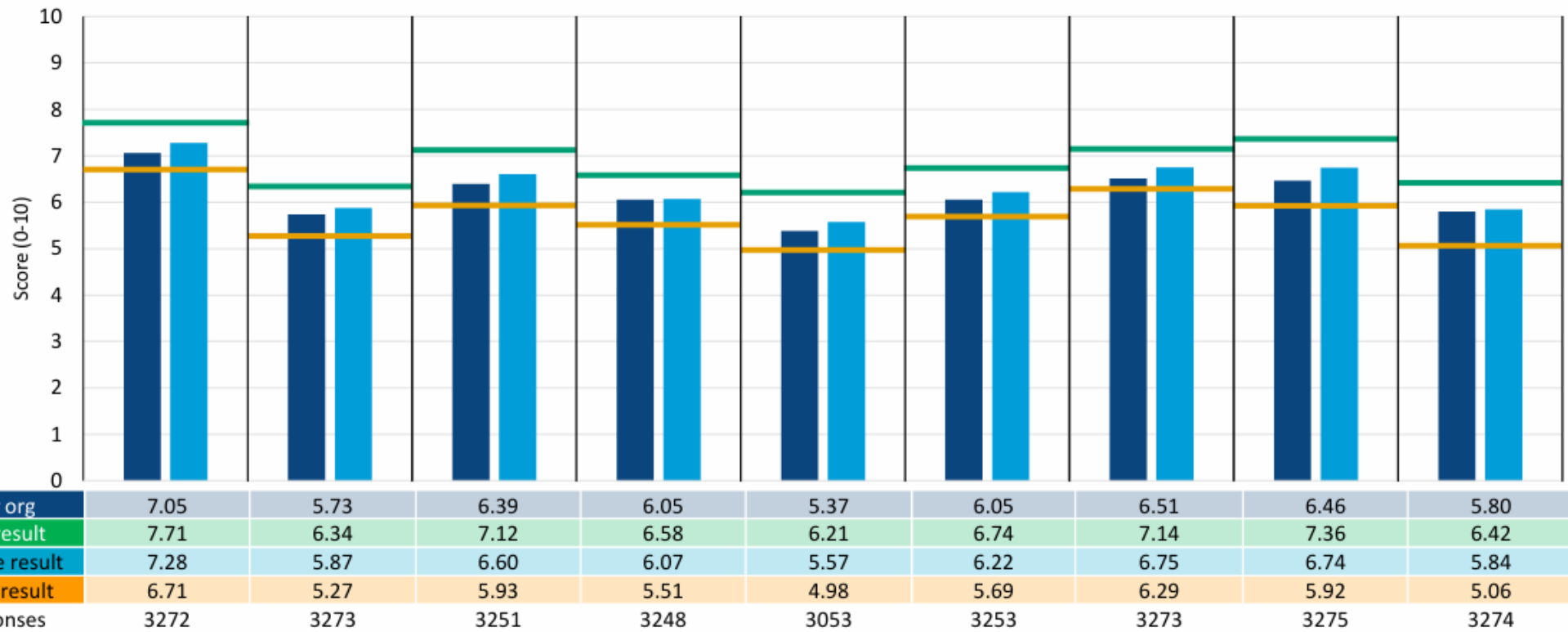
We are a team



Staff Engagement



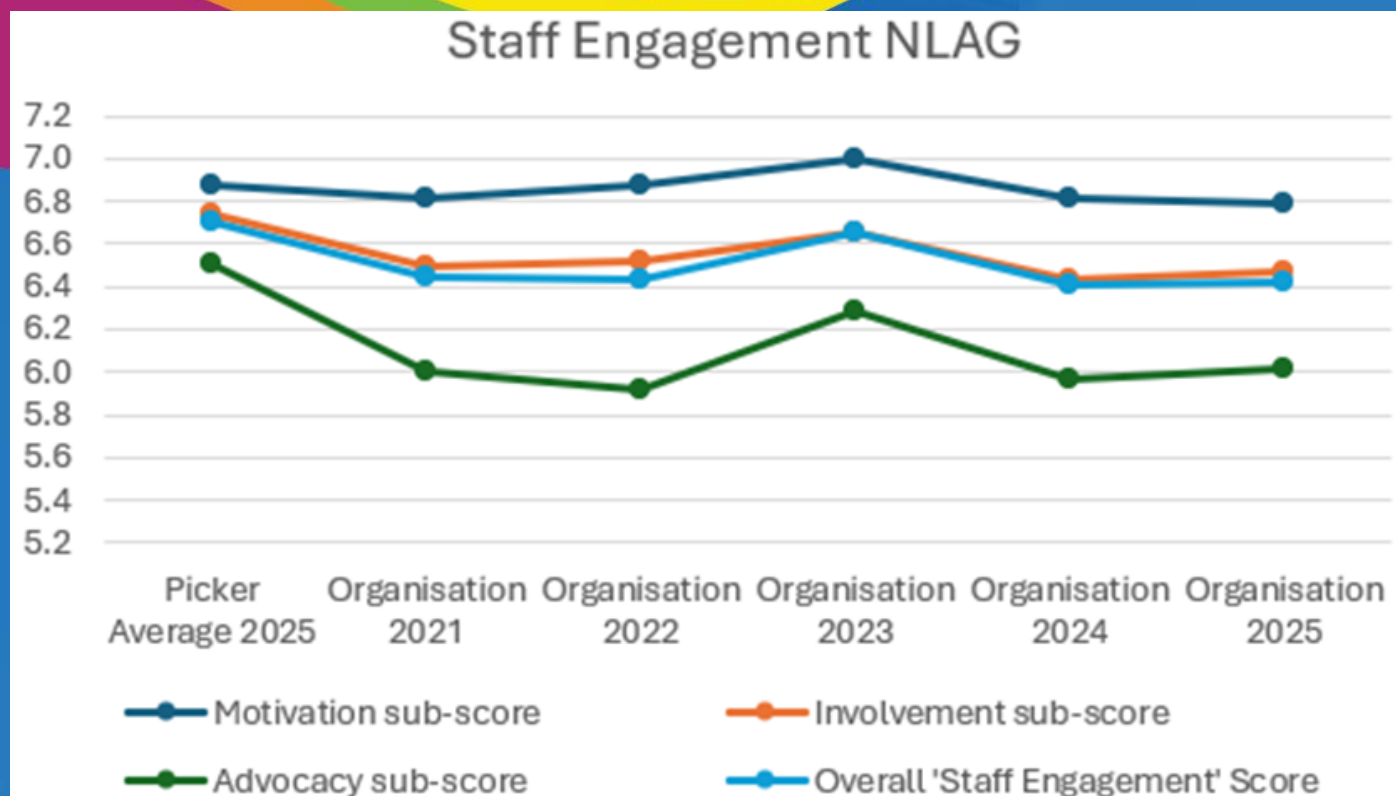
Morale



Positive momentum exists around flexible working, relationships with immediate managers, and work-life balance.

Despite improvements against both our Workforce Race Equality Scheme (WRES) and our Workforce Disability Equality Scheme (WDES) we do have some areas where further improvement is required:

- Ethnically diverse staff and disabled staff experience significantly higher levels of bullying, harassment, and discrimination at both trusts.
- Ethnically diverse staff and disabled staff report lower confidence in equal opportunities and lower engagement scores.



Proposed priorities and areas for action at NLaG are as follows:

- Safety Culture Reset
 - Ward/patient area accreditation scheme
 - Launch and promotion of Learning Improvement and Safety Academy
 - Safety-focused quality improvement projects
 - Reward and recognition aligned to safety objectives
- Civility and Respect Framework
 - Hotspot identification and team-level interventions
 - Compassionate leadership behaviours embedded in leadership training
- Staff voice & Involvement
 - Large scale staff engagement programme, led by senior leaders
 - Improve responses to concerns and reinforce psychological safety
 - Staff-led improvement projects
 - Team huddles, team meetings, Care Group cascade structures formalised
 - Strengthened staff network influence

- Equity and Inclusion Action Plan
 - Civility and anti-bullying/harassment campaign – with strong focus on BAME incidents
 - Sustained and strong focus on addressing equal opportunities for disabled and BAME employees
 - Strengthening inclusive behaviours and understanding/awareness
- Advocacy Recovery Programme
 - Executive visibility
 - Reward and recognition, including executive-led reward schemes (employee of the month)
 - Widespread promotion of safety and staff-led improvements
 - Infrastructure improvement plan – rest rooms/parking/restaurants etc.

In summary the staff survey feedback for 2025/2026 shows a slight improvement across most areas of the People Promise. This may be reflective of the work undertaken during the year to focus on four key issues arising from the 2024 survey: communication, wellbeing, recognition, essentials. Over 1000 managers engaged with executive-led sessions throughout the year and set local action plans to make improvements in Care Groups, wards and departments.

In the 2025 surveys 'overall engagement' has slipped. This is largely due to an unwillingness to recommend the organisation as a place to receive care or work. There is a strong indication that staff feel they are suffering a 'moral injury' through the distress of being unable to provide the safe, effective care our patients require.

Organisational focus on patient safety, safety culture and acting on/learning from incidents will not only benefit patients it will help to reduce that moral injury/stressor for frontline staff. Giving the workforce a voice in terms of raising concerns, learning from incidents and improving the safety of care provision would be beneficial in improving workforce pride and consequently organisational culture.

Inequalities, specifically around opportunities for progression, need to be acted upon.

Staff turnover

The latest information about the trust's staff turnover can be found on the NHS workforce statistics website: <https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics>. This information is updated on a monthly basis.

Gender pay gap

Information on the trust's gender pay gap can be found on the Cabinet Office website (<https://gender-pay-gap.service.gov.uk/>) and more information is available on the trust website: [Attach Link Here](#)

Equality, Diversity and Inclusion

Putting People First and the CARE Programme

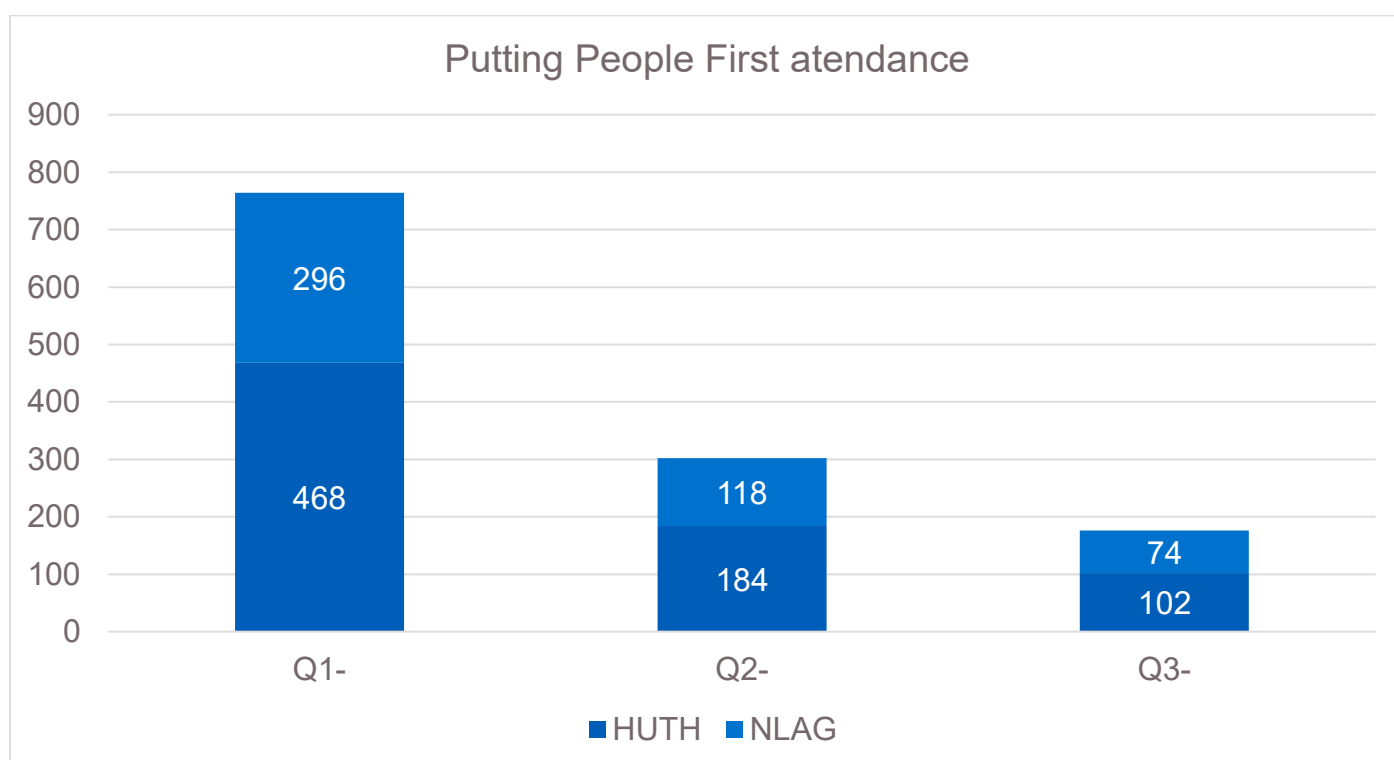
Putting People First is a system-wide culture programme designed to strengthen staff and manager engagement by translating workforce feedback into practical, locally owned action. The programme responded directly to staff survey intelligence and wider cultural assurance, recognising that compassionate leadership, staff experience and wellbeing are critical enablers of safe, high-quality patient care and organisational performance.

The programme was aligned to the Humber Health Partnership People Strategy and group values, providing a clear line of sight between strategic intent and everyday leadership behaviours. Through executive-led sessions and structured resources, Putting People First reinforced the expectation that leading people well is a core leadership responsibility rather than an optional activity.

Central to delivery was the CARE framework: **Communication and Engagement, AID (Health and Wellbeing), Reward and Recognition, and Essentials**. CARE provided a consistent and accessible structure for action, enabling managers to focus on one priority area each quarter and to agree three tangible actions with their teams.

Content was delivered through interactive leadership and management sessions that combined workforce data, facilitated discussion and peer learning. Managers were supported to reflect on their local staff feedback, identify what was within their control, and commit to actions that would make a meaningful difference to staff experience.

Attendance was strong throughout the year and a deliberate pause in Q4 was scheduled due to change in cultural transformation approach with the creation of the Leadership & Improvement Service Academy.



The programme also encouraged leaders to triangulate people metrics alongside quality, safety and operational data, reinforcing the message that staff experience is a core performance indicator and a key driver of patient outcomes.

HHP Leadership Development

To support the development of a values led culture that starts to embed our Group Values and Staff Charter we have been focused on ensuring that there is access to leadership and personal development at all levels of the Trust.

The consolidation of leadership development programmes across the Humber Health Partnership continued with the introduction of:

- **Leadership Essentials Programme (April 2025)**
- **Medical Leadership Programme (October 2025)**
- **NHS Leadership Academy's Mary Seacole Programme**
- **Braver than Before (September 2025)**

Medical Leadership Bitesize courses were introduced in March 2026 with the **Introduction to NHS Finance** course.

Throughout 2025-26 each quarter OD supporting micro-learning leadership events as part of CARE.

Colleagues have been signposted to self-directed learning via the **T2 Hub** which saw significant increases in uptake as each **CARE** quadrant was promoted.

In January of 2025 the **Great Leaders Programme** for existing operational leaders was launched. Great Leaders is an 11 month cohorted programme that is offered on both the North and South banks of the Humber and runs twice a year.



The year in numbers:

- **359** colleagues attended an OD Team-led Leadership Bitesize course over 36 sessions
- **106** professionals – Braver than Before (For Nursing, Midwifery & AHPs)
- **93** colleagues enrolled in the Leadership Essentials programme
- **25** medical colleagues are actively undertaking HHP's Medical Leadership Programme.
- **15** colleagues from across the HHP joined the harmonised Great Leadership Programme.
- **10** HHP Colleagues had fully funded places on the NHS Leadership Academy's Mary Seacole Programme
- **5** staff are actively enrolled on HHP's Lead without Limits Disability Leadership Development Programme

In addition, **104 HUTH** colleagues and **81 NLaG** colleague commenced a Leadership and Management Apprenticeship:

- **Level 3 Team Leader / Supervisor**
- **Level 5 Operational Manager**
- **Level 6 Chartered Manager**
- **Level 7 Senior Leader**
- **Level 7 Senior People Professional**

Bitesize Leadership Courses

Topics include:

- Application and interview skills
- Beyond the Policy: HR through the Leadership Lens
- Civility and professionalism
- Effective wellbeing conversations
- Essential skills for advanced communication
- Embracing the challenge of inclusive leadership
- Goal setting and introduction to project management
- Handling difficult situations
- Introduction to coaching
- The Talent Toolkit

HHP Coaching Network

A Groupwide coaching framework has been developed and implemented this year. Creating a consistent governance structure for the coaching network, including an automated evaluation process.

There have been 83 coaching referrals across the Group. The most common coaching themes are: career development, confidence and managing difficult situations.

HHP Team Development

In 2025/2026 the OD team have supported teams and departments on a variety of subjects including, improving inter and intra team relationships, creating a team mission statement, managing shifting team dynamics, and identifying areas of improvement.

Medical Education

Since January 2026, we have adopted a group structure by appointing a Group Director of Medical Education and two Sites Directors of Medical Education. The Medical Education teams across the group are collaborating to improve how medical education is provided throughout the partnership. Examples include joint efforts on the monthly Medical Education Newsletter, the annual Medical Education Awards, and the annual conference.

The main focus regarding Resident Doctors has been on addressing areas for improvement identified in the 2025 GMC National Training Survey results, which placed NLaG at the bottom of the league table. Subsequently, the Gastroenterology Department was reinstated into Enhanced Monitoring by the GMC. The Medical Education Team along with the Organisational and Development Team has partnered with the gastroenterology department to introduce improvements for Resident Doctors, aiming for these changes to be reflected in the 2026 GMC Survey, closing in May 2026.

A great deal of positive work is being done in the education and training of Resident Doctors at NLaG, and the upcoming year will concentrate on ensuring this progress is both acknowledged and celebrated.

