NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

ANNUAL REPORT & ACCOUNTS 2024/25

United by Compassion:
Driving for Excellence

Working in partnership:
Hull University Teaching Hospitals NHS Trust
Northern Lincolnshire and Goole NHS Foundation Trust

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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

Thank you for taking the time to read our Annual Report and Accounts for 2024/25.

In August 2023, the trust formally joined a group with Hull University Teaching Hospitals (HUTH) NHS Trust, with the new group executive team formed in November 2023. In spring 2024 we formally launched the group's new name – NHS Humber Health Partnership – and also created joint clinical services across both trusts called care groups. Since then our two organisations have continued to work more and more closely together and this report reflects much of these joint working and governance arrangements, whilst still setting out the trust's individual position where we are required to do so.

As you would expect this has been a lot of change for our joint workforce of nearly 19,000 to experience and manage over the last couple of years. This has been done as the NHS nationally, and for us locally, has continued to be under sustained pressure from local people to access services, whether they are urgent or emergency services or in relation to planned care.

So it is only right that I start this round up of the year with a massive thank you to our wonderful staff, whether they have been involved in managing any of these changes or focused on continuing to deliver their service. I know for many it will have been an uncertain time and they coped admirably and continued to keep all our services safe and available to our local communities.

Given the sustained pressure our performance on some key measures was not what we would have liked it to be. Set against national targets our performance overall was mixed at best, with some areas doing very well and others less so. We did struggle to see and treat many patients in a timely way in our emergency departments, as did most hospitals up and down the country. In these departments too many patients had to wait longer than four hours, with many having to wait much longer than that.

I would like to apologise to all those patients. It was a similar picture in relation to patients arriving in an ambulance where thousands of patients waited longer to be taken into our emergency departments than they should have. Despite a lot of work from many people across our group we know we have to work even harder to achieve faster waiting times in these urgent and emergency cases.

As in previous years there is better news in planned care, where we look to make sure patients get their booked procedures and operations. We continued to reduce the number of our longest waiting patients, those waiting 65 weeks or longer. I would like to thank our surgical and diagnostic teams for this work which needs to continue in the year ahead to treat those who have waited the longest and also begin to reduce the total number of patients waiting for treatment.

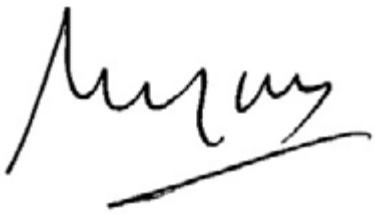
I would also like to thank our capital teams, who are continuing to improve and develop facilities for our patients across NHS Humber Health Partnership. Recently, we opened our new Community Diagnostic Centres in Grimsby and Scunthorpe, which will allow us to provide up to 300,000 additional diagnostic tests each year – and will be opening a further centre in the heart of Hull in summer 2025.

This year will also see us bringing bespoke new facilities online, including the final phase of our new Day Surgery Unit and Allam Centre at Castle Hill. We also have an exciting programme of works planned at Scunthorpe, where we are investing more than £27 million into transforming the site into one of the most environmentally sustainable healthcare settings in the UK.

As I have said before each and every member of staff plays an important part in running our hospitals and community services. Whether they are involved in the delivery of care directly to patients or not, the trust could not run without them. The same is true of our amazing team of volunteers who provide advice and guidance to our patients so often and in such a kind and considerate way.

I would like to thank every single one of them – and all our staff – for their continued professionalism in caring for our patients day in, day out. Thanks also to our team of governors for their challenge and support throughout the year. Finally, a huge thank you to our partners across the health system for their support, without which we could not have achieved many of the things we did.

I hope you will find the report interesting and informative.



Sean Lyons
Chair
Date: 20 June 2025

NHS
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NHS Foundation Trust

THE PERFORMANCE REPORT

ANNUAL REPORT & ACCOUNTS 2024/25

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 2024/25 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 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.

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.

In the 2024/25 financial year the trust's delivery plan reflected many of the ICB's priorities such as: tackling health inequalities; reducing the size of waiting lists; making sure people get timely access to cancer diagnosis and treatment; improving the number of patients waiting four hours and less in hospital emergency departments (EDs); and improving ambulance handover times to allow ambulances to get back on the road as quickly as possible.

The trust's sites and services

Community services

The trust provides a wide range of community services across North Lincolnshire, including district nursing, physiotherapy and psychology, podiatry, and specialist dental services. The community nursing and therapy services staff work with people of all ages and in a variety of settings from health, social care, and educational settings as well as in people's homes. The community and therapy staff recognise the importance of people being able to achieve and maintain their independence and health as far as possible.

Goole and District Hospital (GDH)

This is a purpose-built community hospital. It opened in 1988 and brought together services from a number of scattered sites around the town of Goole. Medical Services include general medicine, elderly, cardiology, rheumatology, gastroenterology, a light treatment service, diabetes and endocrinology, and haematology. Surgical services provided include general surgery, orthopaedics, ophthalmology, Ear, Nose and Throat (ENT), gynaecology and urology. There is also a surgical day case unit which is used to perform urology endoscopic procedures.

Two further main theatres are equipped for major orthopaedic work and other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre and an outpatient department. Audiology services are provided by the Surgery division. Family Services provide outpatient consultant-led gynaecology clinics, colposcopy services, hysteroscopy services and a midwifery-led 'Home from Home' unit for low-risk deliveries.

A consultant-led clinic for obstetrics is also provided with sonographer input. Consultant led paediatric outpatient activity is also delivered from Goole, to try to provide care closer to home. Therapy services are provided for both inpatients and outpatients with physiotherapy, occupational therapy, nutrition and dietetics and psychology services. There are two x-ray rooms together with mobile units, and an ultrasound room.

The diagnostics department also provides a regular mobile Magnetic Resonance Imaging (MRI) / Computed Tomography (CT) service. The hospital also accommodates a neurological rehabilitation centre - the Goole Neuro Rehab Centre, which is now managed by the Community and Therapies Division of the trust. Goole hospital also receives an inpatient pharmacy service and outpatient dispensing service from a community pharmacy contractor based within the hospital grounds.

City Healthcare Partnership CiC (CHCP) operate an Urgent Treatment Centre (UTC) from the hospital site. The UTC offers high-quality urgent medical help for patients when it's not a life or limb-threatening emergency. The UTC is open from 7am to 8pm, seven days a week.

Diana, Princess of Wales (DPoW) Hospital

The hospital is situated on a single site in the south of Grimsby. Built in 1983, it has undergone considerable expansion since then. Projects completed over recent years have provided a centralised fully integrated operations centre, theatres reconfiguration, new CT machine, new MRI, Acute Assessment Unit (AAU), full refurbishment of two medical wards, and new build of key worker accommodation comprising 220 student rooms and self-contained flats. In addition, the redevelopment of the Emergency Department (ED) was completed in October 2023. Diana Princess of Wales Hospital provides the full range of district general hospital services, including emergency care, medicine, surgery and critical care, paediatrics, obstetrics, gynaecology, outpatients, diagnostics and therapy services.

Medical specialties onsite include the ED, Same Day Emergency Care (SDEC), integrated AAU, frail elderly assessment services, diabetes and endocrinology, cardiology (including angiography, cardiac catheterisation, cardiac devices and permanent pacing facilities provided from a purpose-built Cardiology Day Case Unit), respiratory medicine, elderly care, haematology and gastroenterology, stroke services and rheumatology. Oncology, outpatient cardiothoracic surgery, plastic surgery and renal medicine are provided by visiting consultants from Hull University Teaching Hospitals (HUTH). Surgical specialties on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, urology, ophthalmology, ENT and maxillo-facial. The theatre suite provides eight fully equipped theatres each with its own anaesthetic room and two theatres dedicated to orthopaedic use (both with ultra clean air facilities). One theatre is dedicated to emergency work and staffed at all times. A separate session is reserved each day for acute trauma cases, including weekends. Patients requiring admission are admitted to Integrated AAU and streamlined to a speciality ward dependent on capacity. Some emergency mobile patients, if they meet a set criteria, are streamed up to the Same Day Emergency Care (SDEC) unit.

Family Services, where we provide maternity and paediatric services, are located in an estate comprising of maternity wards, a gynaecology ward, dedicated obstetric theatres within the maternity unit, Paediatric and Neonatal in-patient areas, and the Child Development Centre. Complementary to this is the community midwifery service that operates across a number of satellite locations in North East Lincolnshire. The trust provides encompassing care to women and their families throughout the area, including East Lindsey. Our breast imaging and diagnostic service is run from our dedicated unit called the Pink Rose Suite. Emergency/ acute paediatric services are provided through the Emergency/acute paediatric services are provided through the dedicated Paediatric Area within the ED and the Paediatric Assessment Unit located in the paediatric ward.

This is supported by a neonatal unit and children's ward, caring for medical and surgical patients. Four designated beds are provided for babies requiring transitional care within the maternity unit. We have a range of outpatient clinics, providing general paediatric clinics to specialist paediatric clinics. During the Covid-19 pandemic, some outpatient clinics were run virtually and this continues. The pathway is continued through the delivery of community paediatrics, ensuring children are provided appropriate care at an appropriate setting.

All the diagnostic and service departments are based on site including: endoscopy, which has received accreditation from the Joint Advisory Group [JAG] showing it has demonstrated that it has the competence to deliver against the criteria set out in the JAG standards; and radiology with plain film, ultrasound, nuclear medicine, CT and MRI. Medical physics provides neurophysiology, respiratory physiology, urodynamics and medical illustration. The hospital also hosts the Path Links hub laboratory for blood sciences. Community and Therapy services provide a wide range of support for in-patients, out-patients and throughout the community covering physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental.

The Assisted Living Centre operates on site and provides a fully refurbished centre for the assessment and provision of aids and adaptations. A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg. Pharmacy services are delivered from an out-patient dispensary (delivered by a third party), an inpatient dispensary and a centralised Aseptic Services Unit (serving both DPOW and SGH). Medicines stocks are received from the centralised pharmacy store on the Scunthorpe site. The trust medicines information services are also located on the Grimsby site. From October 2021 the outpatient Neurology service transferred over to HUTH, all the outpatients were transferred onto the HUTH patient admin system and the service is now managed by HUTH but delivered at two NLaG hospital sites.

Scunthorpe General Hospital (SGH)

Scunthorpe General Hospital (SGH) was built in the 1920s and occupies a site surrounded by residential properties. The site has expanded over time with modernised structures attached to original buildings. Recent developments completed include a new (accredited by the Joint Advisory Group on GI Endoscopy) Endoscopy Unit and Lower gastro-intestinal Unit, a new General Practice (GP) / Urgent Treatment Centre (UTC) facility and CT scanner. Recent construction schemes include incorporating a CT scanner into the new ED, redevelopment of the ED and to add a geothermal ground source heating system.

SGH provides the full range of district general hospital services, including an ED, medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services. Medical specialties on site include the ED, SDEC, frail elderly assessment services, acute assessment unit, diabetes and endocrinology, cardiology (with facilities for angiography, cardiac catheterisation and pacing), respiratory medicine, elderly care, haematology and gastroenterology, stroke services including Hyperacute, palliative medicine, rheumatology and neurology. Oncology, outpatient, cardiothoracic surgery, plastic surgery and renal medicine are provided by visiting consultants from HUTH.

Surgical specialities on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, urology, ophthalmology, ENT and maxillo-facial. The hospital is equipped with six main theatres, including one theatre dedicated to trauma and orthopaedic use (with ultra clean air facilities). One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

Family Services in SGH provide the maternity pathway using a traditional service model comprising antenatal/postnatal clinics, dedicated Central Delivery Suite, maternity theatre and a dedicated antenatal / postnatal ward. Gynaecology is provided through a range of outpatient clinics and an inpatient ward facility. During the Covid-19 pandemic, some outpatient clinics were run virtually and this continues. Acute/emergency paediatrics is provided by specialist nurses in the ED in conjunction with doctors. The children's ward staff works closely with the ED staff assessing and receiving medical and surgical patients ensuring the pathway is seamless. An inpatient paediatrics service is provided caring for children aged 0 to 16 years, supported by a community service. A neonatal intensive care unit is based close to the Central Delivery Suite allowing easy access for mum to baby. There are four transitional care beds managed by the neonatal team.

All the diagnostic and service departments are based on site including endoscopy, radiology with plain film, ultrasound, CT and MRI. The hospital hosts the Path Links hub laboratory for blood sciences. Community and Therapy services provide a wide range of support for inpatients, outpatients and throughout the community covering community nursing (operating across three networks), physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental.

A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg. Pharmacy services are delivered from an outpatient dispensary (delivered by a third party), an inpatient dispensary and a centralised pharmacy store (receiving the majority of medicines deliveries for the trust then storing and distributing medicines stocks to all three sites). There is a degree of automation with an on-site pharmacy robot.

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
- Three local authorities, and their health overview and scrutiny committees and health and wellbeing boards:
  - North Lincolnshire Council
  - North East Lincolnshire 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

Strategic Framework 2024

In Summer 2024 NHS Humber Health Partnership published a strategic framework setting out its high-level aims for the next few years.

The frameworks reflects the group's, and therefore the trust's, commitment to its people and its local communities – providing the best possible care and making a positive and lasting impact in our communities, going beyond the direct impact of our treatments and support. It includes a new vision, a new set of values and behaviours and five areas of work. The framework is set out over the next few pages.

Vision

- United by Compassion, Driving for Excellence

Values and behaviours

Compassion:

We care. We want the best for our people, places and communities

- Put the safety and care of patients and colleagues at the heart of everything you do
- Listen to your colleagues and patients, understand, empathise and take action to help
- Treat everyone with kindness and support those who need assistance or guidance
- Do the right thing, even if this is more difficult to do

Honesty:

We are honest about our shortcomings and always strive for better

- Take responsibility for your actions, decisions and behaviours
- Report concerns about safety, quality and negative behaviours as quickly as possible
- Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback
- Be open about mistakes, apologise, learn and improve

Respect:

We recognise and respect everyone's unique contribution

- Trust and appreciate your colleagues – say thank you and well done
- Talk to everyone in a respectful and polite manner and listen when others want to speak
- Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone
- Respect and use each other's strengths; act respectfully by giving, receiving and acting on constructive feedback

Teamwork:

We work together to achieve the best for our patients and communities

- Meet regularly as a whole team, discuss goals, actions and ideas for improvement. Commit to being good team members
- Include all colleagues in key discussions about the team or service
- Tackle poor behaviours as they arise
- Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

Ambitions

- To provide excellent care that meets our population's diverse needs
- To support and enable our population to live more years in good health

Areas of work

People

We can only deliver the scale of change that is needed if we have the right people, with the skills, knowledge and motivation to continually improve. Delivering our strategic ambitions will require us to build the confidence and resilience of our people – instilling pride in our group and the work that we do.

We will look after the health and wellbeing of our people:

- We will get the basics right for our teams, improving working environments, providing space for reflection and support to build resilience
- We will improve our approach to flexible working, to ensure we retain talent and enable our people to give their best at work and at home
- We will tackle discrimination head-on and ensure all our people are living out our values of compassion, honesty, teamwork and respect
- We will support our people to grow and develop to their full potential:
- We will work to build a genuinely inclusive culture that celebrates diversity and promotes belonging so that everyone feels safe and can thrive
- We will make it easier for our workforce – including our volunteers – to move around between different organisations and sectors and find the role for them
- We will focus on talent development, supporting people to grow in their roles and work at the top of their professional licence
- We will build a flexible and adaptable workforce for the future:
- We will work with our training partners to develop curricula that focus on core competencies, adaptability and innovation to help our future workforce to be creative and embrace change
- We will build the digital capabilities of our people to ensure they are fully equipped to deliver new ways of working for the future:
- We will make a positive impact on our communities through our people
- We will re-double our efforts to inspire and support our workforce to make healthier choices for them and their families, causing a ripple effect of healthy changes across our communities

Population health
To turn the dial on our performance as a group, we need to radically change what we do and how we do it. We will transform everything that we do and how we do it with a focus on delivering slick processes, eliminating unnecessary bureaucracy, and putting care in its rightful place.

We will streamline processes and remove duplication:
- We will have a laser focus on eliminating manual processes and workarounds
- We will invest to save by building the digital infrastructure that allows us to remove paper-based systems
- We will put in place clear governance processes with as few steps as possible to enable fast and effective decision-making and implementation of change
- We will eliminate unwarranted variation in our service delivery:
- We will develop delivery plans for our 14 Care Groups that align models or care and ways of working across both banks of the Humber, adopting “best in class” from across our organisations

We will do things once:
- We will look at every service and function to identify where improvements and efficiencies could be made by consolidating activities, teams and functions and doing things once across the system
- We will review our physical estate and rationalise wherever possible – looking at our assets across the system, not just within our organisations
- We will develop sustainable models of care:
- We will reorganise our services to make the best use of people, buildings and equipment, focusing on delivering quality local services as close to home as possible and highly specialised care from defined centres of excellence
- We will build robust digital foundations that are secure, resilient and work seamlessly across departments, organisations and sectors
- We will improve the way we use data to drive decision-making in real time and plan more effectively for the future

Patients
Being kept safe and well looked after is one of the top priorities for the people who use our services. As demand for our services continues to grow, we need to think very differently about how services are organised to ensure we can continue to provide safe and good quality services for our local communities. In all that we do, we will strive to provide the kind of care we would want for ourselves and our loved ones.

We will keep our patients safe and reduce avoidable harm:
- We will embed a safety-focused culture, supported by systems and processes that enable teams to deliver reliable, high-quality care
- We will make it easy for patients, loved ones and staff to speak up if they see something that isn’t quite right and build a positive culture of learning and improvement

We will deliver the best outcomes for our patients:

- We will strive to get the best possible outcomes for every patient, recognising that what defines a good outcome will be as individual as each person we treat
- We will empower teams to be responsive to patient needs, giving them space to innovate and try new things and adapt what they do to suit different needs
- We will improve the way our teams communicate with one another, with our patients and with other organisations to ensure they are all working together as effectively as possible

We will work hard to provide a positive experience for our patients and their loved ones:

- We will really listen to our patients and their loved ones and tailor our care and support to their needs and what matters to them
- We will build our services around our patients and their needs, adopting a home first approach radically rethinking how and where we provide care
- We will see carers, family members and loved ones as an asset and encourage them to get involved in their loved one's care

We will equip our patients to live healthier lives:

- We will use every conversation to provide our patients with the tools and the knowledge they need, and the encouragement of a trusted healthcare professional, to make small but impactful changes to their health and wellbeing

Pioneers

We are ambitious for our people and our population. We want to be at the leading edge of healthcare research and innovation. Research and innovation can help us to find the new systems and ways of working we need to adapt to the changing demands of the future. We must re-focus our efforts to maximise the impact of research and innovation.

We will build the infrastructure we need to deliver excellent clinical research:

- We will work with academic and industry partners to deliver the facilities, data and digital infrastructure we need to undertake quality, impactful research
- We will promote our nursing, midwife and allied health professionals to undertake research – giving appropriate time and resources to enable more professionals to be research-active
- We will build confidence and health literacy amongst our patients to enable them to make informed choices about participating in clinical trials and other research opportunities, making research more inclusive to improve our population's health
- We will align our research efforts to the big questions facing our population:
- We will apply the advanced skills and knowledge of our scientific community to the big challenges facing our population and our workforce today
- We will work with leading research institutions who have the expertise and connections we need to find the solutions to our unique set of challenges
- We will leverage our industry partnerships and expertise in carbon reduction and sustainability to ensure we are leading research and helping to define the future of sustainable healthcare

We will build our research capabilities and use our unique skills and assets to support wider economic regeneration in the Humber region
We will equip our people to innovate and transform:

- We will work with training providers to build research skills and capacity into curricula so that we can develop more homegrown researchers and our clinical and professional staff are engaged in relevant research that contributes to continuous improvement of our services
- We will foster creativity and entrepreneurship by giving greater autonomy to teams to deliver objectives within a framework
- We will engage and involve our communities in research and innovation, giving them a voice and influence over shaping the solutions

Partnerships
We cannot achieve success without the support of our partners, our people and our communities. To deliver our strategic ambitions, we must solidify our existing partnerships and leverage the influence we have as a group to forge new relationships with people and organisations within and beyond the Humber.

We will play a vital role in local health and care partnerships:
- We will work with partners in each of our local areas, recognising the unique challenges and opportunities in each geography, taking time to build strong relationships with each place
- We will build trust and credibility with our partners so that together we can take risks to deliver the type of radical change we need
- We will support our teams to develop closer relationships with partners at an operational level, encouraging joint ownership and collaborative problem-solving

We will use our size and scale to bring national and international attention to the Humber region:
- We will leverage the influence we have as a group to forge new relationships with wider academic and industry partners, to advocate for our region and its people and attract investment and increased attention into our area
- We will forge new partnerships with industry – both local and further afield – to deliver our ambitious net-zero targets and play our role in driving economic regeneration on and around the Humber estuary
- We will forge closer links with other like-minded organisations and influential institutions in the North, so that together we can have a stronger voice to advocate for our populations. Working together we will amplify our voice and ability to influence national policy

We will define a new relationship with our communities:
- We will take time to listen to our communities and to really understand their needs, wants and aspirations
- We will be clear with our population about what we need from them – and what they can do to support their own health and wellbeing

Foundations for success

Delivering these actions will only be possible if we also put in place the building blocks we need – digital infrastructure, leadership capacity and capability and a culture for success.

Digital infrastructure
- We will transform our approach to digital, data and technology to enable comprehensive change
- We will build robust digital foundations that are secure, resilient and interoperable
- We will improve the way we use data to drive decision-making in real time and plan more effectively for the future
- We will build a virtual hospital, which will work alongside our physical sites and be fully integrated into our existing service offer
- We will keep digital inclusion at the heart of what we do so that those living in our most deprived communities are not excluded

Leadership capacity and capability
- We will build capacity and capability at every level, growing the leaders we need for today and tomorrow
- We will develop leadership capacity and capability at all levels, giving our people the tools and permission they need to lead change in their area
- We will nurture local talent and develop the dynamic, flexible workforce we need for the future
- We will build on our record of widening participation, youth volunteering and apprenticeship schemes, to grow our own future workforce – going out of our way to offer tailored opportunities that will inspire and enable local people to enter rewarding careers in health and care

Culture for success

- We will build an inclusive, just and learning culture that encourages creativity and collaboration
- We will work to build a genuinely inclusive culture where diversity is celebrated, and the unique skills and perspectives of each individual are recognised and rewarded
- We will build a culture of continuous improvement where all staff feel empowered to lead change.
- We will embed a culture that rewards creativity, encourages appropriate risk-taking and supports people to learn from failure
- We will develop a culture that is outward-looking and willing to embrace new perspectives and ways of doing things

Significant events in 2024/25

Building our future – progress with capital investment

Nothing is more important to us than providing our patients with excellent standards of care, which is why we are continuously striving to upgrade our facilities, buildings, and equipment, providing our clinical teams with the tools and environment they require to meet the needs of our patients. While, like many acute healthcare providers, our aging estates continue to present challenges, our dedicated estates, facilities, and development teams have made a number of successful bids for funding that are helping to modernise and improve our sites.

Most recently, we have been awarded more than £27 million from the Government's Public Sector Decarbonisation Scheme (PSDS) which will be used to transform Scunthorpe hospital into one of the most environmentally sustainable healthcare sites in the UK. Over the next two years we will carry out a wide range of works, which will reduce our carbon footprint by 4,124.93 tonnes a year. That's the equivalent of more than 2,304 flights between London and Sydney, Australia.

At the centre of the scheme are plans to remove our aging gas-powered steam boilers and replace them with state-of-the-art, bespoke, electric-powered boilers, providing ecological and economical heating and hot water for the site. Alongside this, we are installing additional roof-mounted solar panels and putting solar carports into our staff car parks; upgrading our Building Management System and air handling systems; improving our insulation; installing double-glazed, thermally efficient windows and upgrading our electrical systems.

A further £1 million from the Great British Energy Local Power plan will also be invested into Scunthorpe to complement this work, generating estimated savings of £120,000 per year, along with £1.3 million that will be used to install further solar panels at our Grimsby site, which will result in estimated savings of £179,632 a year. We have also invested almost £30 million in improving diagnostic services across our region, partnering with our local authority colleagues in North and North East Lincolnshire, along with the Humber and North Yorkshire Integrated Care Board (ICB) to provide two new Community Diagnostic Centres. Located in the heart of Scunthorpe and Grimsby, each of these centres will enable us to offer an additional 150,000 diagnostic appointments a year, without the need for patients to come to our acute sites. Both are open seven days a week, from 8am to 8pm, providing greater flexibility and improving patient choice.

The £19.4 million centre in Lindum Street, Scunthorpe, has been purpose-built to house a range of diagnostic facilities, including phlebotomy, lung function, and cardiology tests; along with MRI, CT, and ultrasound scans and X-Ray. We have also incorporated Changing Places facilities into the building, which can be used irrespective of whether you are a CDC patient, providing a much-needed asset for disabled visitors to Scunthorpe. In Grimsby we have carried out a £10 million conversion of five units within Freshney Place Shopping Centre, installing facilities for X-Ray, Dexa and ultrasound scanning, along with phlebotomy and cardiology testing. We are also currently developing an area to house our ophthalmology service within the centre, which is due to start welcoming patients this summer.

Digital investment

The coming year will see extensive investment in our digital systems, with a focus on improving the way we manage and share information about patient care and helping our patients to take more control over where and when their appointments happen.
The most significant aspect of this work will be sourcing and implementing a new Electronic Patient Record (EPR) system for use across NHS Humber Health Partnership. This will consolidate all medical data – including medical history, test results, and prescribed medications - into one electronic record, ensuring clinical teams can access and update patients' information in real time across both Hull University Teaching Hospitals NHS Trust and Northern Lincolnshire and Goole NHS Foundation Trust. Importantly, it means our patients will also need to supply this information once.

This is a complex process and one which we are committed to getting right for our patients and staff. We're currently in the initial phases of working with our teams to gauge what needs to be in place to provide the best standards of healthcare for those living and working in our region, assessing both what is needed now and how we will need to operate in the future. This work will also include implementing a new Electronic Document Management System, moving away from the need for paper records and ensuring accurate, real-time information is available digitally .Further work is also underway on creating a new Patient Portal that will allow patients across our group to take greater control of their care. Through the portal – which will be accessible through the NHS App – they will be able to make, cancel, and reschedule appointments, choosing from a range of dates to suit their needs and reducing the number of appointments lost as a result of patients failing to attend.

The portal will also allow our clinical teams to provide information to patients about their appointments, send updates, and ask simple questions straight to their mobile phone or electronic device, reducing the amount of paper we use and speeding up the process of exchanging information.

While we are excited about the benefits these advancements in digital technology will bring, we are also mindful that no patients are adversely affected by the changes, as a result of poor digital literacy or lack of access to internet enabled devices, so we will also be maintaining systems which allow these patients to manage their appointments and care without the need for these devices.

Looking ahead

Of course, these are just the highlights, and there have been many more schemes and projects to improve our estates and digital landscape over the past 12 months.
These are areas we will continue to invest in, as we continuously strive to provide our patients with the highest standards of care and experience.

Humber Acute Services programme

The Humber and North Yorkshire Integrated Care Board (ICB) launched a public consultation, from 25 September 2023 to 5 January 2024, on its proposal to change the way some more complex medical, urgent and emergency care and paediatric (children's) services are delivered at hospitals in Scunthorpe and Grimsby. Nearly 4,000 responses were received via a questionnaire which ran during the consultation period. In addition, a wide range of views were gathered from seldom heard groups and communities through a comprehensive programme of targeted engagement that supported the consultation process.

In July 2024, the ICB approved the decision-making business case (available on the ICB website at the time of writing). Following that decision an Implementation Programme structure was set up within the group to provide oversight of the activities to implement the changes. Relevant Care Group management teams were tasked to review plans for implementation (aligned to the operational planning process for 2025/26) and identify likely timescales for the implementation of any changes and any enablers and interdependencies, such as any capital works and transport.

The programme received a challenge from North Lincolnshire Council, setting out some outstanding concerns with the changes. Discussions with North Lincolnshire Council concluded in early 2025. Despite the extensive discussions and mitigations considered, the council remains concerned about the potential impact of the changes on their residents and has raised these concerns with the Secretary of State for Health and Social Care. At the time of writing (April 2025) the Secretary of State is expected to review the request alongside any other requests that they receive from around the country in respect of other schemes and determine whether to take any further action or not. In the meantime, implementation will continue as per the ICB decision unless and until the group is instructed otherwise.

Review of services in Goole

Towards the end of 2024 the group started a piece of work to review the services it runs in Goole and District Hospital. Other services provided on the site by other providers, including the Urgent Treatment Centre (run by City Health Care Partnership), ambulance station, GP practice and a Children's Day Nursery, are not affected by this review. At the time of writing (April 2025) the group had met with staff, partners and stakeholders which helped to develop several suggestions for the future of the hospital. The group updated the ICB on the work delivered so far in March 2025 and the ICB agreed to undertake more work to develop full proposals on possible options for the healthcare services and the hospital building.

In terms of services within the hospital, the work includes:

- Continue with the Urgent Treatment Centre (UTC)
- Review existing care provision, like end-of-life care, in the local area to see how more people can be cared for in their own homes
- Improve community midwifery by joining up current provision in the town
- Enhance outpatient and diagnostic activity for Goole residents
- Evaluate future demand for mobile CT/MRI provision
- Work with national NHS colleagues to undertake a review of the surgery/theatre provision to explore and determine if Goole is suitable to be a regional centre for some types of surgery
- Work with national and regional NHS colleagues on ways specialist neurorehabilitation can be best provided to meet the needs of patients across Humber and North Yorkshire

In terms of the hospital estate, the work will:

- Assess current and future power provision for all activity
- Work up options and costings for the site's infrastructure
- Discuss with potential partners how vacant areas could be used
- Explore investment options to upgrade the building, facilities and footprint

This is a complicated piece of work which is expected to take around six months and be concluded around summer 2025. In the meantime, services at Goole and District Hospital will remain as they are until these pieces of work are undertaken and decisions are made.

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 2024/25 financial year below.

We have supported a number of great causes across our hospitals. We were left a substantial legacy donation for Scunthorpe hospital by the late Mrs Elizabeth Fairchild. We've used this money to improve dementia facilities. So far, we've done this on Ward 16 and 17, with more areas benefiting from this in the future.

Sue Liburd, Non-Executive Director and

HTF Trustee, and the charity team at the opening of the new dementia facilities on Ward 17

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 the Grimsby Cars fun day to raise funds for NICU at Diana, Princess of Wales Hospital. We also continue to be supported by the Seaview Cancer Charity Shop in Cleethorpes.

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.
Our staff have also supported us with a number of fundraising events including a London to Paris bike ride.

Jenny Smith, Consultant Oncoplastic Breast Surgeon at Grimsby hospital,

who cycled from London to Paris to raise funds for the Pink Rose Suite at Grimsby

We were very pleased to have been supported by the Mayor of North Lincolnshire, Janet Longcake. She selected us as her chosen charity and has raised a number of funds.

In the last financial year, we've received £153,000 from fundraising, £51,000 in donations from individuals, £44,000 from partner charities and £182,000 from legacy donations.

Moving forward, we continue to raise funds for our Little Lives appeal, which will help improve our children's services. We'll also continue the rollout of the Fairchild legacy.

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!

Acting Group Chief Executive's performance statement

The past 12 months have been a period of significant transition for the two organisations which make up NHS Humber Health Partnership: Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and Hull University Teaching Hospitals NHS Trust (HUTH). We launched our new operational structure in April 2024, bringing together clinical and non-clinical services across the Humber region for the first time ever. This not only joins up vital clinical services for our region ensuring we have more clinical expertise available to patients, it helps to ensure those services are more robust and sustainable into the future.

Recruiting to key specialties is difficult nationwide, and therefore working in partnership as a group we can pool our most vital resource – our people – and ensure we are more resilient in the face of any future staff shortages. It also enables us to share other resources, such as equipment and buildings and address capacity issues where we have high demand for services. And, it means our people will have the opportunity to share best practice from a larger pool of skills and knowledge, learn from each other, and work in different ways, with more opportunities for development.

However, as with all change this has not been a transition without a price. Changing the way we work, transforming care pathways, working with newer and larger teams, and getting used to different processes all take time and this can be challenging and stressful for our workforce. We cannot fix all of our problems overnight. It will take time, and we have to ensure we look after our people, giving them the support they need in order for this change to be successful. That means communicating with them effectively and engaging them every step of the way, giving them the chance to tell us how they think we can work most effectively as one group.

Therefore, my overarching message for this annual report introduction is one of thanks to everyone who works at HUTH and NLaG, as well as our key partners, for your patience, your understanding and for working so hard during this first year of major transition. I know it hasn't been easy at times but as ever you've done what we always do in the NHS when called upon and risen to the challenge.

Ultimately of course, the success of our group will come down to how well we care for our patients. We know we have issues we need to resolve. Many patients are still waiting too long for procedures, although we have eliminated all waits of over 78 weeks, and we are making progress towards ensuring no one will be waiting longer than 52 weeks for a procedure.

We're not there yet, and I sincerely apologise to everyone who has been affected by this, but we do have some significant projects coming to fruition in the next few months that will make a big difference. The opening of three community diagnostic centres in Hull, Grimsby and Scunthorpe will reduce waiting times for scans and other diagnostic procedures, and our new day surgery centre at Castle Hill will enable us to see thousands more patients during the year for routine operations.

In terms of emergency care people are also waiting too long in our three emergency departments (ED). The key to addressing this is to focus our efforts on improving the 'flow' of patients through our hospitals. That means ensuring patients move safely and quickly from arrival at an emergency department to a ward with a clear plan and timescale identified for their safe discharge back to their place of residence. We've worked hard in partnership with ambulance providers to reduce the time it takes for crews to handover their patients to us. For the most part this takes less than 45 minutes, enabling paramedics to get back out to patients who need their care much faster

than had previously been achieved. This does of course increase the pressure on our staff inside our hospitals which is why we are working really closely with local authorities and community providers to help patients who need care outside of hospital to be discharged more rapidly. If we can address that challenge as a health system then we free up beds on our wards to move patients out of our emergency departments efficiently and safely, hence reducing waiting times in ED.

Where staffing improvements are concerned, across our group we will have no nurse vacancies by September 2025 and we've made significant strides in reducing consultant vacancies, combined with a substantial reduction in agency spending, saving over £13 million. Furthermore, investment in additional consultant posts will deliver long-term benefits to patient care, not least in our group's emergency departments. All of this has been achieved at the same time we met a challenging cost savings programme, successfully delivering £84m worth of savings in the 2024/2025 financial year.

I hope you find this annual report useful and interesting as a review of 2024/2025. There is a long way for us to go yet. We need to do much more to improve the care we provide to patients and the experience our patients have in our hospitals. We also know that nationally the NHS is being asked to reduce costs and find efficiencies and sometimes these two challenges feel like they are at odds with one another but the key to achieving both comes back to our people. We have to unleash the innovation and creativity of our amazing workforce, and this cultural shift will take time. Organisational culture does not change radically in just 12 months, which is why we are committed to working with our people and with our managers to focus on a long-term programme of 'putting people first'. We need to provide our workforce with the tools and resources they need to do a good job. We have to engage with them, give them the chance to suggest ideas for and deliver improvement, and remove the barriers that might be in the way of them delivering the care they desperately want to deliver. If we can get to a place where our people are prepared to recommend our hospitals as good places to work and they are proud to recommend them as places to receive care then we will be on the right track.

Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

Activity levels in the last three years

	2022/23	2023/24	2024/25
A&E attendances at Grimsby and Scunthorpe	152,856	174,008	**187,436**
Admissions into hospital	122,990	118,523	**139,367**
Number of discharges (patients leaving hospital)	122,951	118,174	**139,348**
Outpatient appointments (attendances)	417,903	339,021	**323,850**
Births	3,719	3,703	**3,658**
Patients who were admitted as an emergency*	54,309	59,683	**68,080**
Total number of operations in theatre	17,544	19,743	**20,464**
Total number of elective operations in theatre	12,911	14,965	**15,630**

* The figures for 'Patients admitted as an emergency' have changed compared to previous Annual Reports. This is due to revisions in our data recording methods and data migration to a new Patient Administration System (PAS) used for tracking.

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

Since 2020, the IPR has taken on the 'Making Data Count' (MDC) approach to the presentation and interrogation of the trust's performance information. This involved redeveloping the IPR using statistical process control (SPC) charts to demonstrate performance. This new IPR style was also applied to board sub-committee reports and to divisional performance reports to provide consistency of reporting throughout the trust. Finally, the new IPR was structured to reflect the national targets outlined in the NHS Oversight Framework 2020/21 along with the trust's annual priorities, including quality priorities. The purpose of this revised approach is to ensure that the Board is provided with robust and timely information on organisational and operational performance. Further information is provided to the board on an exception basis where under performance in a particular area or against a specific target is identified. To provide consistency with this approach the trust's performance measures for both 2022/23 and 2021/22 (for comparison) on the following pages are set out as SPC charts. A key is also available to aid understanding of these charts.

Key to Statistical Process Control (SPC) charts

Variation of the data

This indicates the trend of the data at the time of reporting
(no change, concerning or improving)

Colours:
Grey = no significant change / Blue = significant improvement or low pressure /
Orange = significant concern or high pressure

Improving, declining or staying the same:


No change: common cause – no significant changes, normal variation

Concerning: Special cause of concern or higher pressure due to higher values

Concerning: Special cause of concern or higher pressure due to lower values

Improving: Special cause of improving nature or lower pressure due to higher values

Improving: Special cause of improving nature or lower pressure due to lower values

Assurance of the target

This indicates whether the target is being met (randomly passing, consistently passing, or failing), and if the indicator is expected to reliably hit the target.