Trust staff in numbers

Staff costs (subject to audit)

	HHP Group - £000			
	2025/26			2024/25
	Permanent	Other	Total	Total
Salaries and wages	333,104	2,196	335,300	315,326
Social security costs	42,212	-	42,212	32,442
Apprenticeship levy	1,692	-	1,692	1,609
Employer's contributions to NHS pension scheme	59,605	-	59,605	56,192
Pension cost - other	22	-	22	-
Temporary staff	-	16,663	16,663	16,416
Total gross staff costs	436,635	18,859	455,494	421,985
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	436,635	18,859	455,494	421,985
Of which				
Costs capitalised as part of assets	1,239	-	1,239	812

Average number of employees: WTE basis (subject to audit)

	HHP Group - Number			
	2025/26			2024/25
	Permanent	Other	Total	Total
Medical and dental	774	142	916	955
Ambulance staff	-	-	-	-
Administration and estates	1,393	65	1,458	1,494
Healthcare assistants and other support staff	1,320	74	1,394	1,375
Nursing, midwifery and health visiting staff	1,990	289	2,279	2,230
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,221	29	1,250	1,199
Healthcare Science Staff	-	-	-	-
Social Care Staff	-	-	-	-
Other	-	-	-	-
Total average numbers	6,698	599	7,297	7,253
Of which:	-	-	-	-
Number of Employees (WTE) engaged on capital projects	-	-	-	-

Number of people

	2024/25	2025/26
Medical	799	808
Band 9	5	4
Band 8	251	256
Band 7	603	616
Band 6	917	985
Band 5	1,708	1,721
Band 4	366	378
Band 3	1,032	1,586
Band 2	2,158	1,555
Band 1	2	2
Other	19	14
Apprentices	2	6
Total	7,859*	7,931*

Age profile of staff

	2024/25	2025/26
< 25	594	573
26 – 35	2,019	1,997
36 – 45	1,878	1,951
46 - 50	734	757
51 – 55	931	876
56 – 60	888	920
61-65	644	666
65 plus	171	191
Unknown	0	0
Total	7,859*	7,931*

* includes permanent, fixed term, internal secondment, and maternity leave and VSM

Ethnic minority breakdown of staff

	2024/25		2025/26	
	Number	%	Number	%
Asian	762	9.7	800	10.1
Black	456	5.8	478	6
Mixed	81	1	86	1.1
Other	141	1.8	101	1.3
Unknown	199	2.5	209	2.6
White	6,220	79.1	6,257	78.9
Total	7,859*	100	7,931*	100

* includes permanent, fixed term, internal secondment, and maternity leave and VSM

Analysis of gender distribution of staff 2025/26*

	Female	Male	Total	Female %	Male %
Directors	10	4	14	71%	29%
Other Senior Managers #	178	82	260	68%	32%
Employees excluding the above	6,191	1,466	7,657	81%	19%
Total	6,379	1,552	7,931*	80%	20%

* includes permanent, fixed term, internal secondment, and maternity leave and VSM

Senior Manager is defined as any role at Band 8a and above

Staff profile

	Number of People	
	2024/25	2025/26
Add prof scientific and technical	121	123
Additional clinical services	1712	1,717
Administrative and clerical	1,582	1,558
Allied health professionals	531	526
Estates and ancillary	703	725
Healthcare scientists	226	231
Medical and dental	802	811
Nursing and midwifery registered	2,176	2,230
Students	6	10
Unknown	0	0
Total	7,859*	7,931*

* includes permanent, fixed term, internal secondment, and maternity leave and VSM

Exit package cost band, including any special payment element

(subject to audit)

Reporting of compensation schemes - exit packages 2025/26 - Number			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	1	1
£10,000 - £25,000	-	-	-
£25,001 - 50,000	-	-	-
£50,001 - £100,000	1	1	2
£100,001 - £150,000	-	1	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	3	4
Total resource cost (£)	£70,000	£177,000	£247,000

Reporting of compensation schemes - exit packages 2024/25 - Number			
Exit package cost band (including any special payment element)	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
<£10,000	-	1	1
£10,000 - £25,000	-	-	-
£25,001 - 50,000	1	2	3
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	1	3	4
Total cost (£)	50,000	85,000	135,000

Exit packages: other (non-compulsory) departure payments

	2025/26		2024/25	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£000	Number	£000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	3	114	3	85
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	63		
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	4	177	3	85
<i>Of which:</i>				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

NHS England Code of Governance

The Code of Governance for NHS provider trusts (the Code of Governance) was published in October 2022 and has been applicable to both NHS foundation trusts and NHS trusts since 1 April 2023. It replaces the previous NHS foundation trust code of governance issued by Monitor. The Code of Governance sets out a common overarching framework for the corporate governance of NHS providers, reflecting developments in UK corporate governance and the development of integrated care systems. For the year ended 31 March 2026, the board considers that it was fully compliant with the provisions of the NHS England Code of Governance. Summarised details on the disclosures required by the Code of Governance are set out in the following table.

Summary of requirement	Where the information is available
The board of directors' assessment of effectiveness, efficiency and economy and contribution to the objectives of the ICP, ICB and place-based partnerships.	Annual Report – the Performance Report and the Annual Governance Statement
The board of directors' assessment of culture.	Annual Report – Staff Report and Annual Governance Statement
The board of directors' assessment of how it works with stakeholders, including system and place-based partners.	Annual Report – Performance Report and Annual Governance Statement
Information on Non-Executive Directors.	Annual Report – Accountability Report and trust website
The number of times the board and its committees met, and individual director attendance.	Annual Report – Accountability Report
Statement detailing the roles and responsibilities of the Council of Governors.	Annual Report – Accountability Report
Council of Governors approach to appoint the chair and non-executive directors.	Annual Report – Accountability Report
A description of each director's skills, expertise and experience.	Trust website
All trusts are strongly encouraged to carry out externally facilitated developmental reviews of their leadership and governance using the Well-led framework every three to five years, according to their circumstances. The external reviewer should be identified in the annual report and a statement made about any connection it has with the trust or individual directors.	Annual Report – Accountability Report
Details of how directors and Non-Executive Directors are chosen and how the trust board has been evaluated.	Annual Report – Accountability Report
Summary of requirement	Where the information is available
Governors' work to seek the opinion of the trust's members and the public.	Annual Report – Accountability Report
Information about the trust's auditors and how the audit was completed.	Annual Report – Accountability Report

Directors' responsibility for preparing the annual report and accounts.	Annual Report – Accountability Report
The trust's emerging and principal risks.	Annual Report – Performance Report and Annual Governance Statement
The trust's risk management and internal control systems.	Annual Report – Annual Governance Statement
The directors should state whether they considered it appropriate to adopt the going concern basis of accounting when preparing the accounts.	Annual Report – Notes to the Accounts
Members of the Council of Governors and other information on governors.	Annual Report – Accountability Report
The board of directors should ensure that the NHS foundation trust provides effective mechanisms for communication between governors and members from its constituencies. Contact procedures for members who wish to communicate with governors and/or directors should be clear and made available to members on the NHS foundation trust's website and in the annual report.	Annual Report – Accountability Report and trust website
The directors should state in the annual report the steps they have taken to ensure that the members of the board, and in particular the non-executive directors, develop an understanding of the views of governors and members about the NHS foundation trust, e.g. through attendance at meetings of the council of governors, direct face-to-face contact, surveys of members' opinions and consultations.	Annual Report – Accountability Report
If, during the financial year, the Governors have exercised their power* under paragraph 10C** of schedule 7 of the NHS Act 2006, then information on this must be included in the annual report. This is required by paragraph 26(2)(aa) of schedule 7 to the NHS Act 2006, as amended by section 151 (8) of the Health and Social Care Act 2012. * Power to require one or more of the directors to attend a governors' meeting for the purpose of obtaining information about the foundation trust's performance of its functions or the directors' performance of their duties (and deciding whether to propose a vote on the foundation trust's or directors' performance). ** As inserted by section 151 (6) of the Health and Social Care Act 2012)	n/a

Statement of the Group Chief Executive's responsibilities as the accounting officer of Northern Lincolnshire and Goole NHS Foundation Trust

The NHS Act 2006 states that the chief executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of the accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by NHS England.

NHS England has given Accounts Directions which require Northern Lincolnshire and Goole NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Northern Lincolnshire and Goole NHS Foundation Trust and of its income and expenditure, other items of comprehensive income and cash flows for the financial year.

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

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

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

As far as I am aware, there is no relevant audit information of which the foundation trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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

Signature:

A handwritten signature in black ink that reads "Lyn Simpson". The script is cursive and fluid, with the first name "Lyn" and last name "Simpson" clearly distinguishable.

Lyn Simpson
Group Chief Executive
Date: 18 June 2026

NHS Oversight Framework

NHS England's NHS Oversight Framework is the way this national regulator oversees health systems, including providers, and identifies potential support needs. NHS organisations are allocated to one of five 'segments' through this framework.

A segmentation decision indicates the scale and general nature of support needs, from no specific support needs (segment 1) to a requirement for mandated intensive support (segment 5). A segment does not determine specific support requirements.

By default, all NHS organisations are allocated to segment 2 unless the criteria for moving into another segment are met. These criteria have two components:

- Objective and measurable eligibility criteria based on performance against the six oversight themes using the relevant oversight metrics (the themes are: quality of care, access and outcomes; people; preventing ill-health and reducing inequalities; leadership and capability; finance and use of resources; and local strategic priorities)
- Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 5 where it is one of the most challenged providers in the country, with low performance across a range of domains and low capability to improve or NHS England has identified significant concerns.

Segmentation

This segmentation information is the trust's position as at 20 June 2026. NHS England has placed the trust in segment 5.

Current segmentation information for NHS trusts and foundation trusts is published on the NHS England website: <https://www.england.nhs.uk/publication/nhs-system-oversight-framework-segmentation/>

Annual Governance Statement 2025-26

1. Scope of Responsibility

As Accounting Officer for NLaG NHS Foundation Trust t, I have responsibility for maintaining a sound system of internal control that supports the achievement of the Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the *NHS Foundation Trust Accounting Officer*.

As an Anchor institution, NLaG influence the health and wellbeing of communities, creates social value in the local area and acts as a large local employer or procurer of services.

This Annual Governance Statement relates to NLaG and also refers to the Humber Health Partnership (HHP) Group status. HHP is the overarching Group name with NLaG being one of the sovereign trusts within it. Hull University Teaching NHS Trust is the other sovereign trust within the Group.

2. The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Group, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Group for the year ended 31 March 2026 and up to the date of approval of the annual report and accounts.

3. Capacity to Handle Risk

The Trust has a Board approved Groupwide Risk Management Strategy 2025-28 (reference GM023) which sets the overall objective for the HHP Group to be fully 'risk aware'. The strategy includes a risk management approach which is embedded within the Group's culture and working practices, where open reporting of mistakes is encouraged and lessons are learned, and there is an acceptance that Risk Management is everyone's responsibility. In line with the Group Risk Management Strategy, the two Risk Teams continue to jointly work towards common processes and procedures.

The Strategy sets the policy for developing and maintaining the Group's Risk Register which is captured in the Risk Management Policy (reference GP032). The policy aims to ensure a standard and consistent approach to both risk assessment and the management of risk across the Group. It outlines the process for the identification and ownership of risk as well

as the planning and monitoring of actions to manage, reduce and eliminate those risks. This policy covers the management of risks, such as details of the structures and processes in place to identify, manage and eliminate or reduce risks to a tolerable level. It defines accountability arrangements for the management of risk within the Group. The Policy states the responsibility of Executive Directors and Senior Managers in respect of leadership in risk management and confirms that all staff within the organisation have responsibility for the identification and reporting of risks and incidents.

The Board Committees-in-Common structure provides assurance on, and challenge to, the Group's risk management process. All Committees are chaired by Non-Executive Directors to enhance independent scrutiny, and there are key structures in ensuring quality, safety and management of risk, whilst providing the mechanism for managing and monitoring risk for assurance reporting to the Trust Boards-in-Common. Executive Directors provide leadership on the management of key areas of risk relevant to their roles and are represented across the Board committee structure.

The Audit, Risk and Governance Committees-in-Common has oversight of the internal control and overall assurance processes associated with managing risk, and in turn provides assurance to the Trust Boards-in-Common in relation to all aspects of governance, risk management and internal control.

The Trust and HHP Group continue to play a full part in the Humber and North Yorkshire Integrated Care System (ICS), including membership of the Collaboration of Acute Providers, the Community Collaborative and the Place Partnership Boards for Hull, East Riding of Yorkshire, North East Lincolnshire and North Lincolnshire.

The Risk Management Policy for developing and maintaining the Group's Risk Register describes the organisation's approach to risk and risk management. It defines the leadership roles within the Group for risk management. In addition, staff across the Group receive risk management training, in order to identify and report risks. The Group's mandatory training programme included training on specific risk topics such as fire safety, safeguarding, information governance, moving and handling, and infection control. Staff duties and responsibilities were also regularly reinforced in respect of reporting incidents and duty of candour. Whilst not mandatory, training was provided on Root Cause Analysis in support of the Group's arrangements for investigating and managing incidents. Counter Fraud training is also provided.

The Trust has a well-established process for entering risks onto its risk register and the regular review of risks, which is described below. This includes a strengthened approach to escalating risks at a corporate level and the way in which this informs the strategic risk managed by the Trust Boards-in-Common. This is also described in more detail below.

Instability in the Board and Executive leadership during 2025/26 has restricted our capacity to handle risk effectively and this is reflected in the range of risk matters raised and findings from other reviews.

4. The Risk and Control Framework

4.1 The Management of Risk

The Group is committed to the management of clinical and non-clinical risk in order to improve the quality of care and provide a safe environment for the benefit of patients, staff and visitors by reducing and, where possible, eliminating the risk of loss, harm or damage, protecting its assets and reputation. This is achieved through a process of identification, analysis, evaluation, control, action, elimination or transfer of risk.

The system of internal control is designed to manage risk to a reasonable level. All risks that are entered on the Group risk management system are assigned an inherent, current and target risk rating. Controls are identified to mitigate the level of risk and where there are gaps in the controls, action plans are developed. Risks are identified and reviewed on an ongoing basis across Care Groups and Corporate services.

Risks are identified from a number of different sources, including day-to-day operational working practices and trends arising from incidents, complaints and regulatory compliance. Line managers are responsible for ongoing investigation and assessment of risks and the central Group Risk Team are available to support.

At Trust Board level, the Boards-in-Common assess their performance and discuss associated risks at each meeting, through the presentation of the Integrated Performance Report, which includes NHS England (NHSE) NHS Oversight Framework metrics. An exception report on these measures is discussed in more detail at the Performance, Estates and Finance Committees-in-Common and the more detailed quality issues at the Board's Quality and Safety Committees-in-Common. The positive assurance and gaps in assurance are captured in the Board Assurance Framework, reviewed quarterly by the Trust Boards and their committees.

The Group Executive Risk and Assurance Committee operates to strengthen risk management across the Group and address reported weaknesses. This is aligned with the monthly Care Group Performance and Accountability meetings where risks are monitored and challenged by the Executive Team. New high-scoring risks are notified to the Risk and Compliance Groups for Corporate and Care Groups whilst lower-scoring risks are discussed at the Care Group / Corporate team meetings. All Board Assurance Framework risks and the high-scoring risks are scrutinised at the Group Executive Risk and Assurance Committee.

There are a number of mechanisms in place, which are designed to prevent or minimise the potential of risks occurring. The Group's incident reporting system records near misses as well as actual incidents. The Trust has used the Patient Safety Incident Response Framework (PSIRF) since April 2023.

Responsibility for the management, control and funding of a particular risk rests with the Directorate/Care Group concerned in line with the principles of devolution

within the Trust/Group, and in accordance with the Scheme of Delegation. However, where action to control a particular risk falls outside the control or responsibility of that domain, such issues were escalated to the Executive Group meeting or Trust Boards-in-Common.

During 2025/26 the internal audit function undertook a review of these risk management arrangements and provided a red / amber assessment meaning that they found a partial level of assurance with improvements required. This low level of assurance was also reported by the Audit, Risk and Governance Committees-in-Common earlier in the year. In response to these reports, work has begun to strengthen the arrangements with Care Groups to review risks and better reflect the risk profile of the Trust.

The Trust's Mortality Improvement Group has overseen the formulation and implementation of a new Learning from Deaths policy, which includes a two-tier clinical case note review to identify patient deaths that have any flags for failure or impacts of care that could have been avoided. The Group continues to use the themes and trends report from this, reported to the Trust Boards and the Quality and Safety Committees-in-Common on a quarterly basis. This Committee has also kept oversight of compliance with the national guidance requirements on Learning from Deaths and is satisfied that the Trust/Group have made sufficient progress towards requirements to date.

A framework is in place for managing and controlling risks to data security. There is a Senior Information Risk Owner at Director level and a network of information risk owners across the organisation. Information Governance training is a mandatory requirement for all staff to complete. The Group provides submissions to the Data Security and Protection Toolkit annually and the Audit, Risk and Governance Committees-in-Common and the Boards-in-Common are keeping oversight of the individual Trust's and combined Group's risk positions in relation to systems security and systems resilience.

The Group's updated intranet site contains information to support staff in managing risks across the scope of the Group's business. The Group's formal communication systems (e-news, intranet, daily updates and team brief cascade) are used to remind staff of their responsibilities such as reporting incidents and concerns, and sharing learning when specific initiatives or incidents have occurred. These communications include the consequences arising from information governance incidents investigations during the year.

The Group's website is also fully compliant with the latest accessibility requirements. The website provided members of the public with easy and timely access to information across all areas of Group activity. The Group also made efforts to publicise timely information via e-mail, social media channels such as Twitter and Facebook and, where appropriate, by liaising with the local media.

Whilst our systems of risk management flagged risks with flow throughout 2025/26, the Trust has not yet addressed these risks fully. A Perfect Weeks programme was initiated

towards the end of the year to achieve more timely discharge of patients, to improve movement of patients from the Emergency Department into appropriate wards and specialty areas, to reduce reliance on temporary escalation spaces and to reduce the Operational Pressures Escalation Levels reported across sites. Clinically led, this work is being embedded in 2026/27.

4.2 Freedom to Speak Up Guardians

It is a requirement of the NHS contract that all NHS Trusts in England are required to have a Freedom to Speak Up Guardian (FTSUG). FTSUGs receive initial training from the National Guardian Office (NGO) and follow national guidance from the NGO and NHS England.

The FTSUG supports permanent and temporary staff, trainees, students and volunteers to speak up about any workplace concerns or issues they have and/or ideas for improvement. The reasons for raising a concern are varied and can be related to patient safety, worker safety, inappropriate behaviours, discrimination, bullying and harassment, workload, role or service delivery, general support or any other concerns in an individual's working life.

The FTSUG supports the Trust to encourage a positive culture where people feel able to speak up, are able to have their voices heard and be assured that concerns, suggestions and learning will be acted upon. It can be difficult to know how to speak up and individuals and groups can speak to the FTSUG as an additional and impartial route to raise concerns. They also plays a key role in signposting staff to the appropriate staff support and wellbeing services available at the Trust.

The Trust is committed to enabling staff to speak up and has adopted the national 'Freedom to Speak Up Policy for the NHS'.

NLaG implemented a 0.6 WTE dedicated FTSUG in 2020 and the current role holder, Liz Houchin has been in post since February 2020. There is also a network of FTSU Champions across NLaG, which is a voluntary role supporting the FTSUG. There are currently approximately 25 Champions

The creation of the Humber Health Partnership Group in August 2023 with Hull University Teaching Hospital (HUTH) has led to consistent working and reporting practices with the FTSUG at HUTH.

In 2025/26 Humber Health Partnership implemented a Group Freedom To Speak Up Strategy for 2025-2028 which details the long-term objectives, an action plan and measures of success for the Group, this will be reviewed annually. The Board completed the NHS England Self Development and Planning Tool in May 2025 with an improvement plan signed off which they are now working towards.

During 2025/2026 388 concerns were received by the FTSUG, which is similar to the previous year and puts the Trust in the top quartile nationally.

The FTSUG attends and reports directly to the relevant Group Boards in Common. They also attend and are core members of other Committees and working groups, including the Group Equality, Diversity and Inclusion Steering Committee.

The role of the Freedom To Speak Up Guardian and the promotion of the role to staff continues to be of great importance across the Group and the Guardian continues to work in partnership with the Foundation Trust and Unions to promote speaking up and staff support.

5. Principal Risks to Compliance with the NHS Provider Licence Conditions

The following section provides oversight of the Group's risk identification and categorisation process, concluding with a section as to any principal risks to compliance with the NHS provider licence conditions, particularly the effectiveness of governance structures, responsibilities of directors and Board committees, reporting lines and accountabilities to and from the Trust Board, submission of timely and assurance information to assess compliance with the licence conditions or any associated with the oversight the Board has on Trust/Group performance.

All Trust specific or Group risks are categorised using the same risk matrix and framework based on the likelihood of the risk occurring and the severity of impact, with the highest scoring risk having a score of 25 (almost certain and catastrophic) and the lowest risk of 1 (rare and negligible). The Group now uses a web-based incident reporting and risk management system (Ulysses) and has a 'bottom up' approach to identifying risks. HUTH had been using DATIX as their reporting system but the use of Ulysses is now harmonised across the Group.

- Each Care Group and corporate service area identify and enter risks on to their own operational risk registers; risks are required to be managed and mitigated at local level as far as possible
- The high-scoring operational risks from each area are reviewed by the Group Risk and Compliance Committee. The Committee escalates any high-scoring risk that cannot be managed within an individual Care Group or Corporate service and represent a group-wide risk across the organisation
- The Group Cabinet Risk and Assurance Committee review the Board Assurance Framework (BAF) and high-scoring risks on a monthly basis. This Committee consists of Executive Board members
- The high-scoring risks (risks of 15 and above), are considered and linked to the Board Assurance Framework, which details the key risk areas that could prevent the Trusts from achieving its strategic aims. This consideration of group-wide risk helps the Trust Boards-in-Common identify the corporate risk burden being carried by each Trust and whether this impacts on achieving the individual Trust's strategic goals.
- The Group has undertaken a number of Governance Reviews carried out by external companies such as Value Circle, NHS E and NICHE (external company)

carrying out a Cardiology review) to strengthen governance processes. The Integrated Improvement Plan captures all of the actions in place. The Group has been placed in NOF 5 due to breaching its Provider Licence and is working with the National Provider Improvement Programme to rapidly make improvement in delivery of improved performance and quality and patient safety.

5.1 Risk Reporting 2025/26

Following the alignment of risk management processes across HUTH and NLaG during 2024/25, risk management has continued to strengthen throughout 2025/26 with the merger of the two separate organisational risk registers, into one Groupwide risk register system. However risk management processes have been audited by the Internal Auditors, with an amber-red assessment provided, meaning they found a partial level of assurance with improvements required. An independent review of the risks partway through 2025/26 also found that the organisation is carrying significant and sustained risks particularly around workforce, access and finance. The risks have remained static and more work is being carried out to re-align the risk registers to the BAF. Internal Audit highlighted that mitigations and actions were not delivering reduced risk scores so a full review of the BAF is being undertaken in 2026/27. The BAF risks have been aligned with the Group Strategy.

Risks are escalated to the Groupwide risk register from Ward/Departmental level through discussion at their sub-specialty clinical governance meetings, these are then escalated to the Risk and Compliance meetings which take place monthly for Care Groups and bi-monthly for Corporate Directorates. The purpose of the Risk and Compliance Group is to review and scrutinise new risks, closure of risks and changes in score for risks scored 12 and above, including the high-scoring risks scored at 15 and above.

During 2025/26 the Risk Management Strategy was developed which was approved by the Audit, Risk and Governance Committees-in-Common in November 2025, which saw the development of a three-year strategy focused on Insight, Involvement and Improvement. Key performance indicators were developed alongside this which will be monitored and reported periodically.

During 2026 work has been undertaken to align all high-scoring risks to an Executive Director sponsor and a Committees-in-Common. This is to ensure there is Executive Director oversight of high-scoring risks and to ensure that risks are appropriately described, scored, mitigated, monitored and reviewed.

The table below highlights the Care Groups and Corporate Directorates and the number of high-scoring risks by rating as at March 2026:

Care Group / Corporate Directorate	Total scores for high scoring risks 15 and above				
	15	16	20	25	Total
Acute And Emergency Medicine		6	3	1	10

Care Group / Corporate Directorate	Total scores for high scoring risks 15 and above				
	15	16	20	25	Total
Cancer Network		2			2
Cardiovascular	4	6			10
Chief Nurse		2	4		6
Community, Frailty and Therapies	2				2
Digestive Diseases		2			2
Digital	2	2			4
Estates and Facilities	4	4	7		15
Family Services	1	2			3
Finance		1			1
Head and Neck	6	3	2		11
Neurosciences	1	1			2
Major Trauma					0
Pathology Network	1				1
Specialist Cancer and Support Services	3	6	4		13
Specialist Medicine	1	2			3
Specialist Surgery	3	3	2		8
Theatres, Anaesthetics and Critical Care	5	5			10
Transformation					0
Total	33	47	22	1	103

Each of the high-scoring risks are monitored through the Group Risk and Compliance Committee and the high-scoring risks are also presented to the relevant Committees-in-Common and the Boards-in-Common. The Executive Team also receive the high-scoring risks at the monthly Group Cabinet Risk and Assurance Committee.

5.2 Board Assurance Framework (BAF)

The Group BAF covers all the strategic risks for NLaG. The table below shows the BAF strategic risks and their ratings as at March 2026:

	Strategic Risk	Risk Rating
People	We aim to support our staff. However, if we fail to embed compassionate and inspirational leadership and fail to improve our working environments, then staff engagement scores (from staff surveys) will not improve, and our staff retention and attendance rates will decline.	20
Patients - Access	We aim to achieve all of our constitutional standards. If we fail to develop the necessary skills and capabilities of our teams and have access to drive change to meet these standards, we fail to give patients access to the care they need, when they need it.	20
Patients - Safety	We aim to make sure our patients get the safe, quality care they need and have a good experience. However, if we do not transform our clinical services and keep our patients safe, we will fail to become a CQC outstanding organisation, delivering safe, sustainable and inclusive healthcare services.	20
Pioneers	We aim to invest in robust digital foundations, a virtual hospital and research and innovation infrastructure. However, if we fail to embrace digital and tech, prioritise research and innovation and build skills for transformation, we will fail to adopt new technologies and ways of working for the benefit of our patients and our population.	12
Public Purse	We aim to achieve financial sustainability through streamlining processes and removing duplication. However, if we fail to live within our means, address our estates utilisation, deliver value-based care and reduce our impact on the planet, we will become unsustainable and be subject to regulatory action.	20

The BAF is monitored quarterly by the Executive Lead for each risk. At these meetings the risks, controls and assurances (or any gaps) are reviewed. Any changes are presented to the Group Executive Risk and Assurance Committee (monthly) and then endorsed by the Committees-in-Common on a quarterly basis. The Boards-in-Common have the final authority to approve and changes.

The BAF risk scores have remained fairly static and high during 2025/26. The Trust has developed a range of actions to strengthen its risk management actions, in conjunction with external reviews, that aim to mitigate risks and reduce BAF risk scores during 2026/27.

5.3 Group People Strategy

The Group updated the People Strategy in 2025 and the Boards-in-Common approved it in February 2025. The strategy sets out five workforce themes which have been informed and shaped by our people, partners, and key stakeholders. The Trust's National Staff Survey results show a decline to the lower quartile nationally and the strategy responds

to these results.

The strategy ensures that our people remain centric as the primary enabler for organisational success - the provision of safe, timely and effective care. To enable this, we continue to build on the basics of enabling a solid psychologically safe environment, whilst pushing the boundaries and practicalities of what a positive and healthy staff experience should look and feel like.

The Group complies with national operational planning recommendations using existing staffing data to make an assessment of staffing levels across the Group against known and emerging demand. Staffing trajectories are reviewed annually as part of operational planning based on known demand and emerging system integrations. Workforce metrics against plan are received and reviewed on behalf of the Boards-in-Common by the Workforce, Education and Culture Committees-in-Common.

The Board has received analyses and assessments over safe staffing arrangements, evidenced through triangulated establishment reviews, routine reporting of vacancy, sickness and agency metrics through the Workforce, Education and Culture committees-in-Common and the Boards-in-Common, safer staffing reports, and the alignment of workforce plans with the People Strategy, operational plans and service demand modelling. With the approval of a significant investment in medical and nursing staffing during 2025/26, the Trust is reasonably assured that staffing levels are safe, sustainable and effective and increasingly compliant with National Workforce Safeguards.

5.4 Equality, Diversity and Inclusion

The Group People Strategy 2025-28 outlines that the Group will have allyship programmes that proactively educate all staff to reduce instances of discrimination and work with communities to ensure they understand that discrimination or abuse towards staff is unacceptable. The Group will implement systems to ensure equal access to career opportunities for all staff, regardless of ethnicity, disability, or gender identity.

In 2025/26 the key points to note are:

- Non-clinical vacancy controls have been strengthened to support financial recovery, while clinical recruitment remained protected
- Industrial actions by resident doctors were safely managed with minimal disruption - 90% and elective performance maintained, albeit at significant cost
- Five-year workforce plan submitted to NHSE
- Reduced the majority of the Registered Nurse vacancy position to operational norms.
- Continued to recruit medical Specialist roles to support clinical gaps with now 47 in post across the Group
- Achieved 95% job planning compliance with plans in 2025/26 to transition to team based job planning
- Introduced "Reach" supporting individuals with a disability from day one with reasonable adjustments
- Launched FLEX - the revised approach to flexible working with encouraging improvements in national staff survey scores in this domain

- Continued development of the Learning, Improvement and Safety Academy (LISA), preparing to integrate key education and organisational development functions.

5.5 Care Quality Commission

The Foundation Trust (NLaG) is fully compliant with the registration requirements of the Care Quality Commission (CQC).

The Trust continues to work closely with the CQC, ICB and NHSE. The clinical teams are continuing to make progress in key areas with support given from the Governance Team regarding the collation and submission of evidence to the regulators.

The Trust is committed to ensuring its services are well-led, in line with the CQC Well-Led framework and NHS England guidance. The Board has sought assurance during the year over the leadership and governance arrangements, supported by accountability structures, risk management processes, and oversight of quality, performance and workforce metrics. The Trust promotes an open and inclusive culture, supports continuous learning and improvement, and engages effectively with staff, patients and system partners. The Board also undertakes self-assessments and, where appropriate, external review of its leadership and governance arrangements to identify areas for further development. The Board is aware of the impact arising from leadership and management changes over the period and are satisfied that appropriate systems and processes are now in place to address gaps at a senior level and through better clinical engagement and delivery of integrated plans lead to a well-led organisation and the delivery of high-quality, sustainable care.

6. Conflicts of Interest

The Trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the Group with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. The Trust has a Register of Directors' interests which are reviewed by the Trust Board annually and also published through the Trust Boards-in-Common public meeting papers and within the Trust's Freedom of Information publication scheme. Plans are in place to raise awareness and to improve levels of compliance.

7. NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

8. Environmental Sustainability

The Group has a Board-approved Green Plan 2025-2028. This plan demonstrates the Group's commitment to sustainability, incorporating the requirements of the NHS Delivering a Net Zero NHS report and the NHS Long Term Plan. The Green Plan incorporates a working action plan to address our progress, a document which will grow as the impact of our work, projects and capital investments develop.

The Group has undertaken risk assessments on the effects of climate change and severe weather and has developed a Green Plan following the guidance of the Greener NHS programme. The Group ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

9. Review of economy, efficiency and effectiveness of the use of resources

The Performance, Estates and Finance Committees-in-Common have Board-level oversight of the economic, efficient and effective use of resources. This is discharged through the monthly review of performance against budget and against financial plan, progress towards identifying and achieving cash-releasing efficiency savings, income against plan, performance and activity delivery against plan, cash management and budgetary management. The Performance, Estates and Finance Committees-in-Common report to the Boards-in-Common, including escalation of any areas of concern. Further detail on the work of the Performance, Estates and Finance Committees-in-Common is contained in the 'review of effectiveness' section.

10. Information Governance

The Group continues to strengthen its Information Governance Framework and this includes the following arrangements:

- the Group Chief Medical Officer as the Caldicott Guardian
- the Group has a dedicated Data Protection Officer (DPO) who is also the Lead for Information Governance
- active Information Governance Groups meet monthly and feed directly into the Audit, Risk and Governance Committees-in-Common (where the Group DPO presents a quarterly update)
- an Information Governance Strategy and collection of Information Governance related policies along with a number of dedicated IT Security policies
- the Group has a dedicated Chief Digital Officer (CDO)
- The Interim Chief Digital Officer serves as the Senior Information Risk Owner (SIRO)The Group has a dedicated IT Security Manager
- the Group's Information Governance Team continues to monitor Information Governance Incidents to ensure that the Group meets the statutory reporting

timescale of 72 hours to the Information Commissioners office for any breach that meets the criteria.

NLaG reported five Data Security and Protection Breaches in 2025/26 to the Information Commissioners Office (ICO) as classified in the DSP Toolkit Incident Reporting Guidelines. One breach remains ongoing and the ICO were satisfied with the way the Group investigated and handled the other four incidents, with the result that no action was necessary.

11. Data Quality and Governance

High quality data plays a key role in designing, implementing, and measuring improvements in patient care and patient safety, both within the Group and on a system level. Quality data requires consistency, accuracy, completeness and needs to be processed efficiently and in a timely manner.

The Group are in the final stages of developing a Group Data Quality Strategy with overarching governance amalgamated from the individual Trust Data Quality Strategies. The integrated Data Quality Steering Group commissions, designs and conducts regular reviews of internal as well as external data quality reports including the monthly Secondary Uses Services and Data Quality dashboard reports.

Based on information published in the Secondary Uses Services and Data Quality dashboard, both Trusts are in line with, or exceeding, national valid percentage rates in all but one of the data items routinely monitored nationally.

The Trust participates in a Commissioning Activity Recording Panel that ensures any proposed changes to the recording of Trust/Group data and income generation are approved by a panel of subject matter experts prior to any change being made.

The Group Performance Team ensures all changes to the national performance framework are incorporated within relevant Trust/Group Policies and operational processes, undertaking remedial training and/or process correction where deviation from best practice is detected via internal monitoring, internal audit, and/or national audit as part of the annual Quality Account process.

In addition to routinely reviewing data quality relating to key performance measures, sophisticated monitoring tools have been commissioned and implemented to mitigate and minimise data challenges that are received from local and national commissioners. These tools proactively identify recording gaps and enact remedial correction of records in advance of commissioner challenge to mitigate risk of losing contractual income. Examples include use of the LUNA (digital nerve centre) model and RAIDR (health intelligence tool) model (Vital Hub commissioned) to identify Data Quality issues relating to Referral to Treatment (RTT) patient tracking lists.

The Trust has robust arrangements to assure the quality of elective waiting time (RTT) data, including governance oversight, routine validation of patient tracking lists, and regular audit and monitoring against national standards. However, risks remain, particularly relating to reliance on accurate data entry, variation in pathway recording, and potential timeliness or completeness issues within reporting processes.

An Integrated Performance Report which outlined the Trust's/Group's key performance indicators was submitted to the Committees-in-Common monthly for detailed review and challenge. Any issues are highlighted to the Boards-in-Common.

12. Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Group key Quality Priorities have been identified as:

- Deteriorating Patient and Sepsis
- End of Life Care
- Medication Safety
- Mental Capacity.

The Quality Accounts, and the process that accompanies them is a key tool for delivering the Quality Strategy as well as maintaining stakeholder involvement. The Quality and Safety Priorities will be delivered using the Continuous Quality Improvement Framework and progress will be reported to the Quality and Safety Committees-in-Common.

13. Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control across the Group. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Boards-in-Common, the Audit, Risk and Governance Committees-in-Common, the Quality and Safety Committees-in-Common and the Performance, Estates, the Finance Committees-in-Common, the Strategic Partnerships and Programmes Committees-in-Common and the Workforce, Education and Culture Committees-in-Common and a plan to address weaknesses and ensure continuous improvement of the system is in place.

13.1 The Boards-in-Common

The Trust Board is accountable for all aspects of the performance of the Trust/Group.