Colours:
Grey = hitting the target is inconsistent
Blue = will reliably hit target
Orange = change required to hit target

Can we reliably hit the target:

Random: Variation indicates inconsistently hitting, passing and falling short of the target

Passing: Variation indicates consistently passing the target

Failing: Variation indicates consistently failing the target

Notes to charts
1 Full year position (unless otherwise stated)
2 Representative of the latest data available as reported at the end of the financial year.
3 Indicators not reported in the IPR at this time. Figure provided for reference

2024/25 trust performance

Access and flow

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
A&E - 4 Hour Standard (All)	74.7%	71.0%		Improving		Random
A&E - 4 Hour Standard (Type 1)	58.9%	49.3%		No Change		Random
A&E - 4 Hour Standard (Type 3)	100%	99.2%		No Change		Random
A&E - 4 Hour Standard Breaches (Non-Admitted)	No Target	48,809		No Change		
A&E - Ambulance Handovers Waiting > 30 minutes	No Target	14,334		No Change		
A&E - Ambulance Handovers Waiting > 60 minutes	No Target	7,854		No Change		
A&E - Ambulance Handovers Waiting 15 to 30 minutes	No Target	11,503		Improving		
A&E - Ambulance Handovers Waiting 30 to 60 minutes	No Target	6,480		Concerning		
A&E - Assessed within 30 minutes	No Target	14.2%		No Change		
A&E - Assessed within 60 minutes	No Target	74.9%		No Change		
A&E - Assessed within 15 minutes	No Target	4.2%		No Change		
A&E - Attendances (All)	No Target	187,437		No Change		
A&E - Attendances (Type 1)	No Target	105,969		No Change		

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
A&E - Attendances (Type 3)	No Target	81,468		No Change		
A&E - Beds open on Virtual Wards	No Target	5,468		No Change		
A&E - Conversion Rate	25.0%	24.8%		No Change		Random
A&E - DTA to Admission (minutes)	No Target	640		No Change		
A&E - DTA to Admission < 2 hours	No Target	21.7%		No Change		
A&E - DTA to Admission > 12 hours	0.0%	37.6%		No Change		Failing
A&E - DTA to Admission > 12 hours (number)	0	9,666		No Change		Failing
A&E - DTA to Admission > 4 hours	No Target	65.7%		No Change		
A&E - Left Without Being Seen	5.0%	3.4%		No Change		Random
A&E - Patients on Virtual Wards	No Target	3,955		No Change		
A&E - Time to Initial Assessment (minutes)	15	46		No Change		Failing
A&E - Time to Treatment	60	108		No Change		Failing
A&E - Time to Treatment (Admitted) (minutes)	60	97		No Change		Failing
A&E - Time to Treatment (Non-Admitted) (minutes)	60	111		No Change		Failing

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
A&E - Time to Treatment within 60 minutes	No Target	33.9%		No Change		
A&E - Total Time in A&E (Admitted) (minutes)	180	659		No Change	F	Failing
A&E - Total Time in A&E (minutes)	160	360		No Change	F	Failing
A&E - Total Time in A&E (Non-Admitted) (minutes)	140	279		No Change	F	Failing
A&E - Total Time in A&E (Patients >=65 years) (minutes)	160	476		No Change	F	Failing
A&E - Urgent Community Response Attendances assessed < 2 hours	No Target	96.4%		No Change		
A&E - Virtual Ward Utilisation	No Target	72.3%		No Change		
Cancer - 10 Day Turnaround Delivering Diagnostic Test Results	No Target	19.1%		No Change		
"Cancer - 104+ Day Waits (End of Year Snapshot)"	No Target	29	L	Improving		
Cancer - 2 Week Wait (All Cancers)	93.0%	88.9%	L	Concerning	?	Random
Cancer - 28 Day Faster Diagnosis Standard	77.0%	68.3%		No Change	?	Random
Cancer - 31 Day Wait for Second or Subsequent Treatment	No Target	4.6%		No Change		
Cancer - 31 Day Wait from Diagnosis to First Treatment	96.0%	94.8%		No Change	?	Random
Cancer - 62 Day Wait All Referral Sources	69.3%	48.7%		No Change	?	Random

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Cancer - 62 Day Wait Consultant Upgrade	No Target	57.7%		No Change		
Cancer - 62 Day Wait GP Referral	69.3%	47.4%		No Change	?	Random
Cancer - 62 Day Wait Screening	90.0%	47.7%		No Change	?	Random
Cancer - Decision to Treat within 38 days	No Target	87.9%		No Change		
Cancer - LGI Referrals accompanied with Faecal Immunochemical Test result	58.2%	59.1%	H	Improving	?	Random
Cancer - Request to Test within 14 days	No Target	73.9%		No Change		
Cancer - Request to Test within 7 days	No Target	51.3%		No Change		
Cancer - Tertiary Referrals within 38 days	No Target	21.5%		No Change		
Cancer - Total Waits	No Target	1,852	H	Concerning		
Cancer - Urgent Suspected Cancer Referrals	No Target	17,673		No Change		
"Diagnostics - 6 Week Standard (End of Year Snapshot)"	7.4%	29.1%		No Change	F	Failing
"Diagnostics - Total Activity Levels (End of Year Snapshot)"	27,399	23,706		No Change	?	Random
"Diagnostics - Total Waits (End of Year Snapshot)"	15,267	23,187	H	Concerning	F	Failing
Inpatients - Average Length Of Stay (Elective) (Days)	No Target	0.2		No Change		

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Inpatients - Average Length Of Stay (Non-Elective) (Days)	No Target	3.0		Improving		
Inpatients - Bed Occupancy (General & Acute)	95.1%	92.9%		No Change		Random
Inpatients - Cancelled Operations (%)	No Target	1.38%		No Change		
Inpatients - Cancelled Operations (number)	No Target	384		No Change		
Inpatients - Cancelled Operations 28 Day Breaches	No Target	92		No Change		
Inpatients - Cancelled Operations 28 Day perfomance	5.0%	17.9%		No Change		Random
Inpatients - Day Case Rate	85.0%	90.2%		No Change		Random
Inpatients - Elective Admissions	No Target	62,020		No Change		
Inpatients - Emergency Readmissions within 30 days	No Target	10.2%		Concerning		
Outpatients - Advice & Guidance Requests	No Target	12,674		No Change		
Outpatients - Advice & Guidance to Referral Ratio	No Target	8.96%		No Change		
Outpatients - Attendances All	No Target	323,301		No Change		
Outpatients - Attendances Follow-up	No Target	210,006		No Change		
Outpatients - Attendances New	No Target	113,292		No Change		

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Outpatients - Clinic Session Utilisation	No Target	88.8%		No Change		
Outpatients - Clinic Slot Utilisation	No Target	79.9%		No Change		
Outpatients - Discharged from First Attendance	No Target	26.9%		No Change		
Outpatients - Discharged from Follow-up Attendance	No Target	15.7%	L	Concerning		
Outpatients - DNA Rate	9.0%	8.0%		No Change	?	Random
Outpatients - New to Follow-up Ratio	No Target	1.86	H	Improving		
Outpatients - Non Face to Face Attendances (%)	No Target	19.1%	H	Improving		
"Outpatients - Overdue Follow-up Appointments (Non RTT) (End of Year Snapshot)"	No Target	54,188	H	Concerning		
Outpatients - Patients moved to PIFU	5.0%	3.6%	H	Improving	?	Random
Outpatients - Referrals (All)	No Target	141,578		No Change		
Outpatients - Referrals (GP)	No Target	65,272		No Change		
Outpatients - Referrals (Non-GP)	No Target	76,306		No Change		
Outpatients - Time from Referral to First Appointment (Days)	No Target	49	L	Improving		

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Outpatients - Total Overdue Backlog (3 months+) (End of Year Snapshot)	No Target	33,063		Concerning		
RTT - 104+ Week Waits (End of Year Snapshot)	0	0		No Change		Random
RTT - 52+ Week Waits (End of Year Snapshot)	953	868		No Change		Random
RTT - 65+ Week Waits (End of Year Snapshot)	0	23		Improving		Random
RTT - 78+ Week Waits (End of Year Snapshot)	0	1		Improving		Random
RTT - Incomplete 18 Week Standard (End of Year Snapshot)	65.0%	60.7%		No Change		Failing
RTT - Median Admitted Waiting Time	9	12		No Change		Random
RTT - Median Non-Admitted Waiting Time	5	11		No Change		Failing
RTT - Median Wait for Incomplete	7	14		Improving		Failing
RTT - Pathways Validated within 12 weeks (End of Year Snapshot)	No Target	84.3%		Improving		
RTT - Patients waiting 18 weeks or less for 1st appointment (End of Year Snapshot)	77.8%	71.0%		No Change		Random
RTT - Priority 2 Patients Waiting < 12 weeks (End of Year Snapshot)	No Target	46.6%		No Change		
RTT - Priority 2 Patients Waiting < 4 weeks (End of Year Snapshot)	No Target	20.2%		Improving		

Access and flow continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
RTT - Total Incomplete Pathways (End of Year Snapshot)	42,564	42,286		No Change	?	Random
Theatres - Cancelled Sessions (%)	No Target	23.3%	H	Concerning		
Theatres - Cancelled Sessions (number)	No Target	1,198		No Change		
Theatres - Capped Theatre Utilisation	85.0%	74.0%		No Change	F	Failing
Theatres - Early Finishes	No Target	62.2%	L	Concerning		
Theatres - Elective Sessions Available compared to Sessions Used (April to December)	No Target	88.5%		No Change		
Theatres - Late Starts	No Target	99.3%		No Change		

Quality and safety

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Clinical Harm Reviews - Cancer 104 day wait	No Target	0		No Change		
Complaints - 40 day compliance	85.0%	41.6%		No Change		Failing
Complaints - 60 day compliance	85.0%	72.4%		No Change		Random
Complaints - Average response time	40	42		No Change		Random
Complaints - Received	No Target	344		No Change		
Complaints - Received (per 1,000 bed days)	No Target	1.43		No Change		
"Complaints - Reopened (April to January)"	No Target	39		No Change		
"Duty of Candour - Verbal apology (April to January)"	100%	92.9%		No Change		Random
"Duty of Candour - Verbal apology within 10 working days (April to January)"	100%	87.5%		Concerning		Failing
"Duty of Candour - Written apology (April to January)"	100%	92.6%		No Change		Random
"Duty of Candour - Written apology within 10 working days (April to January)"	100%	77.9%		No Change		Random
Falls - (per 1,000 bed days)	No Target	6.25		No Change		
Falls - Moderate and above (per 1,000 bed days)	No Target	0.1		No Change		

Quality and safety continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Falls - Serious harm or death	No Target	7		No Change		
Falls - Serious harm or death (per 1,000 bed days)	No Target	0.29		No Change		
Falls - Total incidents	No Target	1512		No Change		
"Friends & Family - A&E Score (April to February)"	85.0%	79.3%		No Change	?	Random
"Friends & Family - Antenatal Score (April to February)"	90.0%	81.1%		No Change	?	Random
"Friends & Family - Birth Score (April to February)"	90.0%	99.4%		No Change	P	Passing
"Friends & Family - Community Score (April to February)"	90.0%	97.6%		No Change	?	Random
"Friends & Family - Inpatient Score (April to February)"	90.0%	97.6%		No Change	?	Random
"Friends & Family - Outpatient Score (April to February)"	90.0%	96.4%	H	Improving	?	Random
"Friends & Family - Postnatal Community Score (April to February)"	90.0%	86.6%	H	Improving	?	Random
"Friends & Family - Postnatal Score (April to February)"	90.0%	98.2%	H	Improving	?	Random
Infections - C.Difficile	No Target	37		No Change		
Infections - C.Difficile (per 1,000 bed days)	No Target	0.16		No Change		

Quality and safety continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Infections - E.Coli	No Target	69		No Change		
Infections - E.Coli (per 1,000 bed days)	No Target	0.29		No Change		
Infections - Klebsiella	No Target	32		No Change		
Infections - Klebsiella bacteraemia (per 1,000 bed days)	No Target	0.13		No Change		
Infections - MRSA	No Target	5	H	Concerning		
Infections - MRSA (per 1,000 bed days)	No Target	0.02	H	Concerning		
Infections - MSSA	No Target	29		No Change		
Infections - MSSA (per 1,000 bed days)	No Target	0.12		No Change		
Infections - Pseudomonas aeruginosa	No Target	13		No Change		
Infections - Pseudomonas aeruginosa bacteraemia (per 1,000 bed days)	No Target	0.05		No Change		
Medication Incidents	No Target	921	H	Concerning		
Medication Incidents - Moderate harm	No Target	4		No Change		
Medication Incidents - per 1,000 bed days	No Target	3.81		No Change		
Medication incidents - Serious harm	No Target	1	H	Concerning		

Quality and safety continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Mixed sex accommodation breaches	No Target	30		No Change		
Mortality - Crude Mortality (non-elective)	No Target	1.94%		No Change		
"Mortality - HSMR (November 23 to December 24)"	As expected	89.3	L	Improving	P	Passing
"Mortality - SHMI (September 23 to October 24)"	As expected	0.983		No Change	?	Random
Mortality - Still Births (per 1,000 births)	No Target	2.82		No Change		
Never Events	No Target	2	H	Concerning		
Never Events (per 1,000 bed days)	No Target	0.01		No Change		
PALS - Complaints	1	2,626		No Change	F	Failing
PALS - Complaints compliance within 5 working days	No Target	59.60%		No Change		
Patient incidents	No Target	17,636		No Change		
Patient safety alerts actioned by specified deadline	No Target	97.0%	H	Concerning		
Patient Safety Incidents - % Harmful	No Target	2.82%		No Change		
Patient Safety Incidents - Fatal	No Target	0		No Change		

Quality and safety continued

	2024/25					
Key Performance Indicator	**Target**	**Actual[1]**	**Variation[2]**		**Assurance[2]**	
Patient Safety Incidents - Investigation rate (per 1,000 bed days)	No Target	0.29		No Change		
Patient Safety Incidents - Investigations (PSIIs)	No Target	7		No Change		
Patient Safety Incidents - Low harm	No Target	4,299		No Change		
Patient Safety Incidents - Moderate and above (per 1,000 bed days)	No Target	2.04		No Change		
Patient Safety Incidents - Moderate harm	No Target	473		No Change		
Patient Safety Incidents - No harm	No Target	12,839		No Change		
Patient Safety Incidents - Severe harm	No Target	18		No Change		
Pressure Ulcers - Category 1	No Target	152		No Change		
Pressure Ulcers - Category 2	No Target	1,239		No Change		
Pressure Ulcers - Category 3	No Target	134		No Change		
Pressure Ulcers - Category 4	No Target	18		No Change		
Pressure Ulcers - Device related	No Target	201		No Change		
Pressure Ulcers - Hospital acquired	No Target	2,645		No Change		
Pressure Ulcers - Hospital acquired (per 1,000 bed days)	No Target	10.96		No Change		

Quality and safety continued

Key Performance Indicator	2024/25 Target	Actual[1]	Variation[2]		Assurance[2]	
Pressure Ulcers - Hospital acquired moderate and above (per 1,000 bed days)	No Target	1.51		No Change		
Pressure Ulcers - Suspected deep tissue injury	No Target	500		No Change		
Pressure Ulcers - Total community acquired	No Target	2		No Change		
Pressure Ulcers - Unstageable	No Target	212		No Change		
VTE Risk Assessment	95.0%	94.19%		Concerning		Random
VTE Risk Assessment 14 Hour Standard	No Target	92.70%		No Change		

1 Full Year Position (unless otherwise stated).
2 Representative of the latest data available as reported at the end of the FY.

Health inequalities data

Elective activity vs pre-pandemic levels for under 18s and over 18s

Elective recovery - Under 18 2019/20

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	6	-	-	-	1	-	2	-	-	-	-	**9**
Asian or Asian British - Bangladeshi	6	7	-	-	2	1	2	-	-	-	-	**18**
Asian or Asian British - Indian	-	-	1	-	1	-	-	-	-	-	-	**2**
Asian or Asian British - Pakistani	2	2	-	-	2	-	-	-	1	-	-	**7**
Black or Black British - Any other Black background	1	-	-	-	-	-	1	-	-	-	-	**2**
Mixed - Any other mixed background	9	3	3	-	-	2	2	1	-	-	-	**20**
Mixed - White and Asian	1	-	1	-	1	2	2	1	-	-	1	**9**
Mixed - White and Black African	-	-	1	-	1	-	-	-	-	-	-	**2**
Mixed - White and Black Caribbean	1	-	-	-	-	-	-	-	1	-	-	**2**
Not stated	11	5	4	1	-	1	2	1	2	-	2	**29**
Other Ethnic Groups - Any other ethnic group	-	1	-	-	-	-	-	-	-	1	-	**2**
Other Ethnic Groups - Chinese	-	1	2	-	-	-	-	-	-	-	-	**3**
White - Any other White background	35	12	2	3	7	1	4	-	1	1	-	**66**
White - British	340	121	140	97	101	88	117	66	103	28	15	**1,216**
Total	**412**	**152**	**154**	**101**	**116**	**95**	**132**	**69**	**108**	**30**	**18**	**1,387**

*Unknown Postcode (U.P.)

Elective Recovery - Under 18 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	3	2	-	1	2	-	1	1	-	-	-	**10**
Asian or Asian British - Bangladeshi	1	4	-	-	-	-	1	1	-	-	2	**9**
Asian or Asian British - Indian	-	-	1	-	-	-	-	-	2	1	1	**5**
Asian or Asian British - Pakistani	4	-	1	-	-	-	1	1	-	-	1	**8**
Black or Black British - African	1	-	1	-	1	-	-	2	-	-	5	**10**
Black or Black British - Any other Black background	-	1	1	-	-	-	-	-	1	-	-	**3**
Black or Black British - Caribbean	-	-	-	-	-	-	-	-	1	-	-	**1**
Mixed - Any other mixed background	5	2	1	-	1	-	-	-	1	-	1	**11**
Mixed - White and Asian	1	2			1				1	1	-	**6**
Mixed - White and Black African	1	-	-	-	1	-	1	-	-	-	-	**3**
Mixed - White and Black Caribbean	-	-	-	-	1	-	-	-	-	-	-	**1**
Not stated	59	22	12	10	15	9	28	10	16	3	63	**247**
Other Ethnic Groups - Any other ethnic group	8	1	1	1	2	1	2	1	4	-	7	**28**
Other Ethnic Groups - Chinese	1	-	1	1	-	-	-	-	1	-	-	**4**
White - Any other White background	22	9	5	3	5	1	4	-	1	-	16	**66**
White - British	209	91	87	63	71	48	92	40	79	21	313	**1114**
Total	**315**	**134**	**111**	**79**	**100**	**59**	**130**	**56**	**107**	**26**	**409**	**1526**

Elective recovery - Over 18 2019/20

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	28	19	6	5	3	20	18	8	20	2	3	**132**
Asian or Asian British - Bangladeshi	32	44	2	1	7	4	9	-	5	-	-	**104**
Asian or Asian British - Indian	32	14	12	7	5	16	19	12	18	1	4	**140**
Asian or Asian British - Pakistani	13	7	1	2	3	10	16	1	1		1	**55**
Black or Black British - African	5	-	6	3	-	-	1	3	6	-	2	**26**
Black or Black British - Any other Black background	20	6	2	-	11	-	8	4	1	-	1	**53**
Black or Black British - Caribbean	-	2	-	-	-	-	2	2	-	-	-	**6**
Mixed - Any other mixed background	28	9	8	5	11	3	5	1	6	-	4	**80**
Mixed - White and Asian	6	1	5	-	2	2	5	4	-	-	-	**25**
Mixed - White and Black African	7	4	3	2	-	-	1	4	-	-	-	**21**
Mixed - White and Black Caribbean	2	-	6	3	1	1	2	-	-	-	-	**15**
Not stated	174	130	105	148	122	136	170	123	145	30	101	**1,384**
Other Ethnic Groups - Any other ethnic group	13	9	2	-	6	2	3	1	-	-	-	**36**
Other Ethnic Groups - Chinese	13	5	6	3	8	13	10	2	5	2	3	**70**
White - Any other White background	317	102	147	40	89	45	62	37	55	5	29	**928**
White - British	7,749	3,960	5,760	5,021	5,428	4,756	7,987	4,716	6,735	1,406	1,019	**54,537**
White - Irish	28	6	29	15	14	4	21	18	29	1	4	**169**
Total	**8,467**	**4,318**	**6,100**	**5,255**	**5,710**	**5,012**	**8,339**	**4,936**	**7,026**	**1,447**	**1,171**	**57,781**

Elective Recovery - Over 18 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	19	14	9	11	10	12	23	3	11	-	32	**144**
Asian or Asian British - Bangladeshi	66	45	1	3	2	-	11	1	2	-	26	**157**
Asian or Asian British - Indian	15	23	3	4	6	11	21	1	18	1	39	**142**
Asian or Asian British - Pakistani	3	8	1	4	2	3	15	2	7	3	14	**62**
Black or Black British - African	19	5	7	2	5	2	5	1	5	4	17	**72**
Black or Black British - Any other Black background	4	2	1	3	1	2	-	1	4	-	6	**24**
Black or Black British - Caribbean	2	-	-	1	2	-	3	-	-	-	-	**8**
Mixed - Any other mixed background	22	8	24	3	4	4	3	2	4	-	22	**96**
Mixed - White and Asian	9	4	5	3	13	3	6	3	8	-	13	**67**
Mixed - White and Black African	8	-	1	1	1	2	-	-	1	-	3	**17**
Mixed - White and Black Caribbean	3	-	3	-	-	-	-	-	-	-	2	**8**
Not stated	655	293	320	279	313	268	456	170	332	114	1,105	**4,305**
Other Ethnic Groups - Any other ethnic group	170	106	128	40	62	70	56	54	79	23	188	**976**
Other Ethnic Groups - Chinese	6	1	1	2	5	3	13	3	3	4	10	**51**
White - Any other White background	297	116	74	88	109	53	103	40	102	8	253	**1,243**
White - British	5,724	3,221	4,167	3,349	4,059	3,170	6,256	3,437	4,949	1,015	11,991	**51,338**
White - Irish	14	4	3	9	16	5	8	21	6	-	37	**123**
Total	**7,036**	**3,850**	**4,748**	**3,802**	**4,610**	**3,608**	**6,979**	**3,739**	**5,531**	**1,172**	**13,758**	**58,833**

Emergency admissions for under 18s

Urgent and emergency care - Under 18 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	115	53	13	20	15	11	34	10	13	3	16	**303**
Asian or Asian British - Bangladeshi	107	76	4	11	9	4	42	1	3	1	26	**284**
Asian or Asian British - Indian	47	25	15	33	19	12	18	7	22	5	9	**212**
Asian or Asian British - Pakistani	39	45	9	13	11	4	53	14	12	-	19	**219**
Black or Black British - African	69	28	13	18	36	4	31	9	32	-	16	**256**
Black or Black British - Any other Black background	25	8	7	4	7	1	7	1	14	2	4	**80**
Black or Black British - Caribbean	8	2	1	-	-	-	-	-	3	-	-	**14**
Mixed - Any other mixed background	122	36	54	33	19	12	35	15	19	-	18	**363**
Mixed - White and Asian	41	21	21	12	16	5	18	16	8	3	18	**179**
Mixed - White and Black African	39	12	2	4	9	7	10	2	15	2	1	**103**
Mixed - White and Black Caribbean	40	15	6	11	5	1	12	4	8	2	17	**121**
Not stated	1,048	529	393	230	361	263	334	174	315	38	697	**4,382**
Other Ethnic Groups - Any other ethnic group	652	291	122	88	157	89	138	54	81	12	66	**1,750**
Other Ethnic Groups - Chinese	7	1	3	2	2	4	2	1	2	1	2	**27**
White - Any other White background	864	288	166	77	191	48	134	24	83	16	65	**1,956**
White - British	7,269	2,911	2,762	2,121	2,347	1,582	2,785	1,550	2,757	573	1,261	**27,918**
White - Irish	8	2	-	2	5	2	1	2	1	-	3	**26**
Total	**10,500**	**4,343**	**3,591**	**2,679**	**3,209**	**2,049**	**3,654**	**1,884**	**3,388**	**658**	**2,238**	**38,193**

Smoking cessation

Number of adult acute inpatient settings offering smoking cessation services - 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
White – British	52	24	41	5	19	8	21	6	11	4	5	**196**
White – Irish	--	-	1	-	-	-	-	-	-	-	-	**1**
White - Any other White background	1	1	-	-	1	-	1	-	-	-	-	**4**
Other Ethnic Groups – any other ethnic group	2	-	-	-	-	1	-	-	-	-	-	**3**
Not stated	6	1	1	2	-	1	-	-	1	-	-	**12**
Not known	-	-	-	-	-	-	-	1	-	-	-	**1**
Total	**61**	**26**	**43**	**7**	**20**	**10**	**22**	**7**	**12**	**4**	**5**	**217**

Number of maternity inpatient settings offering smoking cessation services – 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
White – British	611	255	279	216	228	158	275	126	223	65	455	**2,891**
White - Any other White background	101	35	39	9	25	9	14	4	17	2	27	**282**
Asian or Asian British – Pakistani	7	6	2	1	1	-	9	1	1	1	8	**37**
Other Ethnic Groups – any other ethnic group	131	70	19	15	25	15	15	7	18	0	51	**366**
Not stated	3	0	0	1	0	0	1	1	0	0	9	**15**
Not known	1	0	0	0	0	0	0	1	0	0	9	**11**
Total	**854**	**366**	**339**	**242**	**279**	**182**	**314**	**140**	**259**	**68**	**559**	**3,602**

Proportion of adult acute inpatient settings offering smoking cessation services - 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
White – British	0.3%	0.3%	0.4%	0.1%	0.2%	0.1%	0.1%	0.1%	0.1%	0.2%	4.3%	**0.2%**
White – Irish	0.0%	0.0%	7.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.4%**
White - Any other White background	0.1%	0.2%	0.0%	0.0%	0.3%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	**0.1%**
Other Ethnic Groups – any other ethnic group	0.2%	0.0%	0.0%	0.0%	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.1%**
Not stated	1.0%	0.3%	0.4%	0.8%	0.0%	0.4%	0.0%	0.0%	0.3%	0.0%	0.0%	**0.4%**
Not known	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.2%	0.0%	0.0%	0.0%	**0.0%**
Total	**0.3%**	**0.2%**	**0.3%**	**0.1%**	**0.2%**	**0.1%**	**0.1%**	**0.1%**	**0.1%**	**0.1%**	**2.5%**	**0.2%**

Proportion of adult maternity settings offering smoking cessation services - 2023/24

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
White – British	3.4%	2.0%	1.8%	1.9%	0.9%	3.2%	1.8%	1.6%	0.9%	0.0%	0.2%	**1.8%**
White - Any other White background	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	3.7%	**1.1%**
Asian or Asian British – Pakistani	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**2.7%**
Other Ethnic Groups – any other ethnic group	18.3%	0.0%	0.0%	0.0%	0.0%	0.0%	6.7%	14.3%	5.6%	0.0%	0.0%	**7.4%**
Not stated	100%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%	0.0%	0.0%	11.1%	**100%**
Not known	100%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**81.8%**
Total	**6.1%**	**2.2%**	**2.9%**	**2.1%**	**1.4%**	**3.3%**	**2.9%**	**2.9%**	**2.3%**	**0.0%**	**0.5%**	**3.0%**

Elective admissions of hospital based tooth extractions due to dental caries (decay) - Under 10 2024/25

Ethnic group	Index of Multiple Deprivation Decile											Total
	1	2	3	4	5	6	7	8	9	10	U.P.*	
Asian or Asian British - Any other Asian background	1	2	-	1	1	-	-	1	-	-	-	**6**
Asian or Asian British - Indian	-	-	-	-	-	-	-	-	1	-	-	**1**
Asian or Asian British - Pakistani	-	-	-	-	-	-	1	-	-	-	-	**1**
Black or Black British - African	1	-	1	-	-	-	-	-	-	-	2	**4**
Black or Black British - Any other Black background	-	1	-	-	-	-	-	-	-	-	-	**1**
Mixed - Any other mixed background	1	-	1	-	-	-	-	-	-	-	-	**2**
Mixed - White and Asian	1	-	-	-	-	-	-	-	-	-	-	**1**
Not stated	13	3	1	2	4	3	1	-	1	1	17	**46**
Other Ethnic Groups - Any other ethnic group	3	-	-	1	-	-	-	-	1	-	2	**7**
White - Any other White background	6	-	1	1	-	-	1	-	-	-	2	**11**
White - British	40	14	11	7	9	1	10	4	7	1	79	**183**
Total	**66**	**20**	**15**	**12**	**14**	**4**	**13**	**5**	**10**	**2**	**102**	**263**

Data sources and key for health inequalities tables

1. Data Sources
   - Elective recovery - data taken from Annual NLaG APC SUS exports - 19/20 and 24/25 Under Over 18 at Activity Date, Elective Only
   - Emergency admissions - data taken from annual NLaG AAE SUS exports - 23/24 - Under 18 at Activity Date
   - Smoking cessation - data taken from Tobacco Dependence Return - 23/24 (April - February)
   - Elective admissions of hospital based tooth extractions:
     - o Data taken from annual NLaG APC SUS exports - 23/24 - Under 10 at Activity Date / All Procedure codes beginning with F09 or F10 and diagnosis codes K021, K025, K028, K029, K040, K045, K046, K047 Following : CYP Transformation Programme Dashboard
2. Deprivation criteria has been determined using the English indices of deprivation 2019 against SUS postcodes : https://www.gov.uk/guidance/english-indices-of-deprivation-2019-mapping-resources
3. 1 = Most deprived, 10 - Least deprived

2024/25 trust performance

The table on page 24 shows how activity levels in the hospitals have changed in the last three years. The figures show around 187,000 people attend the trust's two emergency departments (EDs) at Grimsby and Scunthorpe between April 2024 and March 2025, which is more than 23,000 over the same time frame in the previous year and not far short of 45,000 more than the year before that. The figures also show that over the same three years there has been an increase in the number of planned operations the trust has carried out in its operating theatres. These two figures show as clearly as anything the levels of pressure and demand the trust is experiencing each day in both unplanned (urgent and emergency) and planned 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 2025. This was a target we were not able to meet, finishing the year with a figure of 74.7%. Handing over patients from ambulance into the EDs continued to be a challenge and 6,450 patients had to wait longer than 60 minutes across the whole year against a target of zero patients. The trust also had a target to have no patients waiting longer than 12 hours to be admitted to a ward and, unfortunately, 9,666 patients had to wait at least this long. Improving urgent and emergency care performance will remain a key priority for the trust in 2025/26.

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 29.1% of patients being seen after this time limit, with no change compared to the year before. The trust improved its performance in dealing with cancers compared to 2024/25. However more work is needed to meet the national targets in this key area of trust activity and NHS England has but the trust into Tier 1 for cancer performance which means enhanced oversight and support to improve 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 2025/26.

Workforce

The year saw a major reduction in registered nursing vacancies following successful domestic and international recruitment campaigns. This resulted in a significant drop in the requirement for agency cover which saved the trust a substantial amount of money running into the millions. There was also a drop in both the staff turnover rate and staff sickness rates. The group is now focusing on reducing the number of senior medical gaps and is a key priority for 2025/26.

Quality and safety

As reported in the 2022/23 Annual Report, the Care Quality Commission (CQC) inspected NLaG's hospitals and community services in early 2022 and published their report in December 2022. The progress the trust had made was recognised in May 2023 when NHS England, the trust's regulator, took the decision to allow NLaG to exit the Recovery Support Programme.

This was an important step and recognised the trust's progress improving both its clinical services and its financial position. The CQC also identified areas that required further improvements and teams across the trust have put together a comprehensive action plan to respond to the improvement requirements of the CQC's published report. This will remain a key area of focus in 2025/26.

End of Life (EOL) care was the single area where the CQC rating was 'Inadequate', their lowest available rating. This is why EOL was chosen again as one of the trust's five quality priorities for 2024/25, specifically to improve personalised palliative and end of life care to ensure patients are supported to have a good death. The trust has also sustained achievement of the Commissioning for Quality and Innovation (CQUIN) recording and response to the National Early Warning Score (NEWS2) for unplanned critical care admissions.

Health inequalities

From the 2023/24 financial reporting year the trust is required to publish information regarding health inequalities, particularly in relation to elective activity, smoking cessation and dental health in young children. This information is set out on pages 44 to 51. In future years this information, and the publishing of it, will be able to show whether there are any differences between the services the trust provides to different patients, especially in relation to age, ethnic group and deprivation. Where differences are identified the trust will need to work towards reducing, and then eliminating, any such differences so that all people in its local communities have the same access to services.

Finance

The group is reporting a break-even position for the 2024/25 financial year in line with the financial plan sat at the start of the year. The group delivered £84.2 million of cost savings against a target of £84.6 million. However, this figure was heavily reliant on non-recurrent savings of £61.5 million. Group capital spend was £84.3 million across the financial year. £0.7 million behind the agreed annual plan. The group over-delivered against Elective Recovery Fund targets at 101.7%, £4.7 million ahead of plan. Across the 2024/25 financial year the group spent £67.3 million on agency and bank staff. This is £12.9 million less than in 2023/24 and now below the NHSE target of 3.2% at 2.7% as a percentage of total pay.

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 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 evolve 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.

Task force on climate-related financial disclosures (TFCD)

NHS England's NHS foundation trust annual reporting manual has adopted a phased approach to incorporating the TCFD recommended disclosures as part of sustainability annual reporting requirements for NHS bodies, stemming from HM Treasury's TCFD aligned disclosure guidance for public sector annual reports. TCFD recommended disclosures as interpreted and adapted for the public sector by the HM Treasury TCFD aligned disclosure application guidance, will be implemented in sustainability reporting requirements on a phased basis up to the 2025/26 financial year. Local NHS bodies are not required to disclose scope 1, 2 and 3 greenhouse gas emissions under TCFD requirements as these are computed nationally by NHS England. The phased approach incorporates the disclosure requirements of the governance, risk management and metrics and targets provides a comprehensive overview of 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. It is underpinned by the Trust Boards-in Common approved Northern Lincolnshire and Goole (NLaG) Green Plan and Travel Plan 2022–2025. Oversight of sustainability initiatives and carbon emissions tracking is provided by the Trust's Sustainability Working Group. The trust invested in a digital carbon tracking platform (Smart Carbon), enabling a more robust and data-driven approach to monitoring, and reducing its organisational carbon footprint. The Sustainability Team has uploaded prior year data to build a comprehensive emissions baseline. Smart Carbon is aligned with the internationally recognised Greenhouse Gas Protocol and integrates the latest UK Government Conversion Factors. It should be noted that updates to these methodologies may influence the comparability of previous years' data. However, the system significantly enhances the trust's ability to track, report, and improve carbon performance with greater accuracy and transparency.

Leadership and trust performance

As part of the Humber Health Partnership, a Group Director has been appointed to lead Estates, Facilities, and Development Services across both Hull University Teaching Hospitals NHS Trust (HUTH) and NLaG. 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.

	2020/21	2021/22	2022/23	2023/24	2024/ 25
Floor Space (m2)	161,070	156,930	163,281	156,909	156,938
Number of Staff	6,923	6,969	6,637	5,589	6,676

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 and water costs totalling £8,177,836 during 2024/25. This expenditure is a year-on-year increase of nearly 11.07% on energy costs from the previous year, as detailed below.

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Gas	kWh	55,207,692	63,240,193	62,278,530	60,687,404	59,651,972
	tCO2e	10,112	11,583	11,347	11,079	10,910

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Gas Oil	kWh	-	-	-	246,740	113,910
	tCO2e	-	-	-	63.3	29.2

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Electricity	kWh	13,576,663	13,999,661	15,209,852	13,691,065	13,719,719
	tCO2e	3,138	0	0	0	3,092

Total Energy

		2020/21	2021/22	2022/23	2023/24	2024/25
CO2e and Cost £	CO2e	14,816	11,917	11,347	11,142	14,031
	Cost £	3,802,393	4,036,886	6,043,772	7,362,486	8,177,836

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 59.6 million kWh in 2024/25. This has resulted in a corresponding decline in carbon emissions from 11,583 tCO_2e in 2021/22 to 10,910 tCO_2e in 2024/25, a 6% reduction over three years.

Electricity use increased by 10.5% between 2020/21 and 2022/23 but then stabilised. Notably, carbon emissions from electricity dropped to zero from 2021/22 to 2023/24 due to grid decarbonisation sourcing of renewable electricity. Emissions reappear in 2024/25 at 3,092 tCO_2e. Total carbon emissions fell from 14,816 tCO_2e in 2020/21 to 11,142 tCO_2e in 2023/24, demonstrating strong progress. However, 2024/25 shows an increase to 14,031 tCO_2e, largely driven by the return of grid related electricity emissions. Energy costs have risen consistently, nearly doubling from £3.8 million in 2020/21 to £8.2 million in 2024/25, reflecting both market conditions and broader inflationary pressures.

Resource use – water

Whilst there has been a 5% rise in recorded water usage across the trust in 2024/25, the increased consumption value is solely down to reconciled consumption at our Mains Water supply at DPoW. Water consumption has fallen more than 15% at both SGH and GDH in the same period.

	Use	2020 - 21	2021 – 22	2022 - 23	2023 - 24	2024 - 25
Mains Water	m3	276,653	203,243	172,330	179,429	188,732
	tCO2e	251	30	60	52	50.5

Resource use – photovoltaic (PV) solar systems

With the completion of the Gym refurbishment at Scunthorpe, the trust now has roof mounted solar panel systems at our three main hospital sites. The latest annual data is:

	Location	2021/22	2022/23	2023/24	2024/25
PV Electric kWh	Grimsby CDC	50,464	44,249	48,618	65,542
	Grimsby Family Services	3354	26,994	22,973	9,885
	Goole	183,387	159,067	133,919	170,339
Totals kWh	-	**267,205**	**230,310**	**205,510**	**245,766**

The generated kWh generally varies due to annual solar radiation, but the increase in electricity yield at Goole is due to replacing several failed inverters.

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.

Despite a reduction in total anaesthetic gas volume, total carbon emissions have increased in 2024/25. This rise is attributed to changes in government carbon conversion factors, rather than an actual increase in gas usage.

	2022/23		2023/24		2024/25	
	Vol (L)	tCO2e	Vol (L)	tCO2e	Vol (L)	tCO2e
Desflurane	3.84	14.28	9.84	25.77	6.24	16.28
Isoflurane	0	0	0.75	0	0	0
Sevoflurane	321.5	63	344.25	106.75	373	122.6
Nitrous Oxide	853.2	477	798.3	394.71	684	339.73
Total tCO2e	853.525	554.28	1,153.14	527.23	1063.24	1258.95

Desflurane use fell sharply in 2024/25, by 37% compared to the previous year, and was used only in a single month. This 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 14%. However, it remains the largest single contributor to anaesthetic-related emissions. As a potent greenhouse gas, further action is required to mitigate its impact. Despite reduced total volume, tCO_2e increased by 139% between 2023/24 and 2024/25. This is due to updated emissions calculation factors applied in national reporting.

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 2024/25, the fleet includes 11 fully electric vehicles and 80 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. Despite continued progress in decarbonising the trust owned fleet, total business travel related emissions (tCO_2e) increased by 18% this year. This rise is primarily attributed to increased mileage undertaken in employee owned and lease vehicles, which remain more carbon intensive on average than trust fleet vehicles. This increase could be aligned to group working practices as an unintended consequence.

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 30 applications for bicycles via the cycle to work scheme in 2024/25. Cross site travel is supported with inter-site transport aimed at reducing unnecessary mileage claims, single occupancy vehicle journeys and reducing emissions further. The following tables detail the miles travelled and associated metric tonnes of carbon dioxide.

	Mode	2020/21	2021/22	2022/23	2023/24	2024/25
Patient and visitor own travel	Miles	15,397,245	17,737,436	18,831,805	21,219,104	16,067,630
	tCO2e	4173	4,808	4,660	5,690	4,315

	Mode	2020/21	2021/22	2022/23	2023/24	2024/25
Staff commute	Miles	6,646,080	6,690,240	6,378,157	5,368,892	6,936,364
	tCO2e	1,801	1,814	1,530	1,439	1,997

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Business travel and fleet	Miles	1,259,839	1,868,015	1,995,880	2,227,343	2,842,696
	tCO2e	341.45	506.28	493.96	596.92	624.77

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Owned EV and PHEV Mileage	Miles	15,546	29311	44,617	78,430	85051
	tCO2e	0	0	0	0	0

	Use	2020/21	2021/22	2022/23	2023/24	2024/25
Total cost of business travel	£	313,759	330,310	1,005,000	1,097,881	944,841

Waste

The trust's waste management services has secured waste contractors which take the waste management strategy through to September 2025 and include some key projects to reduce single use plastics, increased recycling, single use metal instrument recycling, reduction, and removal of all waste to landfill, and new processing techniques to create energy from waste. An emission factor of 21.28 kg has been used to calculate this year's tCo2e which was taken from the UK Government GHG Conversion Factors for Company Reporting 2024. This shows that the tCO2e from waste was slightly increased from 22.69 tCO2e to 22.94 tCO2e and increase of 1.1% against a tonnage increase of 1.4%

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 is calculated on the total general waste tonnage and currently sits at 45%. Recycling hubs have been introduced along with a scheme to encourage re-use of equipment and furniture that would have otherwise been sent for disposal.

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 72%.