The Boards-in-Common met in public on seven occasions during 2025/26 and was quorate at all meetings. The attendance of each individual Board member is set out in this Annual Report and on each copy of the Boards-in-Common minutes. The Boards-in-Common work towards an annual work plan including statutory and mandatory requirements. Arrangements for the discharge of statutory functions by the Boards-in-Common have been checked for irregularities and were found to be legally compliant.

The Boards-in-Common had five committees in 2025/26 which discharged their responsibilities. In addition to the statutory requirement for an Audit, Risk and Governance Committees-in-Common and a Remuneration Committees-in-Common, the Boards-in-Common have a Performance, Estates and Finance Committees-in-Common, a Quality and Safety Committees-in-Common and a Workforce, Education and Culture Committees-in-Common. A Charitable Funds Committee is in place for the management of charitable funds held at each Trust. All Board Committees-in-Common are chaired by a Non-Executive Director and have Non-Executive Director and Executive Director membership (except for the Remuneration Committees-in-Common which is solely Non-Executive Directors). The Group had a Strategic Programme and Partnerships Committees-in-Common which met for the first half of 2025/26 but has since been stood down.

An attendance record is kept for the Board and each of its Committees-in-Common.

13.2 The Audit, Risk and Governance Committees-in-Common including Internal Audit

The Audit, Risk and Governance Committees-in-Common met five times during 2025/26, which is the required number as set by its Membership and Terms of Reference and was quorate for all meetings. The Audit, Risk and Governance Committees-in-Common agenda is comprised of standing items which include a review of the minutes from the Trust Board's Committees-in-Common for any governance or internal control issues that require further examination by the Audit, Risk and Governance Committees-in-Common. There are standing agenda items for external audit, internal audit, counter-fraud, review of the Board Assurance Framework, Risk Register, Digital Security and Information Governance updates. Other agenda items are scheduled at regular intervals during the year and these include the draft and audited Annual Accounts and associated reports, Going Concern status, Digital updates and a number of other routine management reports (e.g. Waivers, Losses and Compensation Payments) in line with its agreed annual work plan.

The Audit, Risk and Governance Committees-in-Common escalated several gaps in assurance around internal controls during the year to the Group Chief Executive, Board and other Committees-in-Common and requested additional assurance as necessary, namely in the management of risk and the Board Assurance Framework and the processes of internal control that require improvement within the organisation to manage risk and mitigating actions to reduce risks to tolerable levels.

Breaches of the Trust's provider licence, including those relating to Board governance and operational and financial performance, resulted in the Group assigning independent firm Value Circle to review the Group's governance arrangements. The Audit, Risk and Governance Committees-in-Common has been charged with overseeing the implementation of the recommendations arising from the Value Circle review. These will therefore be monitored at subsequent meetings of the Audit, Risk and Governance Committees-in-Common during 2026/27 with progress reported to the Boards-in-Common.

Both Trusts within the Group have been enrolled in NHS England's National Provider Improvement Programme (NPIP) and its Intensive Recovery Programme. The NPIP will determine whether the most challenged NHS providers have the necessary conditions in place to deliver sustainable improvement, supported by a deliverable integrated improvement plan. The Audit, Risk and Governance Committees-in-Common will also have a role in delivering improvements in governance arrangements linked to the integrated improvement plan, and reporting to the Boards-in-Common on progress with this.

13.3 Head of Internal Audit Conclusion

The internal audit programme for 2025/26 was informed by each Trust's risk and assurance framework, discussion with a wide range of officers and the broader context of the NHS. It was risk based and developed around the Group's strategic objectives and its business-critical systems.

The Head of Audit Conclusion is as follows:

Governance: Amber/Red – Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed the need to improve the operating effectiveness of controls.

Risk Management: Amber/Red – Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed the need to improve the operating effectiveness of controls.

Financial reporting and management: Amber/Green – Overall findings on design show some controls to be effectively designed with some exceptions and our testing showed some controls to be operating effectively, and others could be more consistently applied.

Data captured and used by the organisation: Amber/Green – Overall findings on design showed controls are effectively designed and our testing showed some controls to be operating effectively, and others could be more consistently applied.

13.4 Board Committees with a Role of Risk Management including Clinical Audit

The Performance, Estates and Finance Committees-in-Common met on 15 occasions in 2025/26 which is in line with their Terms of Reference. Two of the meetings were extraordinary and one was a private developmental meeting. All meetings were quorate.

The focus of each meeting was on the detailed Performance exception report, specifically the Trust and Group's underlying performance against the key NHS Constitution standards and the financial plan, which are standing agenda items discussed at each meeting. Other substantive agenda items have also been the financial position of the Trusts, particularly the financial performance of the Trusts' Care Groups and their contribution to the underlying run-rate. The Committees-in-Common have also monitored capital expenditure in line with plan. The Non-Executive Director Chairs of the meeting provided a briefing to the Board each meeting on these areas.

The Quality and Safety Committees-in-Common met on nine occasions, in line with their Terms of Reference. Two of these meetings were 'Time-Outs' so that the Committees-in-Common could review their workplan and effectiveness. Key issues discussed related to infection, prevention and control, the CQC action plan, safe staffing reports, maternity and neonatal assurance, learning from deaths, equality and quality impact assessments, safeguarding, research and innovation, patient experience and clinical effectiveness. The CIC received a number of annual reports regarding the above mentioned as well as; Medicines optimisation, end of life, organ donation and legal services. Each meeting also received a report from each of the Quality Committee Sub-Committees which included any point of escalation. The Boards-in-Common were advised of any escalation issues following each meeting by the Non-Executive Director Quality Committee Chairs.

The Strategic Programmes and Partnerships Committees-in-Common met on three occasions, with one of the meetings being a 'Time-Out', during 2024/25. All of the meetings were quorate in 2025/26. Agenda items included major developments such as the Community Diagnostic Centres, post capital project evaluations, any major service changes or transformation and the digital plan. In response to the Value Circle work and to focus the Board on its immediate challenges, this committee has been paused.

The Workforce, Education and Culture Committees-in-Common met on 12 occasions in 2025/26 and all meetings were quorate. Agenda items included People Strategy updates, Medical and Dental Job Planning, National Staff Survey results, Safer Nurse Staffing and operational workforce plans.

The Remuneration Committees-in-Common met five times during 2025/26. The Committees-in-Common was quorate for all meetings. There were eight additional meetings during the period of 1 April 2025 to 31 March 2026.

Agenda items included annual Group Executive Director Appraisals, recruitment and succession plans, new recruit reports and a review of its Terms of Reference.

For NLAG the Healthtree Foundation Charity meets quarterly to oversee the funds raised and expenditure made.

13.5 Other Review and Assurance Mechanisms

The Boards-in-Common have previously agreed a framework for Board Development and has chosen to invest additional Board time in development. The Boards-in-Common held four development sessions during the year.

Quality governance arrangements are in place and managed through a team of Quality Assurance specialists, which include clinical audit (delivering an annual clinical audit plan), operational and corporate risk management (with support provided to each Care Group and corporate services from a central team), compliance (including CQC, ward standards and support to safeguarding), claims and safety. A Group wide review of the Quality Strategy was undertaken in 2025 and early 2026 and a revised Group Quality Strategy was published. Actions from this will be monitored through the Quality and Safety Committees-in-Common. These are identified through internal compliance and quality checks, internal audit reports, CQC inspection reports and other internal processes. The Quality and Safety Committees-in-Common monitor and provides assurance to the Trust Boards by way of a highlight report.

The Workforce, Education and Culture Committees-in-Common received a Nursing and Midwifery staffing report and escalated issues to the Trust Boards. The report included the Trust's fill rates (the number of nurses in post and hours of care delivery compared with planned levels) and the Group's plans for nursing recruitment.

In 2025/26, NLaG declared six Never Events, this is a deterioration compared to 2024/25 when the Foundation Trust declared one Never Event.

14. Review of the Effectiveness of Risk Management and Internal Control

The effectiveness of risk management and internal control has been determined through a number of mechanisms. The Audit, Risk and Governance Committees-in-Common monitors the implementation of all internal audit recommendations and receives reports at each meeting to monitor progress on agreed actions. Minutes of the Committee's meetings and highlight/escalation reports are submitted to the Board of Directors.

KPMG provide Internal Audit services for the Group. It provides an independent and objective opinion on the extent to which risk management, controls and governance arrangements support the effective operation of the Trust and the Head of Internal Audit and/or the Internal Audit Manager attend the Audit, Risk and Governance Committees-in-Common meetings. Further details are captured in the Annual Report.

15. Significant Internal Control Issues

In February 2026, the Trusts received a letter regarding its level of compliance with its license under section 87 of the Health and Social Care Act 2012 (the Act). Under section 106 of the Act, NHSE accepted a range of enforcement undertakings to address a number of suspected breaches of licensing requirements. At the same time, NHS England placed the Group in the lowest segment of the National Oversight Framework (NOF5) and, before 31 March 2026, the Group was included in NHSE's Intensive Recovery Programme (IRP), which focuses on a smaller number of organisations facing significant and longstanding structural challenges and financial imbalances.

This position reflects increasing alignment between the national regulatory assessment of the Group and the longstanding issues that have been identified through the Partnership's own work since August 2025. The development of the clinically-led improvement plan, alongside governance review activity and diagnostic work undertaken through the national improvement support programme (NPIP), has brought together for the first time a clear and shared understanding of a number of deep-rooted and interconnected challenges that have developed over several years.

The following issues are therefore deemed to represent the most significant internal control weaknesses identified during the year and are being addressed through delivery of the clinically-led improvement plan and associated governance strengthening actions:

- **Urgent and Emergency Care performance**

Across the Group, the Emergency Departments (EDs) four-hour standard was challenged and persistently below the constitutional standard during the year. This reflects long-standing flow, capacity and wider system challenges. A clinically-led flow programme is now in place, aligned to the Improvement Plan's focus on urgent and emergency care, discharge, and bed modelling, with agreed Group-wide safety red lines defining non-negotiable limits for crowding in the emergency department, escalation spaces and discharge delays.

- **Operational performance and planning alignment**

The Trusts were both in national Tier 1 oversight for Urgent and Emergency Centre (UEC), Cancer, Diagnostics and Referral to Treatment (RTT). These issues reflect long-standing weaknesses in the alignment of workforce, demand, finance and capital planning, and continually increasing demand. This is being addressed through the Improvement Plan's emphasis on clinically-led planning, strengthened operational grip and a more integrated approach to speciality-level demand and capacity modelling.

- **Patient safety and learning (Never Events / Patient Safety Incident Response Framework (PSIRF))**

During 2025/26, NLaG declared six Never. Historic weaknesses in learning and thematic oversight were identified across the HHP Group. The Improvement Plan includes a strengthened focus on PSIRF, Never Events and embedding systematic learning through the Learning, Improvement and Safety Academy and clinically-led governance arrangements.

- **Financial sustainability and Cost Improvement Plan delivery**

The Humber Acute Services Review (2018) identified structural cost and clinical sustainability issues. System planning assumptions relied on the Partnership, to mitigate this gap and support delivery of the overall Cost Improvement Plan (CIP) requirement across the Group. The Group's inclusion in the NHS Intensive Recovery Programme reflects national recognition that these challenges are

longstanding and relate to structural constraints and financial imbalance, which require coordinated system-level intervention.

- **Board and leadership**

Four Group Executive Directors and three Non-Executive Directors from each Trust left the Group during 2025/26. A number of temporary Board level appointments resulted. Through 2026 and into 2026/27 the Trust is seeking to stabilise leadership arrangements at executive and Board level at the Trust.

- **Clinical service concerns (General Medical Council (GMC) – Gastroenterology)**

The GMC placed the NLaG Gastroenterology Department under Enhanced Monitoring in 2025. Targeted improvement plans are in place.

- **External scrutiny and assurance**

There were 23 open external visits across the Group from bodies with enforcement powers (known as Rank 1 bodies) as of March 2026. All visits have associated action plans.

- **Governance, assurance and risk management**

During 2025/26, Committees-in-Common identified areas of limited assurance, reflecting long-standing weaknesses in governance processes:

- Infection Prevention and Control performance required renewed focus and is now a core stabilisation priority within the Improvement Plan
- Complaints and PALS processes were reactive and insufficiently focused on learning and prevention
- Risk management processes and the Board Assurance Framework had not consistently support proactive decision-making, with risk registers functioning primarily as retrospective logs rather than dynamic tools
- Lack of delivery of actions to improve performance against constitutional targets
- Non delivery of the full Cost Improvement Programme in year.

These issues are being addressed through the governance review, strengthening Board oversight, clearer accountability, and embedding clinically-led decision-making structures.

- **Data and information governance**

There were five data safety related incidents reported for the Trust in 2025/26, four are now closed with one awaiting further response from the Information Commissioner's Office (ICO).

16. Conclusion

This annual governance statement has identified significant internal control issues / risks and set these out in the previous section. It also details a range of actions being taken forward to address the significant controls issues experienced.

In conclusion, there remains an understood level of risk due to the volume of clinical activity that the organisation and Group structure can deliver, and the achievement of constitutional and regulatory performance requirements. The Trusts, as part of the HHP Group, are committed to the continuous improvement of processes of internal control and assurance. I am confident in our work to develop the internal control systems and further consolidate arrangements, which will deliver improvements in constitutional standards, quality of service and areas of high risk. This includes the effective tracking of action to mitigate significant control issues through the Board Assurance Framework (which has oversight at the Committees-in-Common and the Boards-in-Common).

Signed:

A handwritten signature in black ink, reading 'Lyn Simpson'.

Accounting Officer (for NLaG): Lyn Simpson, Group Chief Executive

Organisations: Northern Lincolnshire & Goole NHS Foundation Trust (NLaG)

Date: 18 June 2026



**Northern Lincolnshire
and Goole**
NHS Foundation Trust



The Independent Auditor's Report and Conclusion

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF NORTHERN LINCOLNSHIRE AND GOOLE NHS FOUNDATION TRUST

Opinion on financial statements

We have audited the financial statements of Northern Lincolnshire and Goole NHS Foundation Trust (the Trust) for the year ended 31 March 2026, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs), and as interpreted and adapted by the 2025-26 Government Financial Reporting Manual as contained in the Department of Health and Social Care, Group Accounting Manual 2025-26, and the NHS Foundation Trust Annual Reporting Manual 2025-26 issued by NHS England.

In our opinion the financial statements:

- give a true and fair view of the financial position of Northern Lincolnshire and Goole NHS Foundation Trust as at 31 March 2026 and of its expenditure and income for the year then ended;
- have been prepared properly in accordance with the Department of Health and Social Care, Group Accounting Manual 2025-26; and
- have been prepared in accordance with the National Health Service Act 2006.

Basis for opinion on financial statements

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the Financial Reporting Council's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate. Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue. Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The Accounting Officer is responsible for the other information. The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Opinion on information in the Remuneration Report and Staff Report

We have also audited the information in the Remuneration Report and Staff Report that is described in those reports as having been audited.

In our opinion the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2025-26.

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Matter on which we are required to report by exception

We are required to report to you if, in our opinion, we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2026.

We identified a significant weakness in relation to financial sustainability, which will require the delivery of the proposed Integrated Improvement Plan and ongoing engagement with key funders to begin to move the Trust to a trajectory of financial sustainability.

Responsibilities of the Accounting Officer

The Accounting Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources, and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code of Audit Practice issued by the National Audit Office, having regard to the guidance issued by the Comptroller and Auditor General in December 2021.

Other matters on which we are required to report by exception

Under Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice we report to you if:

- in our opinion, the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with our knowledge acquired in the course of the audit; or
- we refer a matter to the regulator under Schedule 10 of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under Schedule 10 of the National Health Service Act 2006.

We have nothing to report in these respects.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Group Chief Executive's Responsibilities as the Accounting Officer of the Trust, the Accounting Officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer either intends to liquidate the Trust or to cease operations, or has no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

In respect of our audit of the financial statements our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Extent to which the audit was capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Our procedures included the following:

- inquiring of management, the Trust's head of internal audit, the Trust's local counter fraud specialist and those charged with governance, including obtaining and reviewing supporting documentation in respect of the Trust's policies and procedures relating to:
 - identifying, evaluating and complying with laws and regulations and whether they were aware of any instances of non-compliance;
 - detecting and responding to the risks of fraud and whether they have knowledge of any actual, suspected or alleged fraud; and
 - the internal controls established to mitigate risks related to fraud or non-compliance with laws and regulations including the Trust's controls relating to Managing Public Money requirements for any special payments;
- discussing among the engagement team and involving relevant internal specialists, including regarding how and where fraud might occur in the financial statements and any potential indicators of fraud. As part of this discussion, we identified potential for fraud in the following areas: revenue recognition, expenditure recognition around year end, and posting of unusual journals;
- obtaining an understanding of the Trust's framework of authority as well as other legal and regulatory frameworks that the Trust operates in, focusing on those laws and regulations that had a direct effect on the financial statements or that had a fundamental effect on the operations of the Trust. Relevant laws

and regulations identified include VAT legislation, PAYE legislation, the DHSC Group Accounting Manual and the NHS Foundation Trust Annual Reporting Manual.

In addition to the above, our procedures to respond to identified risks included the following:

- reviewing the financial statement disclosures and testing to supporting documentation to assess compliance with relevant laws and regulations discussed above;
- enquiring of management, the Audit, Risk and Governance Committee and legal counsel concerning actual and potential litigation and claims;
- reading minutes of meetings of those charged with governance and the Trust Board;
- in addressing the risk of fraud through management override of controls, testing the appropriateness of journal entries and other adjustments; assessing whether the judgements made in making accounting estimates are indicative of a potential bias; and evaluating the business rationale of any significant transactions that are unusual or outside the normal course of business; and
- substantively testing increased samples of income and expenditure around year end.

We also communicated relevant identified laws and regulations and potential fraud risks to all engagement team members including internal specialists and remained alert to any indications of fraud or non-compliance with laws and regulations throughout the audit.

Our audit procedures were designed to respond to risks of material misstatement in the financial statements, recognising that the risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error, as fraud may involve deliberate concealment by, for example, forgery, misrepresentations or through collusion. There are inherent limitations in the audit procedures performed and the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely we are to become aware of it.

A further description of our responsibilities for the audit of the financial statements is located at the Financial Reporting Council's website at:

<https://www.frc.org.uk/auditorsresponsibilities>. This description forms part of our auditor's report.