		2020/21	2021/22	2022/23	2023/24	2024/25
Recycling	Tonnes	377	278	341	348	325
	tCO2e	8.0	5.9	7.25	7.47	6.91

		2020/21	2021/22	2022/23	2023/24	2024/25
Other Recovery	General Waste Tonnes	542.79	569.33	631	676	725
	tCO2e	82.1	86.1	13.42	14.38	15.42

		2020/21	2021/22	2022/23	2023/24	2024/25
High Temperature Disposal	Tonnes	71.37	68.8	38.33	39.5	28.3
	tCO2e	17.1	16.5	0.81	0.84	0.60

		2020/21	2021/22	2022/23	2023/24	2024/25
Landfill	Tonnes	0	0	0	0	0
	tCO2e	0	0	0	0	0

		2020/21	2021/22	2022/23	2023/24	2024/25
Total Waste	Tonnes	991.16	916.13	1010.33	1063.5	1078.3
% Recycled	%	38%	30%	33%	32%	30%
Total Waste	tCO2e	107.2	108.5	21.48	22.69	22.94

Total carbon emissions impact

The trust's total carbon emissions are detailed below:

	2022/23	2023/24	2024/25
Total Energy CO2e	11,347	11,142	14,031
Total Water CO2e	60	52	50.5
Total Medical Gas CO2e	554	527	1,259
Patient & Visitor CO2e	4,660	5,690	4,315
Staff Commute CO2e	1530	1439	1,997
Business Fleet CO2e	494	596	625
Total Waste CO2e	21	22	23
Total CO2e	**18,666**	**19,468**	**22,300.5**

Conclusion

This section of the Annual 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 2024/25. While improvements in energy efficiency and medical gas usage practices are evident, overall emissions increased from 19,411 tCO2e in 2023/24 to 22,351.5 tCO2e in 2024/25 a 15% rise.

This is primarily driven by:

- A 26.9% increase in energy-related emissions, linked to updated conversion factors and energy market pressures.
- A 138.9% increase in medical gas emissions, despite reduced usage volume, due to higher emissions factors for desflurane and nitrous oxide.
- A 38.8% increase in staff commute emissions and 5% increase in business fleet emissions, reflecting changes in travel behaviour and increased reliance on grey fleet.
- These trends underscore the urgency of sustained investment and focus. The Greener NHS agenda has grown in visibility and expectations throughout 2023/24, placing increased pressure on delivery and reporting standards.

To maintain momentum and meet national Net Zero goals, the following actions have been suggested to be in place for 2025/26 and beyond:

- Group resource allocation: Establish a dedicated sustainability data and reporting role within the Humber Health Partnership structure to support consistent carbon data capture, performance analysis, and statutory reporting across both HUTH and NLaG. This resource will provide the necessary capacity to meet increasing Green Plan and Net Zero reporting requirements while ensuring alignment and standardisation across the group.
- 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.

Key issues and risks that affected the trust in 2024/25

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 2024 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
Patient harm	The risk that patients may suffer because the trust fails to deliver treatment, care and support consistently at the highest standard (by national comparison) of safety, clinical effectiveness and patient experience
Timely access to care	The risk that the trust fails to deliver constitutional and other regulatory performance targets which has an adverse impact on patients in terms of timeliness of access to care and/or risk of clinical harm because of delays in access to care
Clinical strategy	The risk that the trust (with partners) will fail to develop, agree, achieve approval to, and implement an effective clinical strategy (relating both to Humber Acute Services and to Place), thereby failing in the medium and long term to deliver care, which is high quality, safe and sustainable
Estate, infrastructure and equipment	The risk that the trust's estate, infrastructure and engineering equipment may be inadequate or at risk of becoming inadequate (through poor quality, safety, obsolescence, scarcity, backlog maintenance requirements or enforcement action) for the provision of high-quality care and/or a safe and satisfactory environment for patients, staff and visitors
Digital infrastructure	The risk that the trust's failure to deliver the digital strategy may adversely affect the quality, efficacy or efficiency of patient care and/or use and sustainability of resources, and/or make the trust vulnerable to data losses or data security breaches
Business continuity	The risk that the trust's business continuity arrangements are not adequate to cope without damage to patient care with major external or unpredictable events (e.g. adverse weather, pandemic, data breaches, industrial action, major estate or equipment failure)
Workforce	The risk that the Trust does not have a workforce which is adequate (in terms of diversity, numbers, skills, skill mix, training etc

Risk type	Nature of risk
In-year finance target	The risk that either the Trust or the Humber and North Yorkshire Integrated Care System fail to achieve their financial objectives and responsibilities, thereby failing in their statutory duties and/or failing to deliver value for money for the public purse
Major capital	The risk that the Trust fails to secure and deploy adequate capital to redevelop its estate to make it fit for purpose for the coming decades
Partnership and collaboration	The risk that the Trust is not a good partner and collaborator, which consequently undermines the Trust's or the healthcare systems collective delivery of: care to patients; the transformation of care in line with the NHS Long Term Plan; the use of resources; the development of the workforce; opportunities for local talent; reduction in health and other inequalities; opportunities to reshape acute care; opportunities to attract investment
Leadership	The risk that the leadership of the Trust (from top to bottom, in part or as a whole) will not be adequate to the tasks set out in its strategic objectives, and therefore that the Trust fails to deliver one or more of these strategic objectives

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.

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-2024/

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

THE ACCOUNTABILITY REPORT

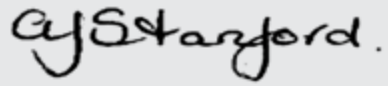
ANNUAL REPORT & ACCOUNTS 2024/25

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 six Non-Executive Directors (NEDs) including the chair and vice chair, and five group executive directors. The board also has one (non-voting) Associate NED and three other (non-voting) executive directors. Each board member brings a variety of individual skills and experience. The vice chair of the trust is an Associate NED at HUTH, and the vice chair at HUTH is an Associate NED at NLaG.

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.



Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

Board of Directors
on 1 June 2025

Non-Executive Directors

Sean Lyons,
Chair

Linda Jackson,
Vice Chair

Julie Beilby

Sue Liburd

Simon Parkes

Gill Ponder

Associate Non-Executive Director

Murray Macdonald

Group Executive Directors

Amanda Stanford, Acting Group Chief Executive

Emma Sayner, Group Chief Finance Officer

Heather McNair, Interim Group Chief Nurse

Clive Walsh, Interim Site Chief Executive - North

Sarah Tedford, Interim Site Chief Executive - South

Dr Kate Wood, Group Chief Medical Officer

Ivan McConnell, Group Chief Strategy and Partnerships Officer

Simon Nearney, Group Chief People Officer

David Sharif, Group Director of Assurance

Directors who left the trust in 2024/25

Non-Executive Directors
Stuart Hall
Kate Truscott

Executive Directors
Lee Bond, Group Chief Finance Officer
Shaun Stacey, Group Chief Delivery Officer

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, with the exception of Linda Jackson, vice chair, who has served a longer term than set out in the 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. Sean Lyons, the Chair of NLaG, is also the Chair of HUTH. 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 five other NEDs, one Associate NED and five 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 Corporate Governance and Assistant Trust Secretary 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 2024 to 31 March 2025. 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. Linda Jackson, a NED, is the vice chair. Gill Ponder is the senior independent director, which is a NED appointed by the board as a whole in consultation with the CoG. 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. With the exception of Linda Jackson, vice chair, who has served a longer term, all the 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 c

hair 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 and follow 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. There is also a comprehensive board development programme and the completion of a formal board well-led review against the Well-Led Framework. Following agreement by the trust boards of NLAG and HUTH to move to a group model and aligned governance and decision making both boards now meet together and have done since January 2024. Aligned membership and terms of reference documents were designed, as well as an aligned annual workplan, and approved by the trust boards in December 2023.

An assessment of whether services are 'Well Led' under the NHSE well led framework was undertaken as part of the trust's CQC inspection in July 2022. The CQC assessment remained as 'requires improvement'. Each of the board completes an annual review of effectiveness, and the outcome including agreed actions, are reported to the trust board. Arrangements are in place to enable appropriate review of the board's balance, completeness and appropriateness to the requirements of the trust. A Well-led review will be conducted during 2025/26.

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. 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 2024/25

Member / Attendee	Apr-24	Jun-24	Aug-24	Oct-24	Dec-24	Feb-25
NLaG members						
Sean Lyons	Y	Y	Y	Y	Y	Y
Jonathan Lofthouse	Y	Y	Y	Y	Y	Y
Lee Bond	Y	Y	Y	-	-	-
Paul Bytheway	-	Y	Y	Y	-	-
Simon Nearney	Y	Y	Y	Y	Y	Y
Emma Sayner	-	-	-	-	Y	Y
David Sharif	Y	Y	Y	Y	Y	Y
Amanda Stanford	Y	Y	Y	Y	Y	Y
Sarah Tedford	-	-	-	-	Y	X
Clive Walsh	-	-	-	-	Y	X
Linda Jackson	Y	X	Y	Y	Y	Y
Kate Wood	Y	Y	Y	X	X	Y
Julie Beilby	-	Y	Y	Y	Y	Y
Sue Liburd	Y	Y	Y	X	Y	Y
Ivan McConnell	Y	Y	Y	Y	Y	Y
Simon Parkes	Y	X	X	Y	Y	Y
Gill Ponder	Y	Y	Y	Y	Y	Y
Shaun Stacey	Y	-	-	-	-	-
Kate Truscott	Y	X	X	-	-	-

Board committees-in-common

Audit, Risk and Governance Committee-in-Common

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
- 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 2024/25 by Audit Yorkshire who commenced on 1 June 2018, following a competitive procurement exercise in early 2018 and were re-appointed following a further tender exercise in 2022 for a three year term with the option to extend for a further year. A competitive tender process was however undertaken during the latter part of the financial year to procure a single Group Internal Audit service provider commencing with 2025/26 audit work. Internal Audit provides an independent and objective opinion 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 opinion on the effectiveness of the system of internal control. The Head of Internal Audit and/or the Internal Audit Manager for the Trust will normally attend Audit, Risk and Governance Committee-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 2024/25, 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 recommendations.

The annual Head of Internal Audit Opinion, which forms part of the Annual Governance Statement, contains details of high risk recommendations 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 'low 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 value of external audit services is disclosed in the Trust's financial statements (note 7.1) and is circa £175k 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 2025 meeting, with the results provided to the Trust Board in February 2025.

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 2025.

Schedule of Attendance at Audit, Risk and Governance Committee-in-common meetings 2024/25

Member / Attendee	April-24	Jul-24	Aug-24	Oct-24	Jan-25
NLAG Members					
Simon Parkes – NLAG NED / NLAG ARG CiC Chair	Y	Y	Y	Y	Y
Gill Ponder – NLAG NED	Y	N[1]	N[1]	Y	Y
Kate Truscott – NLAG NED (to Aug 24)	Y	N[1]	N[1]	-	-
Julie Beilby – NLAG NED (from Jan 25)	-	-	-	-	Y
Regular Attendees					
Jane Hawkard – HUTH NED / HUTH ARG CiC Chair	Y	Y	N[2]	Y	Y
Mike Robson – HUTH NED (to Apr 24)	Y	-	-	-	-
Tony Curry – HUTH NED	Y	Y	N[2]	Y	Y
Helen Wright – HUTH NED (from Jun 24)	-	-	N[2]	Y	Y
Lee Bond – Group Chief Financial Officer (to Aug 24)	Y	Y	Y	-	-
Mark Brearley – Interim Group Chief Financial Officer	-	-	-	Y	-
Emma Sayner – Group Chief Financial Officer (from Jan 25)	-	-	-	-	Y
David Sharif – Group Director of Assurance	Y	Y	N[3]	Y	Y
Rebecca Thompson – Deputy Director of Assurance - HUTH	Y	Y	Y	N	Y
Sally Stevenson - Asst. DoF – Compliance and Counter Fraud	Y	Y	Y	Y	N
Nicki Foley – Group Local Counter Fraud Specialist	Y	Y	N[4]	Y	N
External Audit - NLAG (Sumer NI)	Y	Y	Y	Y	Y
External Audit – HUTH (Forvis Mazars)	Y	Y	N[2]	N	Y
Internal Audit - NLAG (Audit Yorkshire)	Y	Y	Y	Y	Y
Internal Audit – HUTH – (RSM)	Y	Y	N[2]	Y	Y
Group Data Protection Officer / IG Lead (SM)	Y	Y	N[4]	Y	Y
NLAG Governor Observer (Various)	Y	Y	N	Y	Y

Schedule of Attendance at Audit, Risk and Governance Committee-in-common meetings 2024/25 continued

Member / Attendee	Apr-24	Jul-24	Aug-24	Oct-24	Jan-25
Ad-hoc Attendees					
Asst. DoF – Planning and Control (NP)	Y	-	Y	-	-
Director of People Services (HK)	Y	-	-	-	-
Group Chief Technology Officer (TD)	Y	-	-	-	-
Group Chief Digital Officer (AH)	Y	-	-	Y	Y
Group Chair (SL)	-	-	Y	-	-
Group Chief Executive (JL)	-	-	Y	-	-
HUTH Vice Chair / NED (SH)	-	-	-	-	-
Non-Executive Director (SL)	-	Y[1]	-	-	-
NLAG Vice Chair / NED (LJ)	-	Y[1]	Y[1]	-	-
Group Interim Director of Quality Governance (RC)	-	Y	-	-	-
Group Chief Delivery Officer (PB)	-	Y	-	Y	-
Group Operations Director EPRR (MO)	-	Y	-	Y	Y
Director of Procurement (EJ)	-	Y	-	Y	Y
Group Director of IT Performance and Operations (SM)	-	Y	-	-	-
Deputy Director of Assurance – NLAG (AH)	-	-	Y	-	-
Group Deputy Director of Communications (AB)	-	-	Y	-	-
Deputy Group Chief Financial Officer (PR)	-	-	-	Y	-
Senior Head of Finance - Cost Improvement and Efficiency	-	-	-	-	Y
HUTH Freedom to Speak Up Guardian (FM)	-	-	-	-	Y
NLAG Freedom to Speak Up Guardian (LH)	-	-	-	-	Y

Notes:

[1] Sue Liburd and / or Linda Jackson in attendance to ensure quoracy

[2] NLAG audited accounts meeting only

[3] Alison Hurley deputising

[4] Not required to attend, audited accounts meeting only

Capital and Major Projects Committees-in-Common

This committees-in-common oversees all capital bidding and activity, including:

- To review and inform the trust's capital plan, ensuring that major capital investment schemes are in line with and support the agreed strategy and objectives of the trust and wider group
- To monitor delivery of the annual capital programme (i.e. expenditure against plan)
- To scrutinise and evaluate all business cases (including the review of outline and full business cases) for proposed capital investment that require either Capital and Major Projects Committee-in-Common or trust board approval, ensuring that outcomes and benefits are clearly defined and are measurable
- To approve investment (and dis-investment) proposals and business cases within delegated limits and / or to make recommendations to the trust board for approval of business cases above the committee's delegated limits
- To monitor the pace, progress and effectiveness of delivery of major capital projects ensuring that emerging risks are being appropriately managed and mitigated
- To undertake post-project implementation evaluation to determine whether the intended outcomes and benefits have been realised and / or to determine any lessons to be learned for future major capital projects
- To have oversight of and receive assurance on the pace and progress of delivery of agreed areas of major service change / transformation including:
- To have oversight of delivery of the digital strategy and plan including major IT investment programmes and enablers

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 2024/25

	Committees-in-common				Committee
Group (HUTH/ NLAG)	Capital and major projects	Performance, estates and finance	Quality and safety	Workforce, education and culture	Charitable Funds
Number of meetings held	**6**	**11**	**11**	**11**	**3**
Sean Lyons			1		
Jonathan Lofthouse	-	1	1	1	
Amanda Stanford			9	7	
Murray Macdonald	1		1	1	
Kate Wood		10	6	5	
Lee Bond	2	4			1
Mark Brearley	2	2			1
David Sharif	6		8	8	
Paul Bytheway	2	4	3		
Stuart Hall	1		4		
Linda Jackson			2		
Tony Curry			9	8	3
Simon Nearney				10	
Julie Beilby	1		6	6	
Emma Sayner	1	3			1
Sarah Tedford	2	1			
Ivan McConnell	5	8			
Clive Walsh		3	4		
Helen Wright	3	6			
Jane Hawkard		8			3
David Sulch			11	10	

Notes:

1. Not every board member is a member of every committee, although they do sometimes attend a committee for a specific item.
2. 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.

	2024/25		2023/24	
	Number	£000	Number	£000
Total Non -NHS trade invoices paid in the year	**84,933**	**296,078**	84,415	294,666
Total Non-NHS trade invoices paid within target	**81,856**	**283,569**	78,508	280,781
Percentage of Non-NHS trade invoices paid within target	**96%**	**96%**	93%	95%
Total NHS trade invoices paid in the year	**2,361**	**33,931**	2,975	31,810
Total NHS trade invoices paid within target	**2,215**	**31,869**	2,775	30,525
Percentage of NHS trade invoices paid within target	**94%**	**94%**	93%	96%

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 relevant board committee and the Quality Governance Group, transitioning to a HHP wide Patient Safety and Learning Group and a Patient Experience Group.

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. During 2024/25, progressed the embedding of the Patient Safety Incident Response Framework as key milestones for the National Patient Safety Strategy.

The trust ensures there is regular reporting to, and dialogue with NHS England, Integrated Care Board locality teams, and a 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, especially in responding to the consequences of the coronavirus pandemic such as long waiting lists. 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).

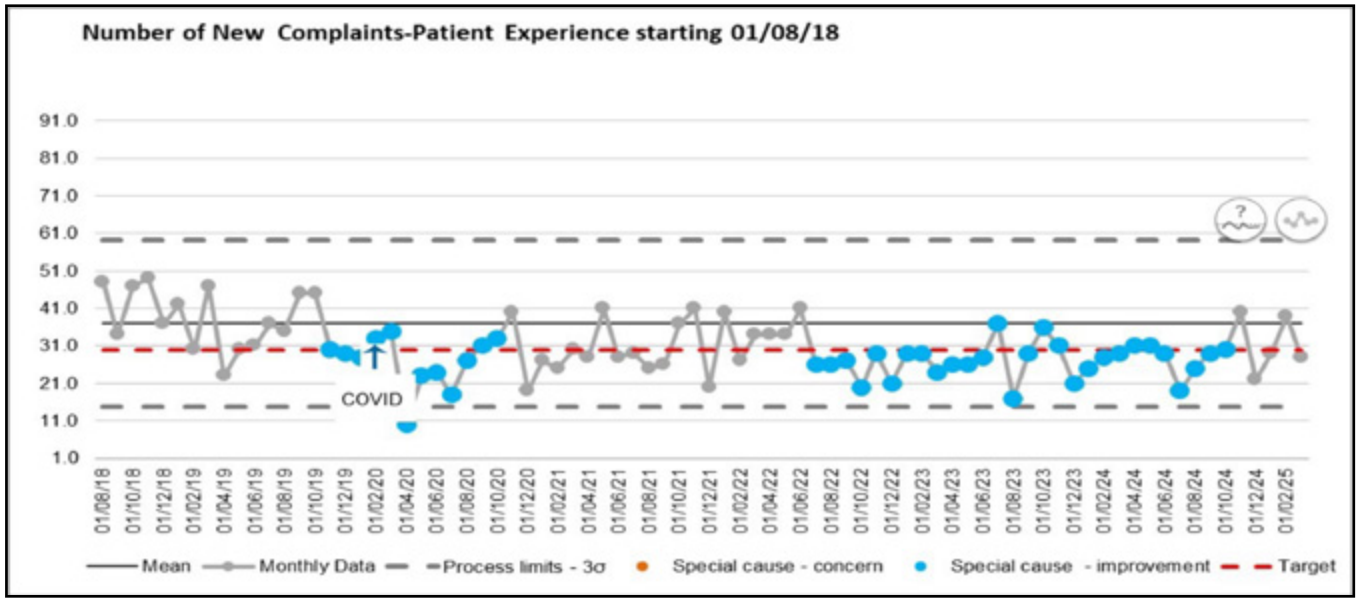
Stakeholders have been updated on this work through regular briefing sessions run in conjunction with local partners. Some of these sessions were held virtually and written updates have also been provided. Throughout the year representatives from the trust have regularly briefed local Members of Parliament (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 report 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.

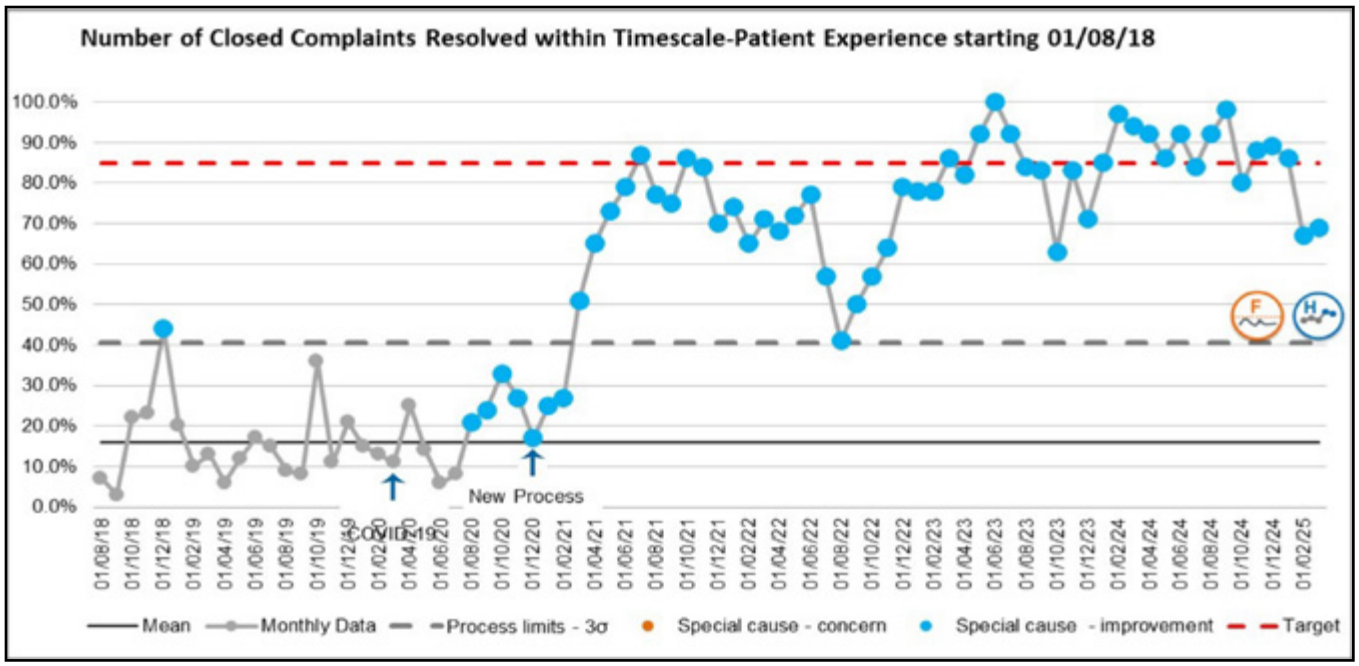
Patient engagement, experience and complaint management

Complaints

The table and chart below shows comparative complaint data for the past five years from April 2020 to March 2025. Complaint numbers have shown a slight increase over this period. The Patient Experience Team are now working as a single team across both NLaG and HUTH with collaborative working between the two offices at both trusts. This work will progress further once a single risk management system is procured improving sharing of information between the team. A key to understand the Statistical Process Control (SPC) charts over the next few pages is available on page 25 of this report.

	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
20/21	10	23	24	18	27	31	33	40	19	27	25	30	307
21/22	28	41	48	29	25	26	37	41	20	40	27	34	396
22/23	34	34	41	26	26	27	20	29	21	29	29	34	340
23/24	26	26	28	37	17	29	36	31	21	25	28	29	333
24/25	**31**	**31**	**29**	**19**	**25**	**29**	**30**	**40**	**22**	**29**	**39**	**28**	**352**





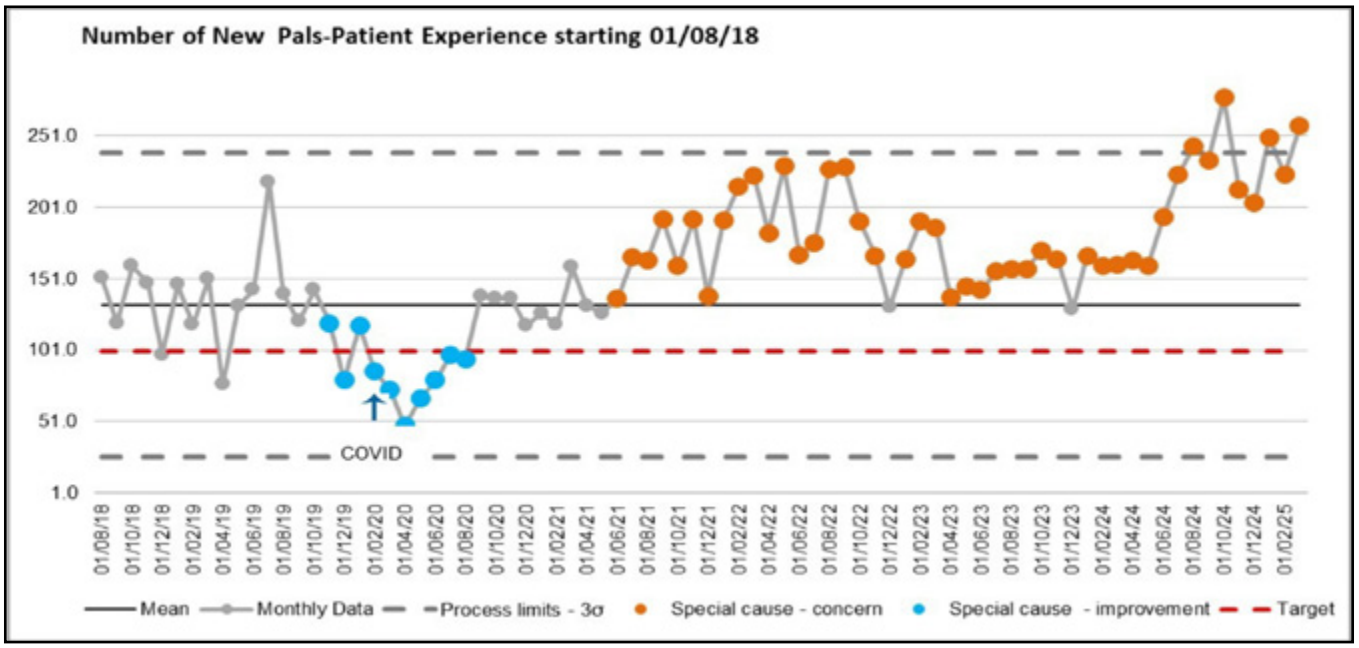
The headline themes remain consistent throughout the year and seen within the data are:

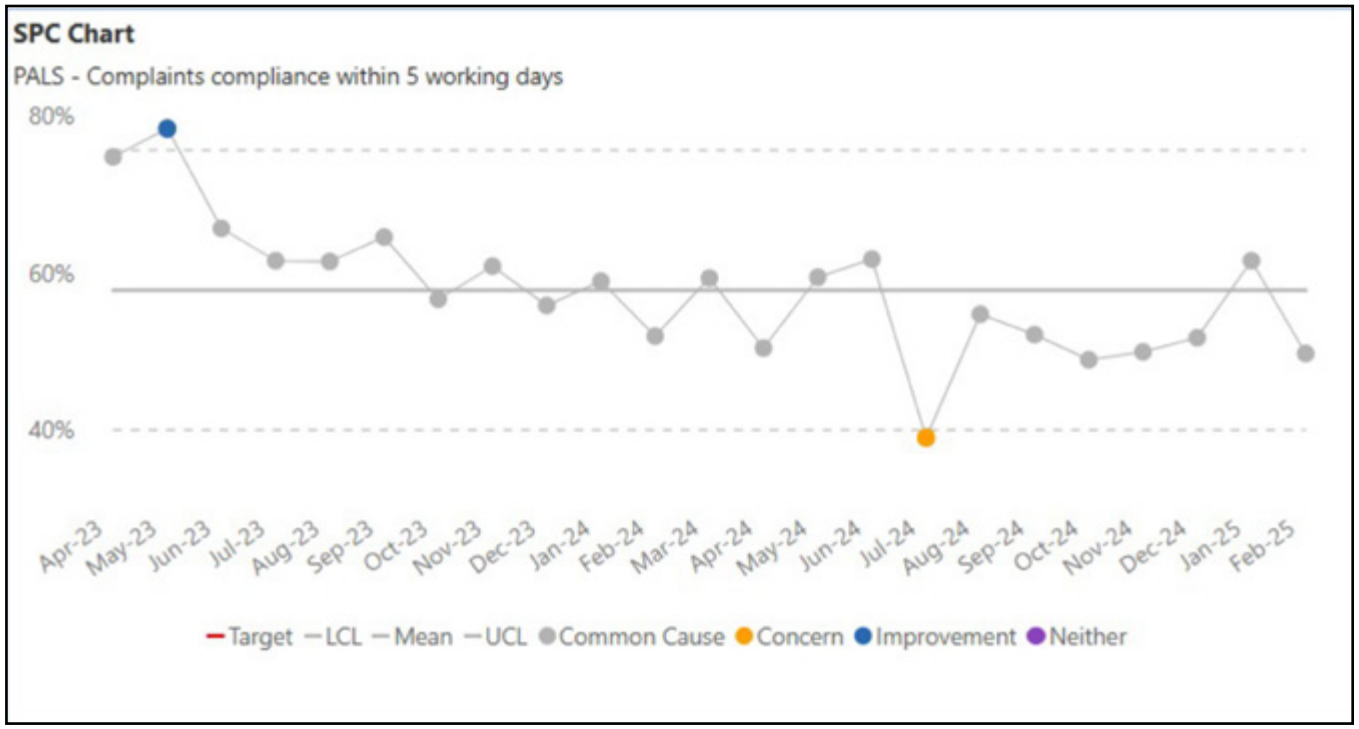
- Clinical treatment
- Clinical care/treatment and nursing care
- Nursing care
- Attitudes and behaviours
- Communication

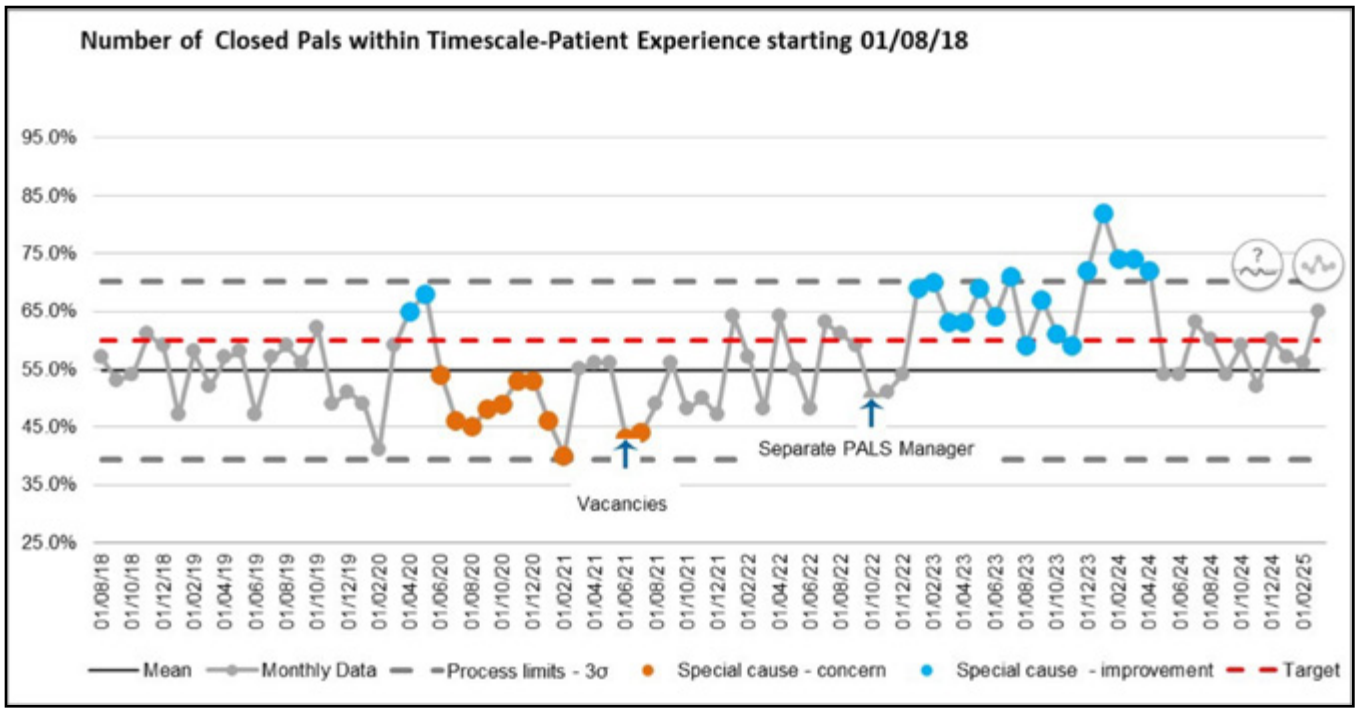
Both HUTH and NLaG have recently seen a downturn in the amount of time it takes to close complaints. Care Groups are now receiving performance reviews and the quality checking process is being reviewed in order to improve towards the closure time target of 85%.

Patient Advice and Liaison Service (PALS)

The PALS Team, led by the two Patient Experience Managers, have responded to 5,607 concerns, enquiries and compliments over the last financial year across the group, 2, 647 of which related to NLaG. Around 59% of these were responded to within 5 days, compared to a target of 60%. Group performance, including HUTH, was 56%. This data is set out graphically in the charts below.







The top 5 PALS themes for NLAG were:
- Clinical treatment – delays and failure in treatment
- Appointments – waiting times for new and follow up appointments.
- Communication with patients/relatives
- Values and behaviours – mainly the attitude of staff
- Waiting times for procedures

It is likely that the waiting time concern would be a national trend given the current NHS position of more than 7 million people currently waiting treatment until the end of February 2025 (NHS England). The Deputy Chief Nurse, Associate Director for Quality and Lead Nurse for Patient Experience are currently exploring options for communication training with a focus on reducing the number of concerns regarding communication and the values and behaviours of our staff.

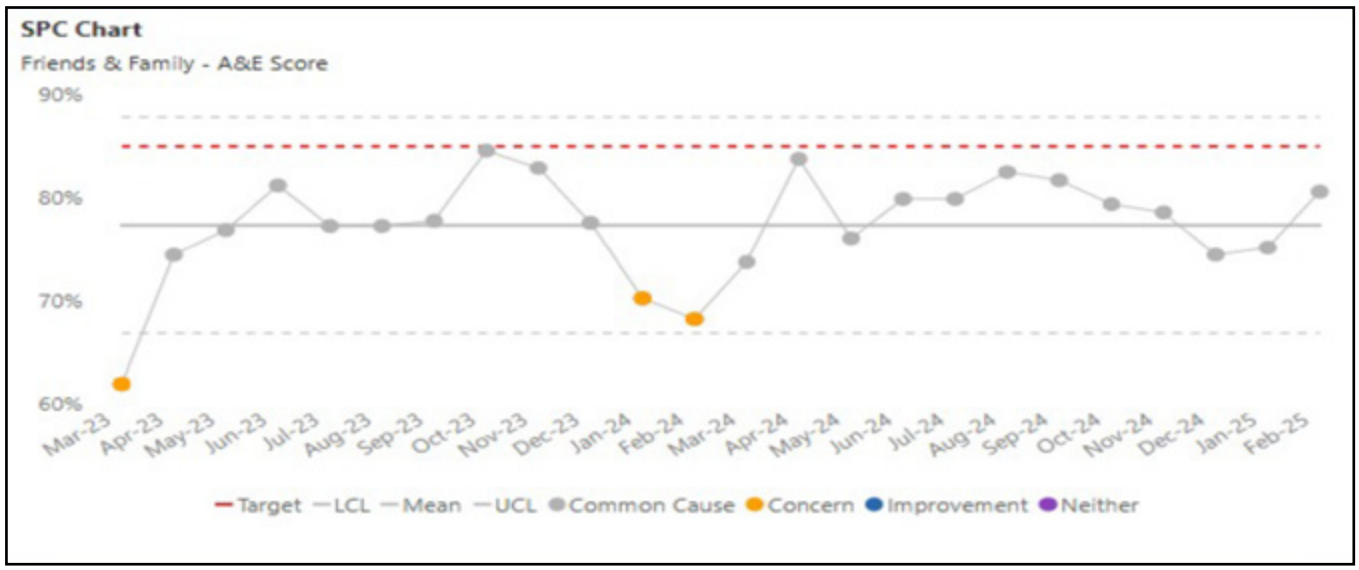
Sharing learning themes and trends

The following processes are used to share the learning from Complaints and PALS:
- Patient stories were taken to meetings of the trust Boards-in-Common and to other relevant groups, for example care group meetings and meetings of corporate teams
- Patient Experience Group (PEG) meetings started with a monthly patient story, acting as a powerful reminder of the purpose of the meeting
- Weekly directorate group meetings undertaken with the Patient Experience Team to track progress, review actions
- Dissemination of information at care group clinical governance and sub-specialty meetings
- Quarterly reports to the Quality and Safety Committees-in-Common
- The Patient Experience Team reported quarterly to the Quality Governance Group meeting
- Updates to external ICB meetings as requested

Friends and Family Test (FFT)

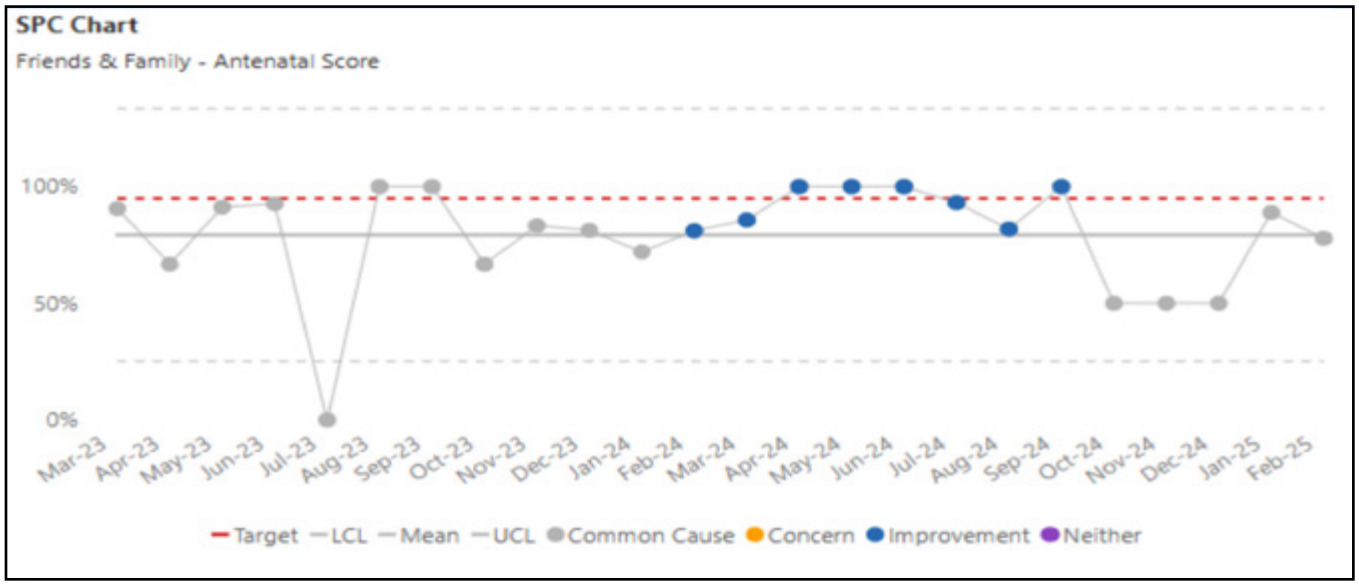
Both Trusts offer patients the opportunity to feedback from all departments and services. This includes inpatient, outpatient, emergency department, day surgery, maternity and community services. The trust received around 23,000 pieces of feedback through these routes between April 2024 and March 2025 from patients and their relatives. This is supporting the care groups in learning lessons and making improvements to patient services throughout the group. All feedback is shared back with ward teams as well as staff in other services and departments where appropriate.