Auditor's other responsibilities

As set out in the 'Other matters on which we report by exception' section of our report there are certain other matters which we are required to report by exception.

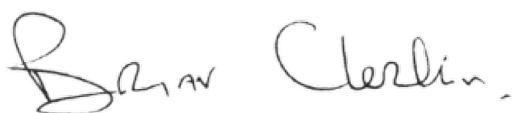
We have nothing to report in respect of these matters.

Delay in respect of certificate of completion of the Audit

As required by Auditor Guidance Note 07, we cannot formally conclude the audit and issue an audit certificate, as confirmation is yet to be issued from the NAO that the audit of the Department of Health & Social Care is complete. We will issue our audit certificate under a separate cover when this has been completed. This will close out the audit.

Use of our report

This report is made solely to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust, as a body, in accordance with Schedule 10 of the National Health Service Act and as set out in paragraph 43 of the Statement of Responsibilities of Auditors and Audited Bodies published by the National Audit Office in April 2015. Our audit work has been undertaken so that we might state to the Directors of the Trust those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Council of Governors of the Trust, as a body, for our audit work, this report, or for the opinions we have formed.



Brian Clerkin
Senior Statutory Auditor
For and on behalf of
Sumer Auditco NI Limited
Statutory Auditors
4th Floor Glendinning House
6 Murray Street
Belfast
BT1 6DN

Date: 24 June 2026



Northern Lincolnshire
and Goole
NHS Foundation Trust



The Annual Accounts for the Year Ended 31 March 2026

Northern Lincolnshire and Goole NHS Foundation Trust

Annual Accounts for the year ended 31 March 2026

Foreword to the Accounts

Northern Lincolnshire and Goole NHS Foundation Trust

These accounts, for the year ended 31 March 2026, have been prepared by Northern Lincolnshire and Goole NHS Foundation Trust in accordance with paragraphs 24 & 25 of Schedule 7 within the National Health Service Act 2006.

Signed .. 

Name Lyn Simpson
Job title Group Chief Executive
Date 18 June 2026

Consolidated Statement of Comprehensive Income

	Note	Group	
		2025/26	2024/25
		£000	£000
Operating income from patient care activities	3	589,153	559,651
Other operating income	4	74,546	54,956
Operating expenses	7,9	(688,095)	(623,809)
Operating surplus / (deficit) from continuing operations		(24,396)	(9,202)
Finance income	11	2,042	2,869
Finance expenses	12	(435)	(516)
PDC dividends payable		(6,698)	(6,446)
Net finance costs		(5,091)	(4,093)
Other gains / (losses)	12	(95)	56
Surplus / (deficit) for the year from continuing operations		(29,582)	(13,239)
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		(29,582)	(13,239)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(3,197)	(2,014)
Revaluations	13	694	1,841
Total other comprehensive income for the period		(2,503)	(173)
Total comprehensive income / (expense) for the period		(32,085)	(13,412)
Surplus / (deficit) for the period attributable to:			
Non-controlling interest, and		-	-
Northern Lincolnshire and Goole NHS Foundation Trust		(29,582)	(13,239)
Total		(29,582)	(13,239)
Total comprehensive income / (expense) for the period attributable to:			
Non-controlling interest, and		-	-
Northern Lincolnshire and Goole NHS Foundation Trust		(32,085)	(13,412)
Total		(32,085)	(13,412)
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(29,582)	(13,239)
Remove impact of consolidating NHS charitable fund		481	(232)
Remove net impairments not scoring to the Departmental expenditure limit		33,183	15,545
Remove I&E impact of capital grants and donations		(18,587)	(2,073)
Adjusted financial performance surplus / (deficit)		(14,505)	1

Statements of Financial Position

	Note	Group		Trust	
		31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Non-current assets					
Intangible assets	16	19,712	13,283	19,712	13,283
Property, plant and equipment	17	284,128	276,388	284,128	276,388
Right of use assets	20	8,991	11,000	8,991	11,000
Other investments / financial assets	21	967	1,146	-	-
Receivables	24	700	751	700	751
Total non-current assets		314,498	302,568	313,530	301,422
Current assets					
Inventories	23	4,889	4,226	4,889	4,226
Receivables	24	21,827	20,872	21,178	20,311
Cash and cash equivalents	28	40,248	32,648	39,939	32,619
Total current assets		66,964	57,746	66,006	57,156
Current liabilities					
Trade and other payables	29	(99,431)	(74,291)	(98,681)	(74,211)
Borrowings	31	(3,364)	(3,685)	(3,364)	(3,685)
Provisions	32	(5,106)	(4,523)	(5,106)	(4,523)
Other liabilities	30	(383)	(194)	(383)	(194)
Total current liabilities		(108,284)	(82,692)	(107,534)	(82,613)
Total assets less current liabilities		273,177	277,622	272,002	275,965
Non-current liabilities					
Borrowings	31	(9,912)	(12,812)	(9,912)	(12,812)
Provisions	32	(3,335)	(3,601)	(3,335)	(3,601)
Total non-current liabilities		(13,247)	(16,413)	(13,247)	(16,413)
Total assets employed		259,930	261,208	258,755	259,552
Financed by					
Public dividend capital		510,427	479,620	510,427	479,620
Revaluation reserve		17,726	20,229	17,726	20,229
Income and expenditure reserve		(269,398)	(240,297)	(269,398)	(240,297)
Charitable fund reserves	22	1,175	1,656		
Total taxpayers' equity		259,930	261,208	258,755	259,552

The notes on pages 8 to 53 form part of these accounts.

Name
Position
Date

Lyn Simpson
Group Chief Executive
18 June 2026

Consolidated Statement of Changes in Equity for the year ended 31 March 2026

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2025 - brought forward	479,620	20,229	(240,297)	1,656	261,208
Surplus / (deficit) for the year	-	-	(29,739)	157	(29,582)
Impairments	-	(3,197)	-	-	(3,197)
Revaluations	-	694	-	-	694
Public dividend capital received	30,807	-	-	-	30,807
Other reserve movements	-	-	638	(638)	-
Taxpayers' and others' equity at 31 March 2026	510,427	17,726	(269,398)	1,175	259,930

Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Charitable fund reserves £000	Total £000
Taxpayers' and others' equity at 1 April 2024 - brought forward	463,627	23,136	(229,560)	1,424	258,627
Surplus / (deficit) for the year	-	-	(14,054)	815	(13,239)
Other transfers between reserves	-	(2,734)	2,734	-	-
Impairments	-	(2,014)	-	-	(2,014)
Revaluations	-	1,841	-	-	1,841
Public dividend capital received	15,993	-	-	-	15,993
Other reserve movements	-	-	583	(583)	-
Taxpayers' and others' equity at 31 March 2025	479,620	20,229	(240,297)	1,656	261,208

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Information on Reserves

Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the Trust, is payable to the Department of Health and Social Care as the public dividend capital dividend.

Revaluation Reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Income and Expenditure Reserve

The balance of this reserve is the accumulated surpluses and deficits of the Trust.

Charitable Funds Reserve

This reserve comprises the ring-fenced funds held by the NHS charitable funds consolidated within these financial statements. These reserves are classified as restricted or unrestricted.

Statements of Cash Flows

	Note	Group		Trust	
		2025/26 £000	2024/25 £000	2025/26 £000	2024/25 £000
Cash flows from operating activities					
Operating surplus / (deficit)		(24,396)	(9,202)	(23,974)	(9,448)
Non-cash income and expense:					
Depreciation and amortisation	7.1	22,759	20,377	22,759	20,377
Net impairments	8	33,183	15,545	33,183	15,545
Income recognised in respect of capital donations	4	(19,497)	(3,095)	(19,497)	(3,095)
(Increase) / decrease in receivables and other assets		(2,246)	2,375	(2,249)	2,328
(Increase) / decrease in inventories		(663)	(169)	(663)	(169)
Increase / (decrease) in payables and other liabilities		8,394	(2,443)	8,394	(2,397)
Increase / (decrease) in provisions		243	3,648	243	3,648
Movements in charitable fund working capital		578	(406)	-	-
Net cash flows from / (used in) operating activities		18,356	26,629	18,196	26,789
Cash flows from investing activities					
Interest received		2,009	2,914	2,009	2,914
Purchase of intangible assets		(8,900)	(4,817)	(8,900)	(4,817)
Purchase of PPE and investment property		(44,376)	(40,479)	(44,376)	(40,479)
Sales of PPE and investment property		33	109	33	109
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(70)	(200)	(70)	(200)
Receipt of cash donations to purchase assets		19,497	3,022	19,497	3,022
Net cash flows from charitable fund investing activities		120	138	-	-
Net cash flows from / (used in) investing activities		(31,687)	(39,312)	(31,807)	(39,451)
Cash flows from financing activities					
Public dividend capital received		30,807	15,993	30,807	15,993
Movement on loans from DHSC		(1,329)	(1,329)	(1,329)	(1,329)
Capital element of lease liability repayments		(2,336)	(2,321)	(2,336)	(2,321)
Interest on loans		(116)	(145)	(116)	(145)
Interest paid on lease liability repayments		(257)	(303)	(257)	(303)
PDC dividend (paid) / refunded		(5,838)	(7,838)	(5,838)	(7,838)
Net cash flows from / (used in) financing activities		20,931	4,057	20,931	4,057
Increase / (decrease) in cash and cash equivalents		7,600	(8,626)	7,320	(8,605)
Cash and cash equivalents at 1 April - brought forward		32,648	41,274	32,619	41,224
Cash and cash equivalents at 31 March	28	40,248	32,648	39,939	32,619

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information

Note 1.1 Basis of Preparation

NHS England has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2025/26 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting Convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

Note 1.2 Going Concern

The Treasury's Financial Reporting Manual (FReM) provides the following interpretation of the going concern requirements set out in IAS1 'that the anticipated continued provision of the service is the important determinant of the basis of preparation of the financial statements for public sector entities.

Northern Lincolnshire and Goole NHS Foundation Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidence by inclusion of financial provision for that service in published documents. The directors have a reasonable expectation that this will continue to be the case.

The accounting rules (IAS 1) require management to assess, as part of the account's preparation process, the Trust's ability to continue as a going concern.

We are also required to disclose material uncertainties in respect of events or conditions that cast significant doubt upon the going concern ability of the Trust to continue as a going concern and these are disclosed below.

The financial performance of the Trust is included in the performance report.

Note 1.3 Consolidation

Entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it has the ability to affect the variable returns from the other entity through its power to direct relevant activities. The income, expenses, assets, liabilities, equity, and reserves of the subsidiary are consolidated in full into the appropriate financial statement lines. The capital and reserves attributable to non-controlling interests are included as a separate item in the Statement of Financial Position. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not coterminous.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'.

The following subsidiaries have been consolidated:

- Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds (The Health Tree Foundation)

Subsidiaries - Charitable Funds

The Trust is the corporate trustee to Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds (The Health Tree Foundation). The Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Trust is exposed to variable returns from its involvement with the charitable fund to obtain benefits for itself, its patients or its staff.

The charitable fund's statutory accounts are prepared to 31 March 2026 in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Trust's accounting policies and
- Eliminate intra-group transactions, balances, gains and losses.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.4 Critical Accounting Judgements and Key Sources of Estimation and Accuracy

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

The below are the judgements made in the process of applying the accounting policies and assumptions about the future and other major sources of estimation uncertainty that have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities.

Going Concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. Please refer to Accounting policy 1.2.

Property Valuations and Asset Lives

Valuations are undertaken by an independent external valuer, Cushman and Wakefield, in line with Royal Institute of Chartered Surveyors (RICS) guidance. These values will therefore be subject to changes in market conditions and market values. The asset lives are also estimated by the independent external valuer.

The valuation exercise was carried out in the final quarter of 2025/26 with a valuation date of 31 March 2026, using the RICS Valuation Global Standards 2020 (Red Book).

Of the £224.8m net book value of land and buildings subject to valuation, £198.9m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

The total net book value of all property, plant and equipment included within these accounts is £284.1m.

Accruals

Accruals included within the accounts are based on the best available information. This is applied in conjunction with historical experience and based on individual circumstances. The total value of accruals included in these accounts is £17.2m.

Provisions

The estimates of outcome and financial effect of provisions are determined by the judgement of the management of the Trust, supplemented by experience of similar transactions and, in some cases, reports of independent experts.

Uncertainties surrounding the amount to be recognised as a provision are dealt with by various means according to the circumstance. Where the provision being measured involves more than one outcome, the obligation is estimated by weighing all possible outcomes by their associated probabilities; the expected value of the outcome. Where there is a range of possible outcomes, and each point in the range is likely as the other, the mid-point of the range is used. Where a single outcome is being measured, the individual most likely outcome may be the best estimate of the liability. However, even in such a case, the Trust considers other possible outcomes.

The Trust is carrying a restructuring provision of £0.36m to support payments in line with the Trust pay protection policy.

The total value of provisions included within these accounts is £8.4m.

Note 1.5 Revenue from Contracts with Customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

Revenue in respect of services provided is recognised when (or as) performance obligations are satisfied by transferring promised services to the customer and is measured at the amount of the transaction price allocated to that performance obligation. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where a patient care spell is incomplete at the year end, revenue relating to the partially complete spell is accrued in the same manner as other revenue. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in the following year, that income is deferred and recognised as a contract liability.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.5 Revenue from Contracts with Customers (continued)

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under the Best Practice Tariff (BPT) scheme. Delivery under the scheme is part of how care is provided to patients. As such BPT payments are not considered distinct performance obligations in their own right; instead they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for BPT on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

The Trust also receives additional income outside of the block payments to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Revenue from Research Contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract. Some research income alternatively falls within the provisions of IAS 20 for government grants.

NHS Injury Cost Recovery Scheme

The Trust receives income under the NHS injury cost recovery scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when performance obligations are satisfied. In practical terms this means that treatment has been given, it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.6 Other Forms of Income

Grants and Donations

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure. Where the grants is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship Service Income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's apprenticeship service account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.7 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment. The schemes are subject to a full actuarial valuation every four years and an accounting valuation every year.

Clinicians who are members of the NHS Pension scheme may face a tax charge in respect of the growth of their NHS pension benefits above their pensions savings annual allowance threshold. The government has committed to allowing this charge to be paid by the NHS Pension Scheme. The NHS employer will make a contractually binding commitment to pay them a corresponding amount on retirement so that they are not disadvantaged by the charge. NHSE have provided a calculation of the required provision. These figures use the latest available information on actual uptake of the scheme. They are derived from combining information on applications to join the 2019/20 scheme under the policy, together with information in the scheme pays election form where present, and with averages assumed where these forms are absent or clearly an estimate (values less than £100). Future liabilities based on individual member data and scheme rules are then discounted to give totals for each Trust.

Note 1.8 Expenditure on Other Goods and Services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.9 Property, Plant and Equipment

Recognition

Property, plant and equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the NHS Foundation Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably;
- the item has cost of at least £5,000, or
- collectively, a number of items have a cost of at least £5,000 and individually have cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.
- Items form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Borrowing costs associated with the construction of new assets are not capitalised.

Measurement

Valuation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at valuation.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the current value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed by professional valuers every five years and in the intervening years by the use of appropriate indices or by interim valuation as necessary to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Current values are determined as follows:

- Freehold Properties – Existing Use Value (EUV);
- Specialised buildings – Depreciated Replacement Cost (DRC) – Modern Equivalent Asset (MEA);
- Others – DRC – EUV;
- Land – Modern Equivalent Asset (MEA).

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and meeting the location requirements of the services being provided.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees. Assets are revalued and depreciation commences when the assets are brought into use.

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.9 Property, Plant and Equipment (continued)

For any new acquisition of property, plant and equipment, the following table details the useful economic lives for the main classes of assets and where applicable, sub categories within each:

Main Assets	Sub Category	Life in Years
Buildings	Structural Engineering	Up to 70 years
Fixtures	Plant, machinery and equipment	5 to 25 years
	Furniture and fittings	5 to 10 years
	IT equipment	Up to 5 years
Vehicles/transport equipment		Up to 7 years
Intangible		Up to 10 years

Valuations are carried out in accordance with the current Valuation Standards and UK Valuation Standards contained within the Royal Institute of Chartered Surveyors (RICS) Valuation Standards – The Red Book, which are consistent with the agreed requirements of the DHSC and HM Treasury.

Property assets have been valued primarily by using the Depreciated Replacement Cost (DRC) approach. In accordance with VS6.6, the DRC will be subject to the prospect and viability of the continued occupation and use by the Trust.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The ultimate objective of the valuation is to place a value upon the asset. In this the value of the land in providing a modern equivalent facility was also considered. The modern equivalent may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at present, which has given rise to reduction in the land values.

The results of these valuations have been incorporated into these financial statements.

Equipment assets that are held for operational use are valued at depreciated historic cost where these assets have a short useful lives or low values or both, as this is not considered to be materially different from current value in existing use. Annually, an equipment review is also conducted by the department/directorate/equipment specialist and the life of the equipment assets is reviewed in conjunction with the experts in the field (medical electronics/suppliers/market intelligence). Assets in the course of construction are valued at current cost and they are revalued by professional valuers when they are brought into use or as part of the five or intervening years valuation whichever occurs first. These assets include any existing land or buildings under the control of a contractor.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation Gains and Losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating expenditure.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of other comprehensive income.

Impairments

In accordance with the DHSC GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised. Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item under "Other Comprehensive Income".

De-Recognition

Assets intended for disposal are reclassified as 'held for sale' once the criteria in IFRS 5 are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.9 Property, Plant and Equipment (continued)

Donated Assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation / grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Within these financial statements, the Trust does not have any donations with conditions attached at this present moment in time.

This includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the Coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Note 1.10 Intangible Assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets. Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Software

Software which is integral to the operation of hardware, eg an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, eg application software, is capitalised as an intangible asset where it meets recognition criteria.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management. From 1 April 2025, subsequent measurement of intangible assets is at cost less amortisation.

Prior to 1 April 2025, intangible assets were held under a revaluation approach reflecting current value in existing use. Revaluation gains and losses and impairments were treated in the same manner as for property, plant and equipment. On 1 April 2025, the carrying value of these assets was carried forward as 'deemed cost' and any related revaluation surpluses in the revaluation reserve were transferred to the I&E reserve.

Intangible assets held for sale are measured at the lower of their carrying amount or fair value less costs to sell.

Amortisation

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful Lives of Intangible Assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Software licences	5	10

Note 1.11 Government Grants

Government grants are grants from Government bodies other than income from Integrated Care Board (ICB) or NHS Trusts for the provision of services. Where a Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Note 1.12 Inventories

Inventories are valued at the lower of cost and net realisable value, using the first-in first-out cost formula.

Note 1.13 Private Finance Initiative (PFI) Transactions

At the 31 March 2026, the Trust did not have any PFI transactions.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.14 Leases

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a Lessee

Recognition and Initial Measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.81% applied to new leases commencing in 2025 and 5.32% to new leases commencing in 2026.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent Measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a Lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

Finance Leases

Amounts due from lessees under finance leases are recorded as receivables at the amount of the Trust's net investment in the leases. Finance lease income is allocated to accounting periods to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating Leases

Income from operating leases is recognised on a straight-line basis or another systematic basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised as an expense on a straight-line basis over the lease term.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.15 Cash and Cash Equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the Trust's cash management. Cash, bank and overdraft balances are recorded at current values.

Note 1.16 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation.

Early retirement provisions and injury benefit provisions both use the HM Treasury's post-employment benefits discount rate of 2.95% in real terms (prior year: 2.40%).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust, has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity. The Trust is carrying a provision of £0.36m to support payments in line with the Trust pay protection policy.

Clinical Negligence Costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at Note 33 but is not recognised in the Trust's accounts.

Non-Clinical Risk Pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.17 Climate Change Levy

The Climate Change Levy (CCL) is the successor scheme to the Carbon Reduction Commitment (CRC). Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

Note 1.18 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 39 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 34, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:

- possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.19 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

The Secretary of State can issue new PDC to, and require repayments of PDC from, the Trust. PDC is recorded at the value received.

A charge, reflecting the cost of capital utilised by the Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, with certain additions and deductions as defined by the Department of Health and Social Care.

This policy is available at <https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts>.

In accordance with the requirements laid down by the Department of Health and Social Care (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the pre-audit version of the annual accounts. The dividend calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

Note 1.20 Value Added Tax (VAT)

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Note 1.21 Corporation Tax

The Trust has carried out a review of corporation tax liability of its non-healthcare activities. At present, all activities are either ancillary to the Trust's patient care activity or are below the de minimus level at which corporation tax is due. Therefore, the Trust has determined that it has no liability for corporation tax. Further guidance is awaited from NHS England, the HM Treasury and the Inland Revenue.

Note 1.22 Foreign Exchange

The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Trust does not have any assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

Note 1.23 Third Party Assets

Assets belonging to third parties in which the Trust has no beneficial interest (such as money held on behalf of patients) are not recognised in the accounts. However, they are disclosed in a separate note (note 28) to the accounts in accordance with the requirements of HM Treasury's *FReM*.

Note 1.24 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis.

The losses and special payments note (Note 40) is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

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Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.25 Financial Assets and Financial Liabilities

Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Classification and Measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets or financial liabilities in respect of assets acquired or disposed of through leasing arrangements are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are classified as subsequently measured at amortised cost, or fair value through profit and loss. The Trust has no financial assets at fair value through profit and loss or fair value through other comprehensive income.

Financial liabilities classified as subsequently measured at amortised cost. The Trust has no financial liabilities at fair value through profit and loss.

Financial Assets and Financial Liabilities at Amortised Cost

Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Financial Assets Measured at Fair Value through Other Comprehensive Income

A financial asset is measured at fair value through other comprehensive income where business model objectives are met by both collecting contractual cash flows and selling financial assets and where the cash flows are solely payments of principal and interest. Movements in the fair value of financial assets in this category are recognised as gains or losses in other comprehensive income except for impairment losses. On derecognition, cumulative gains and losses previously recognised in other comprehensive income are reclassified from equity to income and expenditure, except where the Trust elected to measure an equity instrument in this category on initial recognition.

Financial Assets and Financial Liabilities at Fair Value through Profit and Loss

Financial assets measured at fair value through profit or loss are those that are not otherwise measured at amortised cost or at fair value through other comprehensive income. This category also includes financial assets and liabilities acquired principally for the purpose of selling in the short term (held for trading) and derivatives. Derivatives which are embedded in other contracts, but which are separable from the host contract are measured within this category. Movements in the fair value of financial assets and liabilities in this category are recognised as gains or losses in the Statement of Comprehensive Income.

Impairment of Financial Assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Expected credit losses are determined by reference to past experience within separate categories of debt, classified by level of risk. Judgement is also applied, where the expectation of future credit losses is anticipated to impact upon the recoverable amount of the asset. The age of a receivable is taken into account and the more overdue a receivable becomes, the higher the value of expected credit loss. A different risk classification has been applied to a specific group of private patient billing that is at higher risk of not being collected than usual.

HM Treasury has ruled that central government bodies may not recognise stage 1 or stage 2 impairments against other government departments, their executive agencies, the Bank of England, Exchequer Funds, and Exchequer Funds' assets where repayment is ensured by primary legislation. The Trust therefore does not recognise loss allowance for stage 1 or stage 2 impairments against these bodies. Additionally, the Department of Health and Social Care provides a guarantee of last resort against the debts of its arm's length bodies and NHS bodies (excluding NHS charities), and the Trust does not recognise loss allowances for stage 1 or stage 2 impairments against these bodies.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

The Trust reviews its income receivable from the injury recovery unit on an annual basis taking into account local trends of recovery and appropriate top up provision has been made for irrecoverable debtors (25%), this is over and above the proposed bad debts provision of 24.62% (2024/25: 24.45%) recommended by the Department of Health and Social Care.

In line with policy, the Trust has undertaken a review of all outstanding debts and suitable provisions are recognised within these statements for bad and doubtful debts.

Derecognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Notes to the Accounts

Note 1 Accounting Policies and Other Information (continued)

Note 1.26 Transfers of Functions to / from Other NHS Bodies / Local Government Bodies

For functions that have been transferred to the Trust from another NHS / local government body, the transaction is accounted for as a transfer by absorption. The assets and liabilities transferred are recognised in the accounts using the book value as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets / liabilities transferred is recognised within income / expenses, but not within operating activities.

For property, plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

There has been no transfer of functions to the Trust during the year.

Note 1.27 Early Adoption of Standards, Amendments and Interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2025/26.

Note 1.28 Standards, Amendments and Interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following IFRS Standards to be applied in 2025/26:

IFRS 18 Presentation and Disclosure in Financial Statements - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

IFRS 19 Subsidiaries without Public Accountability Disclosures - The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the standard in future periods has not yet been assessed.

The following future changes to adaptations and interpretations of IAS 16 for the public sector are also not yet adopted:

Changes to valuation of property, plant and equipment (PPE) assets – The DHSC GAM for 2026/27 and associated consultation response document confirms future changes which will impact on the financial statements.

From 2026/27 NHS bodies' valuation methodology will be a mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years. The requirement in IAS 16 to revalue an asset when its fair value differs materially from its carrying value is being withdrawn for the public sector. Given the variation in PPE valuations in any given year, and future changes in indices, it is not possible to quantify the impact of applying these changes in future periods. PPE and right of use assets currently subject to revaluation have a total book value of £225m as at 31 March 2026.

Note 2 Operating Segments

The Trust's major activity is healthcare and therefore is treated as a single segment.

The operating results of the Trust are reviewed monthly by the Trust's chief operating decision maker which is the overall Trust Board and which includes non-executive directors. For 2025/26, the Board of Directors reviewed the financial position of the Trust as a whole in their decision making process.

The single segment of 'Healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

Note 2.1 Income Generation Activities

The Trust undertakes certain activities with an aim of break even or achieving a small surplus, which is then used to support patient care.

Some of these activities are essential for providing the right level of service to patients and visitors and the profit element, if any, is incidental to the service provision.

The following table provides details of activities where the gross cost of generating the income or the gross income exceeded £1m.

<i>i) Car Parking Services</i>	Trust 2025/26 £000	Trust 2024/25 £000
Income	2,526	2,327
Direct costs	(1,690)	(1,624)
Surplus before indirect costs	836	703
Indirect Costs	(696)	(781)
(Deficit) / Surplus	140	(78)

ii) Staff Accommodation

Staff accommodation income amounted to £2.5m (2024/25: £2.3m) during the year. However, the costs associated with the income generation form part of the costs of the total provision of accommodation and property services.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Note 3 Operating Income from Patient Care Activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4

Note 3.1 Income from Patient Care Activities (by nature)	2025/26	2024/25
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	91,687	84,742
Income from commissioners under API contracts - fixed element*	421,460	406,040
High cost drugs income from commissioners	13,725	11,207
Other NHS clinical income	3,034	6,493
Community services		
Income from commissioners under API contracts*	32,838	23,316
Income from other sources (e.g. local authorities)	211	2,288
All services		
Private patient income	298	316
National pay award central funding***		1,074
Additional pension contribution central funding**	23,521	22,208
Other clinical income	2,379	1,967
Total income from activities	589,153	559,651

*Aligned payment and incentive (API) contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2025/26 NHS Payment Scheme documentation.

<https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/>

**Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.38% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%) and related NHS England funding (9.4%) have been recognised in these accounts.

***Additional funding was made available directly to providers by NHS England in 2024/25 for implementing the backdated element of pay awards where government offers were finalised after the end of the 2023/24 financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

Note 3.2 Income from Patient Care Activities (by source)

	2025/26	2024/25
	£000	£000
Income from patient care activities received from:		
NHS England	37,984	51,721
Integrated care boards	548,037	505,351
Department of Health and Social Care	28	46
Other NHS providers	216	280
NHS other	-	4
Local authorities	211	-
Non-NHS: private patients	298	316
Non-NHS: overseas patients (chargeable to patient)	822	1,286
Injury cost recovery scheme	817	647
Non NHS: other	740	-
Total income from activities	589,153	559,651
Of which:		
Related to continuing operations	589,153	559,651
Related to discontinued operations	-	-

Note 3.3 Overseas Visitors (relating to patients charged directly by the provider)

	2025/26	2024/25
	£000	£000
Income recognised this year	822	1,286
Cash payments received in-year	155	143
Amounts written off in-year	525	618

Note 4 Other Operating Income (Group)

	2025/26			2024/25		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	807	-	807	740	-	740
Education and training	23,358	1,731	25,089	21,472	1,144	22,616
Non-patient care services to other bodies	22,457		22,457	21,914		21,914
Receipt of capital grants and donations and peppercorn leases		19,497	19,497		3,095	3,095
Revenue from operating leases		184	184		179	179
Charitable fund incoming resources		386	386		930	930
Other income*	6,126	-	6,126	5,482	-	5,482
Total other operating income	52,748	21,798	74,546	49,608	5,348	54,956
Of which:						
Related to continuing operations			74,546			54,956
Related to discontinued operations			-			-

* Other income included £2.5m (2024/25: £2.3m) for car parking and £2.3m (2024/25: £2.3m) for staff accommodation.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Note 5.1 Income from Activities arising from Commissioner Requested Services

The Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider licence and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	2025/26	2024/25
	£000	£000
Income from services designated as commissioner requested services	562,500	534,945
Income from services not designated as commissioner requested services	26,653	24,706
Total	589,153	559,651

Note 5.2 Profits and Losses on Disposal of Property, Plant and Equipment

	Trust	Trust
	2025/26	2024/25
	£000	£000
Gains on disposal of other property plant and equipment	33	109
Losses on disposal of other property plant and equipment	(29)	(2)
Total gain / (loss) on disposal of assets	4	107

Note 5.3 Fees and Charges (Group)

The following disclosure is of income from charges to service users where the full cost of providing that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2025/26	2024/25
	£000	£000
Income	2,526	2,327
Full cost	(2,386)	(2,406)
Surplus / (deficit)	140	(79)

The fees and charges above relate to Car Parking Services.

Northern Lincolnshire and Goole NHS Foundation Trust - Annual Accounts 2025/26

Note 6 Operating Leases - Northern Lincolnshire and Goole NHS Foundation Trust as Lessor

This note discloses income generated in operating lease agreements where the Trust is the lessor.

Note 6.1 Operating Leases Income

	2025/26	2024/25
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	184	179
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	184	179

Note 6.2 Future Lease Receipts

	31 March 2026	31 March 2025
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	184	179
- later than one year and not later than two years	184	179
- later than two years and not later than three years	184	179
- later than three years and not later than four years	184	179
- later than four years and not later than five years	184	179
- later than five years	-	-
Total	920	895

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Note 7.1 Operating Expenses (Group)

	2025/26	2024/25
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	6,752	4,444
Purchase of healthcare from non-NHS and non-DHSC bodies	10,597	12,177
Staff and executive directors costs	452,957	419,881
Remuneration of non-executive directors	123	150
Supplies and services - clinical (excluding drugs costs)	52,352	49,468
Supplies and services - general	8,452	6,189
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	41,179	39,781
Inventories written down	-	98
Consultancy costs	1,632	1,375
Establishment	3,998	4,219
Premises	24,142	23,085
Transport (including patient travel)	3,122	3,085
Depreciation on property, plant and equipment	20,547	18,695
Amortisation on intangible assets	2,212	1,682
Net impairments	33,183	15,545
Movement in credit loss allowance: contract receivables / contract assets	896	533
Change in provisions discount rate(s)	(122)	11
Fees payable to the external auditor		
audit services- statutory audit	181	174
Internal audit costs	83	74
Clinical negligence	16,921	15,781
Legal fees	210	386
Insurance (as a policy holder)	477	460
Research and development	676	622
Education and training	3,593	2,733
Expenditure on low value leases	598	181
Redundancy	227	135
Car parking & security	1,694	1,624
Hospitality	12	13
Losses, ex gratia & special payments	20	18
Other NHS charitable fund resources expended	170	101
Other*	1,211	1,089
Total	688,095	623,809
Of which:		
Related to continuing operations	688,095	623,809

* Other includes; £0.26m of patient welfare, £0.24m professional fees & £0.1m interpreting services.

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Note 7.2 Other Auditor Remuneration

	2025/26 £000	2024/25 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	-	-
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	-	-
Total	-	-

Note 7.3 Limitation on Auditor's Liability

The limitation on auditor's liability for external audit work is £179k (2024/25: £179k).

Note 8 Impairment of Assets

	2025/26 £000	2024/25 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	33,183	15,545
Total net impairments charged to operating surplus / deficit	33,183	15,545
Impairments charged to the revaluation reserve	3,197	2,014
Total net impairments	36,380	17,559

The impairment losses in 2025/26 were as a result of bringing into use the borehole (£9m), together with decarbonisation and internal funding for high voltage cabling, lighting, windows, roofing and solar (£23m).

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Note 9 Employee Benefits

	2025/26	2024/25
	Total	Total
	£000	£000
Salaries and wages	335,300	315,326
Social security costs	42,212	32,442
Apprenticeship levy	1,692	1,609
Employer's contributions to NHS pensions	59,605	56,192
Pension cost - other	22	-
Temporary staff (including agency)	16,663	16,416
Total gross staff costs	455,494	421,985
Recoveries in respect of seconded staff	-	-
Total staff costs	455,494	421,985
Of which		
Costs capitalised as part of assets	1,239	812

Note 9.1 Retirements due to ill-health

During 2025/26 there were 5 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2025). The estimated additional pension liabilities of these ill-health retirements is £1,295k (£189k in 2024/25).

These estimated costs are calculated on an average basis and will be borne by the NHS Pension Scheme.

Note 9.2 Directors' Remuneration

The aggregate amounts payable to Directors were:

	Group	
	2025/26	2024/25
	Total	Total
	£000	£000
Salary	1,051	1,011
Employer's National Insurance	149	122
Employer's pension contributions	101	102
Total	1,301	1,235

Note 9.3 Management Costs

	Group	
	2025/26	2024/25
	Total	Total
	£000	£000
Management Costs	29,155	27,865
Income	665,953	617,092
Management Costs as a % of income	4.38%	4.52%

The above is excluding Charitable income and costs.

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Note 10 Pension Costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both the 1995/2008 and 2015 schemes are accounted for, and the scheme liability valued, as a single combined scheme. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and Social Care in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting Valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2026, is based on valuation data as at 31 March 2024, updated to 31 March 2026 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full Actuarial (funding) Valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 at 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

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Note 11 Finance Income

Finance income represents interest received on assets and investments in the period.

	2025/26	2024/25
	£000	£000
Interest on bank accounts	2,002	2,832
NHS charitable fund investment income	40	37
Total finance income	2,042	2,869

Note 12.1 Finance Expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	2025/26	2024/25
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	105	134
Interest on lease obligations	256	303
Total interest expense	361	437
Unwinding of discount on provisions	74	79
Total finance costs	435	516

Note 12.2 The Late Payment of Commercial Debts (interest) Act 1998

	2025/26	2024/25
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-

Note 12.3 Other Gains / (Losses)

	2025/26	2024/25
	£000	£000
Gains on disposal of assets	33	109
Losses on disposal of assets	(29)	(2)
Total gains / (losses) on disposal of assets	4	107
Fair value gains / (losses) on charitable fund investments & investment properties	(99)	(51)
Total other gains / (losses)	(95)	56

Note 13 Revaluation of Assets (Property, Plant and Equipment) Cushman & Wakefield Valuations Summary

	Group	
	2025/26	2024/25
	£000	£000
Impairments		
Impairments charged to Revaluation Reserve	(3,197)	(2,014)
Impairments charged to Statement of Comprehensive Income	(35,420)	(16,972)
Total Impairments due to Market Changes	(38,617)	(18,986)
	Group	
	2025/26	2024/25
	£000	£000
Revaluation gains		
Revaluation gains credited to Revaluation Reserve	694	1,841
Revaluation gains relating to previous impairments credited to Statement of Comprehensive Income	2,237	1,427
Total Revaluation gains due to Market Changes	2,931	3,268

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Note 14 Trust Income Statement and Statement of Comprehensive Income

In accordance with Section 408 of the Companies Act 2006, the Trust is exempt from the requirement to present its own income statement and statement of comprehensive income. The Trust's deficit for the period was £29.1 million (2024/25: £13.7 million). The Trust's total comprehensive income/(expense) for the period was £31.6 million (2024/25: £13.9 million).