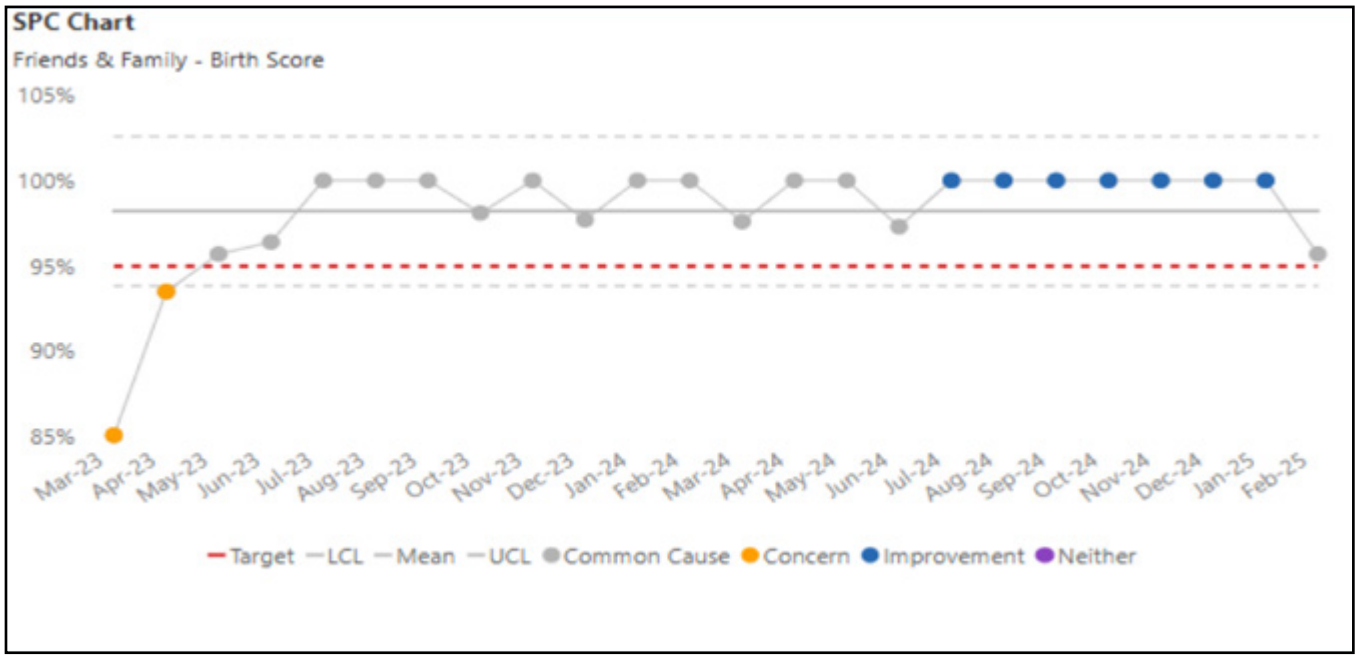
Emergency Department



The above chart shows positive performance against a KPI of 85% for the trust's emergency departments. Patient results are classified as Very good, Good, neither good nor poor, Poor, Very poor or don't know. With Very good or Good returning a positive result.

Maternity





The charts show positive performance against a KPI of 95% for maternity services (both antenatal and birth scores). However it is worth noting that response rates for this survey are very low and this should be considered when analysing any data.

Governors' Report

Council of Governors

As a foundation trust, the trust has a Council of Governors (CoG). The board of the trust is directly responsible for the performance and success of the trust and satisfying the CoG that the board is achieving its aims and fulfilling its statutory obligations. Governors act as a link to the local community and report matters of concern raised with them, to the board, via their quarterly CoG 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.

Role of Governors

The CoG 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 or any 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 Group Chief Executive
- Approve and if appropriate, remove the trust's auditor
- Receive the trust's Annual Report and Accounts at a general meeting of the CoG
- Hold the Non-Executive Directors, individually and collectively, to account for the performance of the Trust's Board of Directors for trust performance and its contribution to the delivery of the objectives for the Humber and North Yorkshire 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, an application by the trust to enter into a merger or acquisition and any 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 Integrated Care System. 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 CoG. The CoG 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 CoG, 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 2024/25

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		
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						
Tony Burndred	24.04.19	17.05.22	3 years	17.05.25	11.06.24	
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		3 years	21.11.25		
Karen Green	21.11.22		3 years	21.11.25	30.09.24	
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		
David Cuckson	16.11.21		3 years	16.11.24	16.11.24	
Wendy Lawtey	14.11.24		3 years	14.11.27		
Shiv Nand	16.11.21		3 years	16.11.24	16.11.24	
Caroline Ridgway	14.11.23		3 years	14.11.26		
Vacancy						

Members of the Council of Governors during 2024/25 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		
Raquel Jakins	14.11.23		3 years	14.11.26	07.08.24	
Corrin Manaley	14.11.23		3 years	14.11.26		
Anthonia Nwafor	16.11.21		3 years	16.11.24	16.11.24	
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 Mundey – North Lincolnshire Place	30.09.22		3 years	30.09.25		
Cllr Paul Henderson – North East Lincolnshire Council	23.05.24		1 year	23.05.25		Inde-pendent
Cllr David Howard – East Riding of Yorkshire Council	17.07.23		2 years	17.07.25		Inde-pendent
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 2024

The Annual Governor elections were held in November 2024 as a result of five Governors reaching the end of their term of office and vacant seats. The election resulted in one public Governor re-elected for a term of three years for North East Lincolnshire and one new public Governor for East and West Lindsey, two new public Governors for Goole and Howdenshire, one public Governor for North Lincolnshire all elected for a term of three years. The staff Governor elections were contested and determined by ballot resulting in two new staff Governors elected, one for a period of three years and one for two years due to an unexpired remaining term of office.

Council of Governor meetings

The Council of Governors meets sufficiently regularly to discharge its duties. During the year April 1 2024 to March 31 2025 attendance at meetings was as follows:

Key to tables

- P – Present / A – Absent / * - Representative Attendance / N/A - Attendance not required
- NL – North Lincolnshire / NEL – North East Lincolnshire / ERY – East Riding of Yorkshire

Council of Governor meetings (held in person or virtually)

	Business	Business	Annual Review and Busines	Annual Members Meeting	Business	Business	Business	TOTAL
Name	**18.04**	**18.06**	**22.08**	**12.09**	**31.10**	**09.01**	**25.02**	
Public Governors – East and West Lindsey								
Jenny Aspinwall						A	A	**0/2**
Jeremy Baskett	P	A	P	P	A	P	P	**5/7**
Dr Gorajala Vijay	A	P	A	P	P	P	P	**5/7**
Public Governors – Goole and Howdenshire								
Tony Burndred	A							**0/1**
Brent Huntington						P	P	**2/2**
Rob Pickersgill	P	P	A	P	P	P	P	**6/7**
Clare Woodard						P	P	**2/2**
Public Governors – North East Lincolnshire								
Diana Barnes	P	P	P	P	P	P	P	**7/7**
Mike Bateson	P	P	A	P	P	P	P	**6/7**
Karen Green	A	P	A	A				**1/4**
David James	P	P	A	A	P	P	A	**4/7**
Ian Reekie	P	A	P	P	P	P	P	**6/7**

Council of Governor meetings - attendance continued

Name	Business 18.04	Business 18.06	Annual Review and Busines 22.08	Annual Members Meeting 12.09	Business 31.10	Business 09.01	Business 25.02	TOTAL
Public Governors – North Lincolnshire								
Kevin Allen	P	P	P	P	A	P	A	**5/7**
Paula Ashcroft	A	P	P	A	A	P	A	**3/7**
David Cuckson	P	P	P	P	P			**5/5**
Shiv Nand	P	A	A	A	P			**2/5**
Caroline Ridgway	P	P	P	A	P	A	P	**5/7**
Staff Governors								
Ahmed Aftab	P	P	P	A	A	P	P	**5/7**
Raquel Jakins	P	A						**1/2**
Corrin Manaley	P	A	A	P	P	A	P	**4/7**
Anthonia Nwafor	A	A	A	A	A			**0/5**
Dr Sandeep Saxena						P	P	**2/2**
Jackie Weavill						A	P	**1/2**
Stakeholder Governors								
Emma Mundey – NL Place	A	P	A	P	A	P	A	**3/7**
Cllr David Howard – ERY Council	P	A	A	P	A	P	P	**4/7**
Cllr Paul Henderson – NEL Council		P	P	A	P	A	P	**4/6**

Council of Governor meetings - attendance continued

During the year April 1 2024 to March 31 2025 attendance by Executive and Non-Executive Directors at the Council of Governor meetings was as follows:

	Business	Business	Annual Review and Busines	Annual Members Meeting	Business	Business	Business	TOTAL
Name	**18.04**	**18.06**	**22.08**	**12.09**	**31.10**	**09.01**	**25.02**	
Julie Beilby - NED	P	P	P	P	P	P	P	**7/7**
Lee Bond – Group Chief Financial Officer	A*	A	N/A					**0/2**
Mark Brearley – Interim Group Chief Financial Officer			N/A	A*	P			**1/2**
Paul Bytheway – Interim Group Chief Delivery Officer		P	N/A	A				**1/2**
Stuart Hall – Associate NED	P	A	A	P	P			**3/5**
Linda Jackson - Vice Chair	P	A	P	A	P	P	A	**4/7**
Jonathan Lofthouse – Group Chief Executive	P	P	N/A	P	P	P	N/A	**5/5**
Sue Liburd - NED	P	P	P	A	P	P	A*	**5/7**
Sean Lyons - Group Chair	P	P	A*	P	P	P	P	**6/7**
Murray Macdonald – Associate NED						P	P	**2/2**
Ivan McConnell - Group Chief Strategy and Partnerships Officer	P	P	N/A	A	P	P	N/A	**4/5**
Simon Nearney – Group Chief People Officer	P	A	N/A	A	P	A*	N/A	**2/5**

Council of Governor meetings - attendance continued

Name	Business 18.04	Business 18.06	Annual Review and Busines 22.08	Annual Members Meeting 12.09	Business 31.10	Business 09.01	Business 25.02	TOTAL
Simon Parkes - NED	P	P	P	P	A	P	P	**6/7**
Gill Ponder – Senior Independent Director	P	P	P	A	P	P	P	**6/7**
Emma Sayner - Group Chief Financial Officer						A*	N/A	**0/1**
David Sharif – Group Director of Assurance	P	P	P	P	P	P	P	**7/7**
Shaun Stacey – Group Chief Delivery Officer	P							**1/1**
Amanda Stanford – Group Chief Nurse		P	N/A	P	A	P	N/A	**3/4**
Sarah Tedford – Site Chief Executive - South						A	N/A	**0/1**
Clive Walsh – Site Chief Executive - North						N/A	N/A	**0/0**
Kate Truscott - NED	P	A*	A*					**1/3**
Dr Kate Wood – Group Chief Medical Officer	A	P	N/A	P	P	P	N/A	**4/5**

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 August. 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 the 15 Step Reviews (replaced by ACE – A Commitment to Excellence as of March 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.

Eight such briefings were held during 2024/25 on topical health matters which included:

- South Site Triumvirate Team
- Group Strategy Development Session
- Integrated Performance Report, Cost Improvement Plan and Board Assurance Framework
- Group Strategic Framework and Governor Engagement
- Digital Strategy Developments
- Goole & District Hospital Engagement
- Member and Public Engagement Strategy
- Evolution of the Health and Local Government Interface
- Update on Options for Goole & District Hospital

Additional briefings within the CoG meetings were held during 2024/25 on topical matters which included:

- Integrated Care System Update
- Humber Acute Services – Decision Making Business Case
- Trust Priorities 2024/25
- Operational Plan 2024/25
- Group Digital Developments
- Public Health in Northern Lincolnshire
- Integrated Care System (ICS) Working – including Place, the Collaborative of Acute Providers and Integrated Care Board (ICB)
- Culture and Leadership Transformation
- Health Tree Foundation Update
- Finance Update

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 2024/25 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. Open advertising and advice from NHS England's Non-Executive Talent and Appointments team was used in the recruitment of Non-Executive Directors (NEDs), as recommended by the Code of Governance. The trust did not engage any external consultants for Board recruitment in the reporting period.

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. For all board members, the trust has introduced appraisal processes based on the NHS Leadership Competency Framework.

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 2024 have been undertaken and reported to the full Council.

For the Council of Governors, the chair also oversees the provision of development opportunities and ensures that governors have the necessary knowledge and skills to undertake their role. This includes:

- Access to briefings and development sessions on key service priorities and system changes
- Participation in structured visits, review activities, and NHS England-aligned training
- Annual individual development reviews for governors to assess support needs

Through these arrangements, the Chair supports a well-informed and capable governance body that contributes effectively to the trust's success and accountability to its stakeholders.

Key items discussed in 2024/25 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 and Assurance Group (MPEAG)
  - Appointments and Remuneration Committee (ARC)
- Reports from Board Committees-in-Common: Audit, Risk and Governance; Capital and Major Projects; Performance, Estates and Finance; Quality and Safety; and Workforce, Education and Culture

Membership Report

Membership strategy

During 2023/24 the trust's governors started a programme of work to update the strategy to respond to two changes since the previous strategy was developed in 2019. The first is an addendum to governors' statutory responsibilities and duties which are set out in the National Health Service 2006 Act. Within those duties, councils of governors are legally responsible for representing the interests of the members of the NHS foundation trust and the public.

To support collaboration between organisations and the delivery of better, joined-up care, councils of governors are required to form a rounded view of the interests of the 'public at large' and feed this back to the trust board. The second is the formation of the group with Hull University Teaching Hospitals, the NHS Humber Health Partnership.

The new strategy, which was formally agreed by the CoG in April 2025, set out five objectives:

1. Ensure members are kept informed and given accurate information on a timely basis about services and developments in the Humber Health Partnership
2. Create a range of opportunities and activities so that our members have the opportunity to feedback and be involved in shaping our service plans
3. Develop and increase the membership base and member related activities in order to achieve a representative and engaged membership
4. Ensure members know who their local Governor is, what they do/their role and why and how to contact them
5. Maintain an up to date and active membership database

A copy of the strategy was made available in the Council of Governors pack of papers for their April 2025 meeting. This pack was available on the trust website at the time of publishing this report here . https://www.nlg.nhs.uk/resources/council-of-governors-meeting-papers-2025/

The membership

As of 26 March 2025, the trust has 3,172 public members. These members must live within one of the four constituencies (which are set out in the Governors' Report in the previous section of this report) 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 significantly reduced the total numbers of members. Membership applications have increased in number from the Goole and Howdenshire area after the local Governors suggested joining as part of the work to look at the future of Goole and District Hospital. There are demographic and geographic groups that are under-represented within our membership, such as people from younger working age groups. The Trust's public membership for 2024/25 is set out below.

	2024/25
Public members	3,172
Minimum of public members required under the Trust Constitution	1,400
Staff members	5,936

The following tables provide a more detailed breakdown:

Breakdown by age

Age group – public members	Number	Percentage of members
0 to 16	0	0
17 to 21	282	8.9%
22 +	2,724	86%
DoB not stated	163	5.1%
Total	**3,172**	**100**

Breakdown by constituency

Constituency	Male	Female	Total
Goole and Howdenshire	137	189	326
North East Lincolnshire	397	1,060	1,457
North Lincolnshire	382	701	1,083
East and West Lindsey	85	221	306
Staff	1,095	4,841	5,936
Total	**2,096**	**7,012**	**9,108**

Breakdown by ethnicity

Ethnicity	Number	Percentage of members	Population	Percentage of population served by the trust
White	2,967	93.55%	372,737	97.63
Mixed	13	0.4%	1,854	0.49
Asian or Asian British	62	1.95%	5,529	1.45
Black or Black British	31	0.98%	882	0.23
Other	4	0.13%	786	0.21
Not stated	95	2.99%	0	0
Total	**3,172**	**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 the trust. A 'welcome' email or letter is issued to all new members. This provides an outline of the trust and what it does. During the 2024/25 year the trust sent a regular newsletter to those members who remained on the membership database. This email was distributed primarily through emails and was also sent through the post to those members who has expressed a preference for receiving it this way. The trust's communications team manages the development and distribution of the newsletter and will be working with governors on the content throughout 2025/26 and beyond as part of the refreshed member and public engagement approach.

As well as the newsletter the trust also made 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
- The trust's and group's social media accounts, specifically X (formerly known as Twitter) and Facebook
- Governors have started regular sessions to meet with their constituents by holding Drop-In sessions in our hospitals (and off-site if pre-arranged)
- In conjunction with local HealthWatch organisation Governors hold regular informal engagement sessions within our hospitals to survey the views of patients and visitors

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 focuses 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 in consideration. The key decisions made on senior managers' remuneration in 2024/25 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 of the Group Fit and Proper Persons Policy for submission to Trust Boards-in-Common
- Agreement to extend Interim roles to cover structures gaps
- An annual Remuneration Committees-in-Common work plan
- 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 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 Group Chief Executive had his appraisal during 2024/25, this was undertaken by the Group Chair. From the appraisal, a report is submitted to the Remuneration Committees-in-Common and also to the Council of Governors. 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 2024/25	Salary 2023/24
Sean Lyons *	**£37,500**	£37,500
Linda Jackson	**£19,353**	£19,353
Stuart Hall	**£13,000**	£13,000
Susan Liburd	**£13,735**	£13,735
Fiona Osborne	**-**	£13,735
Julie Beilby	**£13,735**	-
Simon Parkes	**£16,132**	£16,132
Gillian Ponder	**£16,132**	£16,132
Kate Truscott	**£13,735**	£13,735
Murray Macdonald	**£13,000**	-

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

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

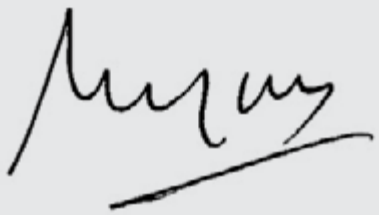
There is currently no provision within the Remuneration Policy for payment for loss of office on senior managers contracts.

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.



Sean Lyons
Chair
Date: 20 June 2025

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. However, during 2024/25 the committee has taken advice internally from the Group Chief People Officer.

The tables overleaf illustrate the attendees and their attendance at the committee meetings held between 1 April 2024 and 31 March 2025.

Name	Title	Dates of Attendance
Sean Lyons	Group Chair	2024: 4 April, 28 May, 3 October, 27 November
Linda Jackson	Vice Chair	2024: 28 May, 27 November
Julie Beilby	Non-Executive Director	2024: 28 May, 3 October, 27 November
Susan Liburd	Non-Executive Director	2024: 4 April, 28 May, 3 October, 27 November
Simon Parkes	Non-Executive Director	2024: 4 April
Gillian Ponder	Non Executive Director	2024: 4 April, 28 May, 3 October, 27 November
Kate Truscott	Non-Executive Director	2024: 4 April, 28 May
Stuart Hall	Associate Non-Executive Director	2024: 4 April, 3 October
Simon Nearney	Group Chief People Officer	2024: 4 April, 28 May, 3 October
Jonathan Lofthouse	Group Chief Executive	2024: 4 April, 28 May, 3 October, 27 November
David Sharif	Group Director of Assurance	2024: 4 April, 28 May, 3 October, 27 November

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 2024/25 are set out in the table below and overleaf.