Note 15 Discontinued Operations

	2025/26	2024/25
	£000	£000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Gain on disposal of discontinued operations	-	-
(Loss) on disposal of discontinued operations	-	-
Corporation tax expense attributable to discontinued operations	-	-
Total	-	-

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Note 16.1 Intangible Assets - 2025/26

Group	Software licences £000	Intangible assets under construction £000	Total £000
Cost at 1 April 2025 - brought forward *	17,840	5,427	23,267
Additions	1,251	7,386	8,637
Reclassifications	4	-	4
Disposals / derecognition	(49)	-	(49)
Cost at 31 March 2026	19,046	12,813	31,859
Amortisation at 1 April 2025 - brought forward	9,984	-	9,984
Provided during the year	2,212	-	2,212
Disposals / derecognition	(49)	-	(49)
Amortisation at 31 March 2026	12,147	-	12,147
Net book value at 31 March 2026	6,899	12,813	19,712
Net book value at 1 April 2025	7,856	5,427	13,283

* From 1 April 2025, the option to apply the revaluation model in IAS 38 to intangible assets has been withdrawn prospectively. Where assets were previously revalued, the carrying value at the transition date was carried forward as 'deemed cost'.

Note 16.2 Intangible Assets - 2024/25

Group	Software licences £000	Intangible assets under construction £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	14,794	3,069	17,863
Additions	3,046	2,358	5,404
Valuation / gross cost at 31 March 2025	17,840	5,427	23,267
Amortisation at 1 April 2024 - as previously stated	8,302	-	8,302
Provided during the year	1,682	-	1,682
Amortisation at 31 March 2025	9,984	-	9,984
Net book value at 31 March 2025	7,856	5,427	13,283
Net book value at 1 April 2024	6,492	3,069	9,561

Note 17.1 Property, Plant and Equipment - 2025/26

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2025 - brought forward	9,056	199,769	17,119	22,764	63,242	186	28,448	1,858	342,442
Additions	-	24,167	411	31,370	5,091	-	416	16	61,471
Impairments	(741)	(2,230)	(226)	-	-	-	-	-	(3,197)
Revaluations	59	(40,412)	232	-	-	-	-	-	(40,121)
Reclassifications	-	18,661	-	(20,254)	1,589	-	-	-	(4)
Disposals / derecognition	-	-	-	-	(3,354)	-	(3,133)	(493)	(6,980)
Valuation / gross cost at 31 March 2026	8,374	199,955	17,536	33,880	66,568	186	25,731	1,381	353,611
Accumulated depreciation at 1 April 2025 - brought forward	-	84	-	-	44,608	180	19,976	1,207	66,055
Provided during the year	-	8,275	366	-	6,085	6	3,098	182	18,012
Impairments	-	35,301	119	-	-	-	-	-	35,420
Reversals of impairments	-	(1,684)	(553)	-	-	-	-	-	(2,237)
Revaluations	-	(40,883)	68	-	-	-	-	-	(40,815)
Disposals / derecognition	-	-	-	-	(3,325)	-	(3,133)	(493)	(6,951)
Accumulated depreciation at 31 March 2026	-	1,093	-	-	47,368	186	19,941	896	69,484
Net book value at 31 March 2026	8,374	198,862	17,536	33,880	19,200	0	5,790	485	284,128
Net book value at 1 April 2025	9,056	199,685	17,119	22,764	18,634	6	8,472	651	276,388

Note 17.2 Property, Plant and Equipment - 2024/25

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Valuation / gross cost at 1 April 2024 - as previously stated	9,381	174,736	17,195	43,433	59,519	186	25,119	1,511	331,080
Additions	-	20,785	7	10,639	2,373	-	2,946	53	36,804
Impairments	(341)	(1,646)	(27)	-	-	-	-	-	(2,014)
Revaluations	16	(20,875)	(56)	-	-	-	-	-	(20,915)
Reclassifications	-	26,769	-	(31,308)	3,862	-	383	294	(0)
Disposals / derecognition	-	-	-	-	(2,512)	-	-	-	(2,512)
Valuation / gross cost at 31 March 2025	9,056	199,769	17,119	22,764	63,242	186	28,448	1,858	342,442
Accumulated depreciation at 1 April 2024 - as previously stated	-	-	-	-	41,306	171	17,327	1,070	59,874
Provided during the year	-	6,938	357	-	5,813	9	2,649	137	15,903
Impairments	23	16,949	-	-	-	-	-	-	16,972
Reversals of impairments	-	(1,213)	(214)	-	-	-	-	-	(1,427)
Revaluations	(23)	(22,590)	(143)	-	-	-	-	-	(22,756)
Disposals / derecognition	-	-	-	-	(2,511)	-	-	-	(2,511)
Accumulated depreciation at 31 March 2025	-	84	-	-	44,608	180	19,976	1,207	66,055
Net book value at 31 March 2025	9,056	199,685	17,119	22,764	18,634	6	8,472	651	276,388
Net book value at 1 April 2024	9,381	174,736	17,195	43,433	18,213	15	7,792	441	271,206

Note 17.3 Property, Plant and Equipment Financing - 31 March 2026

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	8,374	190,029	17,536	24,624	18,178	0	5,783	449	264,974
Owned - donated/granted	-	8,833	-	9,256	1,022	-	7	36	19,154
NBV total at 31 March 2026	8,374	198,862	17,536	33,880	19,200	0	5,790	485	284,128

Note 17.4 Property, Plant and Equipment Financing - 31 March 2025

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	9,056	196,321	17,119	12,647	16,626	6	8,461	598	260,835
Owned - donated/granted	-	3,364	-	10,117	2,008	-	11	53	15,553
NBV total at 31 March 2025	9,056	199,685	17,119	22,764	18,634	6	8,472	651	276,388

Note 17.5 Property, Plant and Equipment Assets subject to an Operating Lease (Trust as a lessor) - 31 March 2026

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	1,465	-	-	-	-	-	-	1,465
Not subject to an operating lease	8,374	197,397	17,536	33,880	19,200	0	5,790	485	282,663
NBV total at 31 March 2026	8,374	198,862	17,536	33,880	19,200	0	5,790	485	284,128

Note 17.6 Property, Plant and Equipment Assets subject to an Operating lease (Trust as a lessor) - 31 March 2025

Group	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Subject to an operating lease	-	1,497	-	-	-	-	-	-	1,497
Not subject to an operating lease	9,056	198,188	17,119	22,764	18,634	6	8,472	651	274,891
NBV total at 31 March 2025	9,056	199,685	17,119	22,764	18,634	6	8,472	651	276,388

Note 18 Donations and Grants of Property, Plant and Equipment

The Trust received donations and grants to support capital purchases as follows;

	2025/26	2024/25
	£000	£000
Buildings ex Dwellings	10,071	2,803
Assets under Construction	9,256	-
Plant and machinery	170	220
Intangible	-	-
	19,497	3,022

Note 19 Revaluations of Property, Plant and Equipment

The Trust's property has been revalued on a Modern Equivalent Asset basis. On the 31 March 2026, the Trust's Valuers, Cushman & Wakefield completed a revaluation of the estate which resulted in a net valuation decrease. The results of this valuation have been included in these financial statements.

The property asset lives are as stated in the revaluation by the Trust's Valuers.

Basis of Valuation

The valuations have been carried out primarily on the basis of Market Value Existing Use using the depreciated replacement cost (DRC) methodology on a modern substitute basis. Non-operational property, including surplus land, has been valued to Fair Value.

Unless otherwise stated, the assumption has been made that the properties valued will continue to be in the occupation of the Trust for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

Method of Valuation

Depreciated Replacement Cost (DRC) is the method of valuation adopted for arriving at the value of specialised operational property for financial accounting purposes as recommended by UK GAAP, the Royal Institution of Chartered Surveyors and HM Treasury.

DRC is based on an estimate of the market value for the existing use of the land, plus the current gross replacement (reproduction) costs of the improvements, less allowances for physical deterioration and all relevant forms of obsolescence and optimisation.

Where the actual use of the property is so special that it proves impossible to categorise it in general market terms, land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site. In these circumstances, the Market Value for the Existing Use (MVEU) of the land has been arrived at having regard to the cost of purchasing a notional replacement site in the same locality that would be equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use.

The valuation exercise was carried out with a valuation date of 31 March 2026, using the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 (Red Book).

The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. The valuer has exercised professional judgement in providing the valuation and this remains the best information available to the Trust.

Of the £224.8m net book value of land and buildings subject to valuation, £198.9m relates to specialised assets valued on a depreciated replacement cost basis. Here the valuer bases their assessment on the cost to the Trust of replacing the service potential of the assets.

Property Valuations Summary

The Trust Valuers (Cushman & Wakefield) completed a valuation of the Property Assets at 31 March 2026 and concluded that there were changes to the Value of Property Assets. The Trust identified that these changes are material and therefore, the results have been incorporated into these financial statements. The outcome from the valuation was that, on all three sites, some of the assets suffered revaluation gains whilst other assets had an impairment. The approximate net impact of the Trust's valuations are given below.

	Description	Net Change in Valuation (increase) Decrease £000	Charged to Expenses £000	Impairment Reversals Credited to Expenses £000	Changes to Revaluation Reserves £000
Site					
Diana, Princess of Wales Hospital, Grimsby	Land and Buildings	2,825	3,467	(1,195)	552
Scunthorpe General Hospital	Land and Buildings	32,847	31,953	(1,018)	1,912
Goole & District Hospital	Land and Buildings	14	-	(24)	38
Other	Land and Buildings	-	-	-	-
Total		35,686	35,420	(2,237)	2,502

All the above changes relate to properties in the Trust's main healthcare segment.

a lessee

This note details information about leases for which the Trust is a lessee.

The Trust's leases are for property, equipment and vehicles and vary in terms from 1 to 10 years.

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Note 20 Leases (continued)

Note 20.1 Right of Use Assets - 2025/26

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2025 - brought forward	15,789	501	1,703	17,993	12,700
Additions	82	-	118	200	-
Remeasurements of the lease liability	344	(18)	-	326	-
Disposals / derecognition	(309)	(202)	(468)	(979)	-
Valuation / gross cost at 31 March 2026	15,906	281	1,353	17,540	12,700
Accumulated depreciation at 1 April 2025 - brought forward	5,775	375	843	6,993	3,978
Provided during the year	1,944	67	524	2,535	1,348
Disposals / derecognition	(309)	(202)	(468)	(979)	-
Accumulated depreciation at 31 March 2026	7,410	240	899	8,549	5,326
Net book value at 31 March 2026	8,495	41	454	8,991	7,375
Net book value at 1 April 2025	10,013	126	860	11,000	8,723
Net book value of right of use assets leased from other NHS providers					4,700
Net book value of right of use assets leased from other DHSC group bodies					2,674

Note 20.2 Right of Use Assets - 2024/25

Group	Property (land and buildings)	Plant & machinery	Transport equipment	Total	Of which: leased from DHSC group bodies
	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	15,956	915	1,399	18,270	12,768
Additions	61	23	570	654	-
Remeasurements of the lease liability	(228)	-	-	(228)	(68)
Disposals / derecognition	-	(437)	(266)	(703)	-
Valuation / gross cost at 31 March 2025	15,789	501	1,703	17,993	12,700
Accumulated depreciation at 1 April 2024 - brought forward	3,796	562	546	4,904	2,637
Provided during the year	1,980	250	563	2,792	1,341
Disposals / derecognition	-	(437)	(266)	(703)	-
Accumulated depreciation at 31 March 2025	5,775	375	843	6,993	3,978
Net book value at 31 March 2025	10,013	126	860	11,000	8,723
Net book value at 1 April 2024	12,160	353	853	13,366	10,132
Net book value of right of use assets leased from other NHS providers					5,558
Net book value of right of use assets leased from other DHSC group bodies					3,164

Note 20.3 Reconciliation of the Carrying Value of Lease Liabilities

Lease liabilities are included within borrowings in the statement of financial position. A breakdown of borrowings is disclosed in note 31.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April	10,898	13,066	10,898	13,066
Lease additions	130	381	130	381
Lease liability remeasurements	326	(228)	326	-228
Interest charge arising in year	256	303	256	303
Lease payments (cash outflows)	(2,593)	(2,624)	(2,593)	-2624
Other changes	-	-	-	-
Carrying value at 31 March	9,017	10,898	9,017	10,898

Lease payments for short term leases, leases of low value underlying assets and variable lease payments not dependent on an index or rate are recognised in operating expenditure.

These payments are disclosed in Note 7.1. Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

Note 20.4 Maturity Analysis of Future Lease Payments at 31 March 2026

	Group		Trust	
	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2026	2026	2026	2026
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,194	1,452	2,194	1,452
- later than one year and not later than five years;	5,876	5,343	5,876	5,343
- later than five years.	1,586	1,336	1,586	1,336
Total gross future lease payments	9,656	8,131	9,656	8,131
Finance charges allocated to future periods	(639)	(511)	(639)	(511)
Net lease liabilities at 31 March 2026	9,017	7,620	9,017	7,620
Of which:				
Leased from other NHS providers		4,774		4,774
Leased from other DHSC group bodies		2,846		2,846

Note 20.5 Maturity Analysis of Future Lease Payments at 31 March 2025

	Group		Trust	
	Of which leased from DHSC group bodies:		Of which leased from DHSC group bodies:	
	Total		Total	
	31 March	31 March	31 March	31 March
	2025	2025	2025	2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,552	1,477	2,552	1,477
- later than one year and not later than five years;	6,176	5,460	6,176	5,460
- later than five years.	3,037	2,673	3,037	2,673
Total gross future lease payments	11,765	9,610	11,765	9,610
Finance charges allocated to future periods	(867)	(695)	(867)	(695)
Net finance lease liabilities at 31 March 2025	10,898	8,915	10,898	8,915
Of which:				
Leased from other NHS providers		5,619		5,619
Leased from other DHSC group bodies		3,296		3,296

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Note 21 Other Investments / Financial Assets (non-current)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	1,146	1,297	-	-
Movement in fair value through income and expenditure	(99)	(51)	-	-
Disposals	(80)	(100)	-	-
Carrying value at 31 March	967	1,146	-	-

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Note 22 Analysis of Charitable Fund Reserves

The Northern Lincolnshire and Goole NHS Foundation Trust Board is the Corporate Trustee of the NHS Charitable Funds and therefore, the charitable funds represents a subsidiary of the Trust on the basis that it:

- has control over the NHS charitable fund (as determined by IRFS 10) and
- benefits from the NHS charitable fund.

From 2013/14 Northern Lincolnshire and Goole NHS Foundation Trust has consolidated the NHS charitable funds into its accounts.

For 2025/26, the NHS Charitable Funds balances are as follows:

	31 March 2026 £000	31 March 2025 £000
Unrestricted funds:		
Unrestricted income funds	1,175	1,656
	1,175	1,656

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

Note 23 Inventories

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Drugs	1,577	1,233	1,577	1,233
Consumables	2,710	2,491	2,710	2,491
Energy	89	62	89	62
Other	513	440	513	440
Total inventories	4,889	4,226	4,889	4,226
of which:				
Held at fair value less costs to sell	-	-	-	-

Inventories recognised in expenses for the year were £44,611k (2024/25: £43,581k). Write-down of inventories recognised as expenses for the year were £0k (2024/25: £98k).

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Note 24.1 Receivables

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Contract receivables	16,466	14,595	15,911	14,603
Allowance for impaired contract receivables / assets	(1,367)	(1,002)	(1,367)	(1,002)
Prepayments (non-PFI)	5,252	4,726	5,252	4,726
Interest receivable	217	224	217	224
PDC dividend receivable	19	879	19	879
VAT receivable	1,117	860	1,117	860
Other receivables*	29	21	29	21
NHS charitable funds receivables	94	569	-	-
Total current receivables	21,827	20,872	21,178	20,311
Non-current				
Other receivables**	700	751	700	751
Total non-current receivables	700	751	700	751
Of which receivable from NHS and DHSC group bodies:				
Current	5,256	8,200	4,689	8,200
Non-current	700	751	700	751

* Other receivable relates to Clinicians pension tax provision reimbursement funding from NHS England.

** Non-current other receivables relates to Clinicians pension tax provision reimbursement funding from NHS England.

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Note 24.2 Allowances for Credit Losses - 2025/26

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2025 - brought forward	1,002	-	1,002	-
New allowances arising	1,101	-	1,101	-
Reversals of allowances	(205)	-	(205)	-
Utilisation of allowances (write offs)	(531)	-	(531)	-
Allowances as at 31 Mar 2026	1,367	-	1,367	-

Note 24.3 Allowances for Credit Losses - 2024/25

	Group		Trust	
	Contract receivables and contract assets	All other receivables	Contract receivables and contract assets	All other receivables
	£000	£000	£000	£000
Allowances as at 1 Apr 2024 - as previously stated	1,105	-	1,105	-
New allowances arising	804	-	804	-
Reversals of allowances	(271)	-	(271)	-
Utilisation of allowances (write offs)	(636)	-	(636)	-
Allowances as at 31 Mar 2025	1,002	-	1,002	-

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Note 25 Finance Leases (Northern Lincolnshire and Goole NHS Foundation Trust as a lessor)

Northern Lincolnshire and Goole NHS Foundation Trust has no leasing arrangements in place that would be classified as finance leases and where the Trust is the lessor.

Note 25.1 Reconciliation of the Carrying Value of Finance Lease Receivables (net investment in the lease)

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
Finance lease receivables at 1 April	-	-	-	-
Prior period adjustments	-	-	-	-
Finance lease receivables at 1 April - restated	-	-	-	-
Transfers by absorption	-	-	-	-
Additions	-	-	-	-
Interest arising (unwinding of discount)	-	-	-	-
Remeasurements of lease receivables	-	-	-	-
Lease receipts (cash payments received)	-	-	-	-
Derecognition due to early termination	-	-	-	-
Finance lease receivables at 31 March	-	-	-	-

Note 25.2 Finance Lease Receivables Maturity Analysis as at 31 March 2026

	Group		Trust	
	Total	Of which leased to DHSC group bodies:	Total	Of which leased to DHSC group bodies:
	31 March 2026	31 March 2026	31 March 2026	31 March 2026
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
not later than one year;	-	-	-	-
later than one year and not later than two years;	-	-	-	-
later than two years and not later than three years;	-	-	-	-
later than three years and not later than four years;	-	-	-	-
later than four years and not later than five years;	-	-	-	-
later than five years.	-	-	-	-
Total future finance lease payments to be received	-	-	-	-
Estimated value of unguaranteed residual interest	-	-	-	-
Unearned interest income	-	-	-	-
Allowance for uncollectable lease payments	-	-	-	-
Net investment in lease (net lease receivable)	-	-	-	-
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

Note 25.3 Finance Lease Receivables Maturity Analysis as at 31 March 2025

	Group		Trust	
	Total	Of which leased to DHSC group bodies:	Total	Of which leased to DHSC group bodies:
	31 March 2025	31 March 2025	31 March 2025	31 March 2025
	£000	£000	£000	£000
Undiscounted future lease receipts receivable in:				
not later than one year;	-	-	-	-
later than one year and not later than two years;	-	-	-	-
later than two years and not later than three years;	-	-	-	-
later than three years and not later than four years;	-	-	-	-
later than four years and not later than five years;	-	-	-	-
later than five years.	-	-	-	-
Total future finance lease payments to be received	-	-	-	-
Estimated value of unguaranteed residual interest	-	-	-	-
Unearned interest income	-	-	-	-
Allowance for uncollectable lease payments	-	-	-	-
Net investment in lease (net lease receivable)	-	-	-	-
of which:				
Leased to other NHS providers		-		-
Leased to other DHSC group bodies		-		-

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Note 26 Other Assets

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Other assets	-	-	-	-
Total other current assets	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
Non-current				
Net defined benefit pension scheme asset	-	-	-	-
Other assets	-	-	-	-
Total other non-current assets	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

Note 26.1 Non-Current Assets Held for Sale and Assets in Disposal Groups

At the Statement of Financial Position date the Trust does not have any assets held for sale.

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Note 27 Liabilities in Disposal Groups

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Categorised as:				
Provisions	-	-	-	-
Trade and other payables	-	-	-	-
Other	-	-	-	-
Total	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>

Note 28.1 Cash and Cash Equivalents Movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2025/26	2024/25	2025/26	2024/25
	£000	£000	£000	£000
At 1 April	32,648	41,274	32,619	41,224
Net change in year	7,600	(8,626)	7,320	(8,605)
At 31 March	40,248	32,648	39,939	32,619
Broken down into:				
Cash at commercial banks and in hand	849	614	540	585
Cash with the Government Banking Service	39,399	32,034	39,399	32,034
Total cash and cash equivalents as in SoFP	40,248	32,648	39,939	32,619
Total cash and cash equivalents as in SoCF	40,248	32,648	39,939	32,619

Note 28.2 Third Party Assets Held by the Trust

Northern Lincolnshire and Goole NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March	31 March
	2026	2025
	£000	£000
Monies on deposit	6	6
Total third party assets	<u>6</u>	<u>6</u>

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Note 29.1 Trade and Other Payables

	Group		Trust	
	31 March	31 March	31 March	31 March
	2026	2025	2026	2025
	£000	£000	£000	£000
Current				
Trade payables	24,589	21,135	24,022	21,135
Capital payables	36,589	19,757	36,589	19,757
Accruals	17,326	14,357	17,326	14,357
Social security costs	10,421	8,757	10,421	8,757
Pension contributions payable	4,977	4,609	4,977	4,609
Other payables	5,346	5,596	5,346	5,596
NHS charitable funds: trade and other payables	183	80	-	-
Total current trade and other payables	99,431	74,291	98,681	74,211
Non-current				
Total non-current trade and other payables	-	-	-	-
Of which payables from NHS and DHSC group bodies:				
Current	6,707	9,313	6140	9,313
Non-current	-	-	-	-

Note 29.2 Early Retirements in NHS Payables above

The payables note above includes amounts in relation to early retirements as set out below:

Group and Trust	31 March	31 March	31 March	31 March
	2026	2026	2025	2025
	£000	Number	£000	Number
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-

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Note 30 Other Liabilities

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Deferred income: contract liabilities	383	194	383	194
Total other current liabilities	383	194	383	194
Non-current				
Total other non-current liabilities	-	-	-	-

Note 31 Borrowings

	Group		Trust	
	31 March 2026 £000	31 March 2025 £000	31 March 2026 £000	31 March 2025 £000
Current				
Loans from DHSC	1,363	1,374	1,363	1,374
Lease liabilities	2,001	2,311	2,001	2,311
Total current borrowings	3,364	3,685	3,364	3,685
Non-current				
Loans from DHSC	2,896	4,225	2,896	4,225
Lease liabilities	7,016	8,587	7,016	8,587
Total non-current borrowings	9,912	12,812	9,912	12,812

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Note 31.1 Reconciliation of Liabilities Arising from Financing Activities

Group - 2025/26	Loans from DHSC £000	Lease liabilities £000	Total £000
Carrying value at 1 April 2025	5,599	10,898	16,497
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,329)	(2,336)	(3,665)
Financing cash flows - payments of interest	(116)	(257)	(373)
Non-cash movements:			
Additions	-	130	130
Lease liability remeasurements	-	326	326
Application of effective interest rate	105	256	361
Carrying value at 31 March 2026	4,259	9,017	13,275

Group - 2024/25	Loans from DHSC £000	Lease liabilities £000	Total £000
Carrying value at 1 April 2024	6,939	13,066	20,005
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,329)	(2,321)	(3,650)
Financing cash flows - payments of interest	(145)	(303)	(448)
Non-cash movements:			
Additions	-	381	381
Lease liability remeasurements	-	(228)	(228)
Application of effective interest rate	134	303	437
Carrying value at 31 March 2025	5,599	10,898	16,497

Note 32 Provisions for Liabilities and Charges Analysis

Group	Pensions: early departure costs £000	Pensions: injury benefits £000	Legal claims £000	Re- structuring £000	Pay-related claims (including Agenda for Change) £000	Other £000	Total £000
At 1 April 2025	986	2,234	211	139	3,782	772	8,124
Change in the discount rate	(14)	(108)	-	-	-	(56)	(178)
Arising during the year	83	112	60	483	627	-	1,365
Utilised during the year	(201)	(172)	(11)	(266)	(207)	(29)	(886)
Reversed unused	-	-	(100)	-	-	(5)	(105)
Unwinding of discount	21	53	-	-	-	47	121
At 31 March 2026	875	2,119	160	356	4,202	729	8,441
Expected timing of cash flows:							
- not later than one year;	191	168	160	356	4,202	29	5,106
- later than one year and not later than five years;	608	624	-	-	-	80	1,312
- later than five years.	76	1,327	(0)	(0)	-	620	2,023
Total	875	2,119	160	356	4,202	729	8,441

The provision for early departure costs and injury benefits represents amounts payable to the NHS Business Services Authority, pensions division, to meet the costs of early retirement and industrial injury benefits. The provision is based on estimate of life expectancy and therefore there is a degree of uncertainty about the value of payments in the future.

The restructuring provision is to support payments in line with the Trust pay protection policy.

Equal pay provision relates to the Health Care Support Worker Band 2 to Band 3 rebanding claims.

Other provisions includes £729k relating to clinician pension tax reimbursement. A reimbursement has been recognised within non current debtors.

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Note 33 Clinical Negligence Liabilities

At 31 March 2026, £184,798k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northern Lincolnshire and Goole NHS Foundation Trust (31 March 2025: £144,175k).

Note 34 Contingent Assets and Liabilities

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(88)	(48)	(88)	(48)
Gross value of contingent liabilities	(88)	(48)	(88)	(48)
Amounts recoverable against liabilities	-	-	-	-
Net value of contingent liabilities	(88)	(48)	(88)	(48)
Net value of contingent assets	-	-	-	-

Note 35 Contractual Capital Commitments

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
Property, plant and equipment	671	5,565	677	5,565
Intangible assets	-	-	-	-
Total	671	5,565	677	5,565

Note 36 Defined Benefit Pension Schemes

The Trust has no defined benefit pension schemes.

Note 37 On-SoFP PFI, LIFT or Other Service Concession Arrangements

The Trust does not have any PFI or LIFT schemes at 31 March 2026.

Note 38 Off-SoFP PFI, LIFT and Other Service Concession Arrangements

The Trust does not have any Off-SOFP, PFI or LIFT schemes at 31 March 2026.

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Note 39 Financial Instruments

Note 39.1 Financial Risk Management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Trust has with its commissioners (Integrated Care Systems and NHS England) and funding flows from the Treasury, the Trust is not exposed to the degree of financial risk faced by business entities. Clinical Commissioning Groups did not exist as from 1st July 2022, when the commissioning relationship transferred to the Integrated Care System. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the Finance Directorate, within parameters defined formally within the Trust's Standing Financial Instructions and policies agreed by the Board of Directors. The Trust's treasury activity is subject to regular review by the Performance, Estates and Finance Committee and the Trust's internal auditors.

Currency Risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest Rate Risk

The Trust currently has borrowings of £4.225m (£5.554m 2024/25), (excluding interest), and the following table provides details of the interest rates, purpose of the loan and outstanding balance. The current interest rates are fixed and therefore has low exposure for the Trust.

	Interest	Balance at
	Rate	31 March 2026
Loan - Purpose	%	£000
Residential Accommodation DPoW Phase 1	2.06%	2,365
Energy Performance Contract	2.39%	1,860
Total		4,225

Credit Risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2026 are in receivables from customers and investments held by the charitable fund as shown note 21, as disclosed in the Trade and other receivables note 24.

Liquidity Risk

The Trust's operating costs are incurred under contracts with Integrated Care Systems, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds and funds obtained from Department of Health and Social Care or Independent Financing Facility loans. The Trust has in place Liquidity Support Funding agreed with the Department of Health and Social Care and the Independent Financing Facility for short term working capital support. This gives the Trust liquidity assurance to cover the period prior to regulator approval of future plans and to manage normal variations in cashflow.

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Note 39 Financial Instruments (continued)

Note 39.2 Carrying Values of Financial Assets (Group)

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2026				
Trade and other receivables excluding non financial assets	14,708	-	-	14,708
Cash and cash equivalents	39,939	-	-	39,939
Consolidated NHS Charitable fund financial assets	1,358	-	-	1,358
Total at 31 March 2026	56,005	-	-	56,005

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2025				
Trade and other receivables excluding non financial assets	14,528	-	-	14,528
Cash and cash equivalents	32,619	-	-	32,619
Consolidated NHS Charitable fund financial assets	1,244	-	-	1,244
Total at 31 March 2025	48,391	-	-	48,391

Note 39.3 Carrying Values of Financial Assets (Trust)

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2026				
Trade and other receivables excluding non financial assets	14,708	-	-	14,708
Cash and cash equivalents	39,939	-	-	39,939
Total at 31 March 2026	54,647	-	-	54,647

	Held at amortised cost £000	Held at fair value through I&E £000	Held at fair value through OCI £000	Total book value £000
Carrying values of financial assets as at 31 March 2025				
Trade and other receivables excluding non financial assets	1,428	-	-	1,428
Cash and cash equivalents	32,619	-	-	32,619
Total at 31 March 2025	34,047	-	-	34,047

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Note 39 Financial Instruments (continued)

Note 39.4 Carrying Values of Financial Liabilities (Group)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	4,259	-	4,259
Obligations under leases	9,017	-	9,017
Trade and other payables excluding non financial liabilities	82,922	-	82,922
Provisions under contract	8,441	-	8,441
Consolidated NHS charitable fund financial liabilities	183	-	183
Total at 31 March 2026	104,822	-	104,822

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	5,599	-	5,599
Obligations under leases	10,898	-	10,898
Trade and other payables excluding non financial liabilities	60,576	-	60,576
Provisions under contract	4,609	-	4,609
Consolidated NHS charitable fund financial liabilities	80	-	80
Total at 31 March 2025	81,762	-	81,762

Note 39.5 Carrying Values of Financial Liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2026	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	4,259	-	4,259
Obligations under leases	9,017	-	9,017
Trade and other payables excluding non financial liabilities	82,916	-	82,916
Provisions under contract	4,977	-	4,977
Total at 31 March 2026	101,169	-	101,169

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost £000	Held at fair value through I&E £000	Total book value £000
Loans from the Department of Health and Social Care	5,599	-	5,599
Obligations under leases	10,898	-	10,898
Trade and other payables excluding non financial liabilities	60,576	-	60,576
Provisions under contract	4,609	-	4,609
Total at 31 March 2025	81,682	-	81,682

Note 39.6 Fair Values of Financial Assets and Liabilities

The carrying value of short term trade and other payables is a reasonable approximation to fair value, all trade payables are considered to be short term. The nature of obligations relating to finance leases and other borrowings are that they are arms length transaction with values determined by contract. There is no significant difference between the carrying value and the fair value of these liabilities.

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Note 39 Financial Instruments (continued)

Note 39.7 Maturity of Financial Liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the statement of financial position which are discounted to present value.

	Group		Trust	
	31 March 2026	31 March 2025	31 March 2026	31 March 2025
	£000	£000	£000	£000
In one year or less	92,381	69,547	91814	69547
In more than one year but not more than five years	10,175	11,943	10175	11943
In more than five years	3,609	5,273	3609	5273
Total	106,165	86,763	105,598	86,763

Note 40 Losses and Special Payments

	2025/26		2024/25	
Group and Trust	Total number of cases Number	Total value of cases £000	Total number of cases Number	Total value of cases £000
Losses				
Cash losses	18	16	18	13
Bad debts and claims abandoned	151	520	261	623
Stores losses and damage to property	12	40	19	25
Total losses	181	576	298	661
Special payments				
Compensation under court order or legally binding arbitration award	6	7	1	1
Ex-gratia payments	12	9	20	17
Total special payments	18	16	21	18
Total losses and special payments	199	592	319	679
Compensation payments received				

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Note 41 Related parties (Group)

During the year none of the DHSC Ministers, Trust Board Members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Lincolnshire and Goole NHS Foundation Trust.

The DHSC is regarded as a related party. During the year, this Trust has had a significant number of material transactions with other entities for which the DHSC is regarded as the parent department. These entities are:

NHS England, Integrated Care Systems, NHS Trusts, NHS Foundation Trusts and NHS Resolution.

In addition, the Trust has had a number of material transactions with other Government departments and other central and Local Government bodies.

The Trust has also received revenue and capital payments from a number of charitable funds. The trustees of the charitable funds are also members of the Trust Board.

	2025/26	2025/26	2025/26	2025/26
	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Care Quality Commission	-	312	-	-
Department of Health and Social Care	34	1,240	-	-
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	82	232	99	59
Harrogate & District NHS Foundation Trust	70	10	1	9
Hull University Teaching Hospitals NHS Trust	3,939	4,663	3,073	3,737
Humber Teaching NHS Foundation Trust	-	124	-	-
Lancashire Teaching Hospitals NHS Foundation Trust	-	430	-	40
Leeds Teaching Hospitals NHS Trust	675	627	-	194
Lincolnshire Community Health Services NHS Trust	349	-	130	-
Lincolnshire Partnership NHS Foundation Trust	206	-	19	-
Manchester University NHS Foundation Trust	0	30	0	24
NHS Blood & Transplant	-	1,833	-	31
NHS Business Services Authority	8	329	37	160
NHS Derby & Derbyshire ICB	134	-	-	-
NHS England	37,677	29	403	113
NHS Greater Manchester ICB	157	-	-	-
NHS Humber & North Yorkshire ICB	471,760	-	394	570
NHS Leicester, Leicestershire and Rutland ICB	97	-	-	-
NHS Lincolnshire ICB	72,270	-	13	-
NHS North East and North Cumbria ICB	143	-	-	-
NHS Nottingham and Nottinghamshire ICB	397	-	-	-
NHS Pension Scheme	-	59,605	-	4,978
NHS Property Services	-	875	181	454
NHS Resolution	-	17,205	-	24
NHS South Yorkshire ICB	1,693	-	-	-
NHS West Yorkshire ICB	594	-	-	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	103	-	20	-
North Cumbria Integrated Care NHS Foundation Trust	70	-	11	8
North East Lincolnshire Council	126	89	-	-
North Lincolnshire Council	85	46	589	-
North Tees and Hartlepool NHS Foundation Trust	-	140	-	10
North West Anglia NHS Foundation Trust	40	-	9	-
Northampton General Hospital NHS Trust	583	0	0	0
Northamptonshire Healthcare NHS Foundation Trust	53	-	53	-
Nottingham University Hospitals NHS Foundation Trust	165	302	80	255
Oxford Health NHS Foundation Trust	-	101	-	-
Oxford University Hospitals NHS Foundation Trust	-	75	-	33
Portsmouth Hospitals University NHS Trust	-	107	-	3
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	152	196	313	29
Sheffield Children's NHS Foundation Trust	78	219	105	115
Sheffield Teaching Hospitals NHS Foundation Trust	44	525	10	230
UK Health Security Agency	-	262	-	47
United Lincolnshire Teaching Hospitals NHS Trust	13,546	1,854	189	34
University Hospitals Birmingham NHS Foundation Trust	-	677	-	404
University Hospitals of Leicester NHS Trust	138	139	4	41
York and Scarborough Teaching Hospitals NHS Foundation Trust	1	227	30	57
Yorkshire Ambulance Service NHS Trust	38	103	11	62
Other (Total)	1,087	276	42	91

Total Related Parties

606,594	92,882	5,816	11,812
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HM Revenue and Customs (Taxes and Duties)

-	43,904	1,117	10,421
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Other Government Departments

-	43,904	1,117	10,421
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Comparatives 2024/25

Total Related Parties

575,963	87,409	8,318	13,981
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Other Government Departments

-	34,051	-	8,757
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Related Party Transactions with bodies outside of the whole of government accounting were are follows:

	2025/26	2025/26	2025/26	2025/26
Organisation name/Trust Officer/ Nature of Relationship	Income	Expenditure	Receivables	Payables
	£000	£000	£000	£000
Health Service Journal - Chief Executive / Hospitality	-	13	-	-
Healthcare Financial Management Association Ltd - Chief Financial Officer	-	4	-	4
NHS Providers - Chief Executive / Hospitality	-	30	-	-



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