Name	Title	Date of contract	Notice period from the Trust	Notice period to the Trust
Jonathan Lofthouse	Group Chief Executive	01/08/2023	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
Shaun Stacey	Group Chief Delivery Officer	01/11/2023 – 31/5/24	Three months	Three months
Ivan McConnell	Group Chief Strategy and Partnerships Officer	01/11/2023	Three months	Three months
Lee Bond	Group Chief Financial Officer	06/11/2020 – 8/9/2024	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 2024/25 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
Kate Truscott	03/10/2022	03/10/2022	24/08/2024
Stuart Hall	01/04/2020	01/10/2024	31/12/2024

The Appointments and Remuneration Committee

The Appointment 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 Associate Non-Executive Director appointed to a Non-Executive Director position and one Associate Non-Executive Director appointed in 2024/25.

ARC attendance 2024/2025

	30/05/24	03/10/24	20/02/25	Total
Public / Staff Governor Members				
Ian Reekie (ARC Chair)	P	P	P	3 out of 3
Ahmed Aftab			A	0 out of 1
Jeremy Baskett	P	P	P	3 out of 3
Mike Bateson			P	1 out of 1
David Cuckson	P	P		2 out of 2
Karen Green	P			1 out of 1
David James	P	A	A	1 out of 3
Rob Pickersgill	P	A	P	2 out of 3
In attendance				
Paul Bunyan (Director of Planning, Recruitment, Wellbeing and Improvement)	A	A*	P	1 out of 3
Linda Jackson (Vice Chair)	P	A	A	1 out of 3
Sean Lyons (Trust Chair)	P	P	P	3 out of 3
Gill Ponder (NED and SID)	P			1 out of 1
David Sharif (Group Director of Assurance)	P	P	P	3 out of 3
David Sprawka (Group Head of Workforce Transformation)		P		1 out of 1

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

Off payroll engagements

Table 1: Highly-paid off-payroll worker engagements as at 31 March 2025 earning £245 per day or greater

	Number
Total number of existing engagements as of 31 March 2025	0
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	0
for between two and three years at the time of reporting	0
for between three and four years at the time of reporting	0
for four or more years at the time of reporting	0

Table 2: All highly-paid off-payroll workers engaged at any point during the year ended 31 March 2025 earning £245 per day or greater

	Number
Number of off-payroll workers engaged during the year ended 31 March 2025	0
Of which:	
Not subject to off-payroll legislation *	0
Subject to off-payroll legislation and determined as in-scope of IR35 *	0
Subject to off-payroll legislation and determined as out-of-scope of IR35 *	0
Number of engagements reassessed for compliance or assurance purposes during the year	0
Of which:	
Number of engagements that saw a change to IR35 status following review	0

* A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the Trust must undertake an assessment to determine whether that worker is in scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2024 and 31 March 2025

	Number
Number of off-payroll engagements of board members, and/or senior officers with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed 'board members, and/or, senior officials with significant financial responsibility', during the financial year. This figure should include both on payroll and off-payroll engagements	19

Directors and governors expenses

2024/25			
	Total in office	Total receiving expenses	Total expenses £00's
Directors	21	11	£128
Governors	19	7	£122

2023/24			
	Total in office	Total receiving expenses	Total expenses £00's
Directors	20	9	£96
Governors	19	6	£10

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 2024/25 has spent £1,375,000 on consultancy fees compared to £658,000 in the previous financial year.

Directors' remuneration 2024/25 (subject to audit)

			Salary (bands of £5,000)	Benefits in kind (£s, to the nearest £100)	Pension Related benefit (bands of £2,500)	Total (bands of £5,000)
Name	**Title**	**Note**	**£000**	**£**	**£000**	**£000**
Mr S Lyons	Group Chair	2	40 - 45	-	-	40 - 45
Mrs L Jackson	Group Vice Chair and Associate Non-Executive Director	3	15 - 20	-	-	15 - 20
Mr JM Lofthouse	Group Chief Executive Officer	4	140 - 145	-	-	140 - 145
Mrs S Tedford	Chief Executive South	6	60 - 65	-	-	60 - 65
Mr P Bytheway	Group Chief Delivery Officer (Resigned October 2024)	7	35 - 40	-	-	35 - 40
Mr S Stacey	Group Chief Delivery Officer (Resigned May 2024)	8	30 - 35	-	-	30 - 35
Mr S Nearney	Group Chief People Officer	1,9	85 - 90	-	-	85 - 90
Mrs A Stanford	Group Chief Nurse (Appointed April 2024)		90 - 95	-	-	90 - 95
Dr KA Wood	Group Chief Medical Officer	1, 11, 22	145 - 150	4,800	125.0 - 127.5	280 - 285
Mrs E Sayner	Group Chief Financial Officer (Appointed December 2024)	12	30 - 35	-	-	30 - 35
Mr M Brearley	Interim Group Chief Financial (September 2024 - December 2024)	13	30 - 35	-	-	30 - 35
Mr L Bond	Group Chief Financial Officer (Resigned September 2024)	14	50 - 55	-	-	50 - 55

Directors' remuneration 2024/25 (subject to audit) continued

			Salary (bands of £5,000)	Benefits in kind (£s, to the nearest £100)	Pension Related benefit (bands of £2,500)	Total (bands of £5,000)
Name	**Title**	**Note**	**£000**	**£**	**£000**	**£000**
Mr IP McConnell	Group Chief Strategy and Partnerships Officer	15	80 - 85	-	47.5 - 50.0	130 - 135
Mr D Sharif	Group Director of Assurance	17	65 - 70	-	-	£65 - £70
Mr S Hall	Associate Non-Executive Director (Resigned December 2024)	19	5 - 10	-	-	5 - 10
Mrs J Beilby	Non-Executive Director (Appointed April 2024)	20	10 - 15	-	-	10 - 15
Ms SP Liburd	Non-Executive Director		10 - 15	-	-	10 - 15
Mr M MacDonald	Associate Non-Executive Director (Appointed January 2025)	21	0 - 5	-	-	0 - 5
Mr S Parkes	Non-Executive Director		15 - 20	-	-	15 - 20
Mrs G Ponder	Non-Executive Director		15 - 20	-	-	15 - 20
Mrs K Truscott	Non-Executive Director (Resigned September 2024)		5 - 10	-	-	5 - 10
		£000	**£'s**			
Gross remuneration, including national insurance and pension contributions		1,235				

Directors' remuneration 2023/24 (subject to audit)

			Salary (bands of £5,000)	Benefits in kind (£s, to the nearest £100)	Pension Related benefit (bands of £2,500)	Total (bands of £5,000)
Name	**Title**	**Note**	**£000**	**£**	**£000**	**£000**
Mr S Lyons	Group Chair	2	40 - 45	-	-	40 - 45
Mrs L Jackson	Vice Chair	3	15 - 20	-	-	15 - 20
Mr JM Lofthouse	Group Chief Executive (Appointed August 2023)	4	95 - 100	-	-	95 - 100
Dr PR Reading	Chief Executive (Resigned May 2023)	1, 5	30 - 35	6,100	-	40 - 45
Mr S Stacey	Group Chief Delivery Officer (Appointed November 2023, Resigned May 2024)	8	130 - 135	-	47.5 - 50.0	180 - 185
Mrs A Shanker	Interim Chief Operating Officer (Part Year)	1, 22	10 - 15	1,800	-	10 - 15
Mr S Nearney	Group Chief People Officer (Appointed November 2023)	1, 9	80 - 85	-	-	80 - 85
Mrs E Monkhouse	Chief Nurse	10, 22	255 - 260	-	-	255 - 260
Dr KA Wood	Group Chief Medical Officer (Appointed November 2023)	1, 11, 22	200 - 205	1,700	-	205 - 210
Mr L Bond	Group Chief Financial Officer	14	105 - 110	-	-	105 - 110
Mr IP McConnell	Group Chief Strategy and Partnership Officer (Appointed November 2023)	15	45 - 50	-	40.0 - 42.5	85 - 90

Directors' remuneration 2023/24 (subject to audit) continued

			Salary (bands of £5,000)	Benefits in kind (£s, to the nearest £100)	Pension Related benefit (bands of £2,500)	Total (bands of £5,000)
Name	**Title**	**Note**	**£000**	**£**	**£000**	**£000**
Mr J Johal	Director of Estates and Facilities (Exited December 2023)	16, 22	75 - 80	-	-	75 - 80
Mr D Sharif	Group Director of Assurance (Appointed March 2024)	17	0 - 5	-	-	0 - 5
Mrs SN McMahon	Chief Information Officer (Resigned November 2023)	18	45 - 50	-	62.5 - 65.0	110 - 115
Mr S Hall	Associate Non-Executive Director	19	10 - 15	-	-	10 - 15
Ms SP Liburd	Non-Executive Director		10 - 15	-	-	10 - 15
Mrs F Osborne	Non-Executive Director (resigned December 2023)		10 - 15	-	-	10 - 15
Mr S Parkes	Non-Executive Director		15 - 20	-	-	15 - 20
Mrs G Ponder	Non-Executive Director		15 - 20	-	-	15 - 20
Mrs K Truscott	Non-Executive Director		10 - 15	-	-	10 - 15
		£000	**£'s**			
Gross remuneration, including national insurance and pension contributions		1,235	1,516	9,600		

Pay multiple statement (subject to audit)

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, median and 75th percentile is set out below. 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 organisations workforce. The ratio is obtained by dividing the highest paid directors salary by the median salary, the 25th percentile salary and 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 increased by 5.6% in the year.

Pay multiple table 2024/25 (subject to audit)

Notes				
23	Banded remuneration of the highest-paid director	£280,000 - £285,000		
	Change between years	5.6%		
		25th Percentile	**Median**	**75th Percentile**
23	Pay and benefits excluding pension	£24,000	£30,000	£45,000
23	Pay and benefits excluding pension: pay ratio for highest paid director	11.6	9.4	6.3
		Lowest	**Highest**	
23	Range of remuneration for employees of the Trust as a whole	£13,000	£278,000	
		Average		
24	Percentage change in average employee remuneration	4.2%		
25	Number of employees that received remuneration in excess of the highest paid director	0		

Notes to director remuneration and pay multiple tables

1 - Benefit in kind relates to lease cars.

2 - Mr S Lyons is joint chair with Hull University Hospitals NHS Trust. The table above represents remuneration relating to Northern Lincolnshire and Goole NHS Foundation Trust only.

3 - Mrs L Jackson is Vice Chair of Northern Lincolnshire and Goole NHS Foundation Trust and is an Associate Non-Executive Director of Hull University Hospitals NHS Trust. The above table represents remuneration relating to NLaG only.

4 - Mr JM Lofthouse is Group Chief Executive, this a joint role with Hull University Hospitals NHS Trust. The table above represents remuneration relating to NLaG only. The pension benefit is excluded from this table as this will be reported by Hull University Teaching Hospitals.

5 - Mr P Reading resigned as Chief Executive in May 2023.

6 - Mrs S Tedford was appointed Chief Executive South in December 2024.

7 - Mr P Bytheway was Group Chief Delivery Officer between June and October 2024.

8 - Mr S Stacey resigned from his role as Group Chief Delivery Officer in May 2024. This was a joint role with Hull University Hospitals NHS Trust. The table above represents remuneration relating to NLaG only, apart from the pension benefit which is the benefit for the joint role.

9 - Mr S Nearney is Group Chief People Officer, this is a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to NLaG only. The pension benefit is excluded from this table as this will be reported by Hull University Teaching Hospitals.

10 - Mrs E Monkhouse was Group Chief Nurse until November 2023. The table above for 2023/24 includes compensation for loss of office, £147,000.

11 - Dr K Wood was appointed as Group Chief Medical Officer in November 2023, this is a joint role with Hull University Hospitals NHS Trust. The table above represents remuneration relating to NLaG only.

12 - Mrs E Sayner was appointed as Group Chief Financial Officer in December 2024. This is a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to NLaG only.

13 - Mr M Brearley was Interim Group Chief Financial Officer for the period September to December 2024. This is a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to NLaG only.

14 - Mr L Bond was Group Chief Financial Officer until September 2024. This was a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to NLaG only. The pension benefit is excluded from this table as this will be reported by Hull University Teaching Hospitals.

15 - Mr IP McConnell is Group Chief Strategy and Partnerships Officer, this is a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to NLaG only, apart from the pension benefit which is the benefit for the joint role.

16 - Mr J Johal was Director of Estates and Facilities for Northern Lincolnshire and Goole NHS Foundation Trust until June 2023 when this became a joint role with Hull University Teaching Hospitals NHS Trust on an interim basis. Mr J Johal exited the trust in December 2023. The table above represents remuneration relating to NLaG only, apart from the pension benefit which is the benefit for the joint role.

17 - Mr D Sharif is Group Director of Assurance, this is a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to Northern Lincolnshire and Goole NHS Foundation Trust only. The pension benefit is excluded from this table as this will be reported by Hull University Teaching Hospitals.

18 - Mrs SN McMahon resigned as Group Chief Information Officer in November 2023, this was a joint role with Hull University Teaching Hospitals NHS Trust. The table above represents remuneration relating to Northern Lincolnshire and Goole NHS Foundation Trust only, apart from the pension benefit which is the benefit for the joint role.

19 - Mr S Hall is an Associate Non-Executive Director of Northern Lincolnshire and Goole NHS Foundation Trust and Vice Chair of Hull University Hospitals NHS Trust. Mr Hall resigned in December 2024. The above table represents remuneration relating to Northern Lincolnshire and Goole NHS Foundation Trust only.

20 - Mrs J Beilby was appointed in April 2024 as a Non-Executive Director of Northern Lincolnshire and Goole NHS Foundation Trust.

21 - Mr M MacDonald was appointed in January 2025 as an Associate Non-Executive Director of Northern Lincolnshire and Goole NHS Foundation Trust and Vice Chair of Hull University Hospitals NHS Trust. The above table represents remuneration relating to Northern Lincolnshire and Goole NHS Foundation Trust only.

22 - These Directors are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023. Negative values are not disclosed in this table but are substituted with a zero.

23 - 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, median 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 organisations workforce. The ratio is obtained by dividing the highest paid directors salary by the median salary, the 25th percentile salary and 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 increased by 5.6% in the year.

24 - 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.

25 - The number of employees that received remuneration in excess of the highest paid director is based on the full time equivalent cost.

Pension Benefits 2024/25 (subject to audit)

Name	Title	Note	Real Increase/(Decrease) in pension at pension age (bands of £2,500)	Real Increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2025 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000)	Cash Equivalent Transfer Value at 1 April 2024	Real Increase/(Decrease) in Cash Equivalent Transfer Value	Cash Equivalent Transfer Value at 31 March 2025	Employer's contribution to stakeholder pension
			£000	£000	£000	£000	£000	£000	£000	£000
Mr JM Lofthouse	Group Chief Executive	1	20 - 22.5	47.5 - 50.0	80 - 85	200 - 205	1,155	394	1,661	-
Mr L Bond	Group Chief Financial Officer	2	-	-	75 - 80	210 - 215	1,717	-	1,842	-
Mr IP McConnell	Group Chief Strategy and Partnerships Officer	3	2.5 - 5.0	-	25 - 30	-	381	42	470	-
Mr S Nearney	Group Chief People Officer	4	2.5 - 5.0	-	35 - 40	-	484	47	584	-
Mr D Sharif	Group Director of Assurance	5	0 - 2.5	-	15 - 20	20 - 25	266	27	327	-
Mr P Bytheway	Group Chief Delivery Officer	6	-	-	45 - 50	125 - 130	1,069	68	1,218	-
Mr S Stacey	Group Chief Delivery Officer	7	-	-	20 - 25	-	699	-	343	-
Mrs A Stanford	Group Chief Nurse	8	0 - 2.5	-	0 - 5	-	-	5	9	-
Dr KA Wood	Group Chief Medical Officer	9	7.5 - 10.0	7.5 - 10.0	90 - 95	230 - 235	1,800	136	2,090	-

Notes to pension benefits table

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-Executive Directors.

1 - Mr JM Lofthouse is Group Chief Executive. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr JM Lofthouse in this joint role.

2 - Mr L Bond was Group Chief Financial Officer until September 2024. This was a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr L Bond in this joint role.

3 - Mr IP McConnell is Group Strategy and Partnerships Officer. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr IP McConnell in this joint role.

4 - Mr S Nearney is Group Chief People Officer. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr S Nearney in this joint role.

5 - Mr D Sharif is Group Director of Assurance. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr D Sharif in this joint role.

6 - Mr P Bytheway was Group Chief Delivery Officer for the period June to October 2024. This was a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr P Bytheway.

7 - Mr S Stacey was Group Chief Delivery Officer until May 2024. This was a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mr S Stacey in this joint role.

8 - Mrs A Stanford was appointed Group Chief Nurse in April 2024. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mrs A Stamford in this joint role.

9 - Mrs K Wood was appointed Group Chief Medical Officer in November 2023. This a joint role with Hull University Hospitals NHS Trust. The table above represents the total benefits for Mrs K Wood in this joint 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 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 2023/24 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.

Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

Staff Report

Overview

Workforce highlights

NHS Humber Health Partnership's group model across Northern Lincolnshire and Goole NHS FT and Hull University Teaching Hospitals is now maturing, seeing workforce integration across all sites and services. The work continues to further refine the operating model and importantly, how our people fit and thrive in a workforce model that continues to evolve as we seek to provide the best possible services to our patients both in and out of hospital environments.

2024/25 saw a major reduction in registered nursing vacancies following successful domestic and international recruitment campaigns, resulting in a significant drop in the requirement for agency cover. We also saw a drop in both turnover and sickness rates, which now rank among some of the best performance in the country. The group is now focusing on reducing the number of senior medical gaps and is a key priority for 2025/26

As a result of some significant change programmes, the group has experienced a drop in National Staff Survey performance. In response, the group will launch our "Putting Our People First" campaign in 2025/26, which aims to holistically improve the employee experience. If we ensure our people have an excellent experience, so will our patients. This coincides with the launch of our new Group People Strategy for the next three years. Key themes of the strategy focus on health and wellbeing, leadership and talent development, culture and engagement, including a focus on Equality Diversity and Inclusion (EDI) and further work to enable the creation of agile workforces that reach beyond hospital boundaries.

Workforce design

The focus remains on providing efficient, effective, high-quality services for our patients. 2024/25 focused on the operational model as part of our group design. This was successfully implemented, seeing the establishment of care groups, across the group. This has enabled the design of patient pathways that utilise the full skill and experience of our entire group workforce.

Community Diagnostics Centres (CDCs) opened across our geography with direct patient and GP access. This avoids the need for hospital attendances, with appointments nearer to population centres. The associated workforce model has been designed to be transient between CDC's and hospital services enabling access to highly skilled and experiences clinical staff in the community.

Digital enablers were also invested in seeing the implementation of the DrDoctor patient led booking system, this enables patients to be in far more control of their appointment and interaction with the hospital and has the potential to reduce hospital administrative tasks. In addition, artificial intelligence was also piloted alongside robotic process automation. These projects will be developed further in 2025/26 but have the potential to replace transactional processes in both corporate and clinical environments to create more efficient and effective services. 2025/26 will see a national overhaul of how corporate services are managed within hospital environments. This review seeks to improve the efficiency of services whilst exploring the opportunity for system-led services to release funds for direct patient care.

Development of culture and leaders

In response to the evolving needs of our patients, staff, and community, we have redefined our organisational values to guide us towards excellence. This initiative was a collaborative effort involving various stakeholders from across the NHS Humber Health Partnership, facilitated by the Organisational Development team with key contributions from leaders and staff.

We conducted 88 values sessions (67 face-to-face and 21 online) across Grimsby, Scunthorpe, Hull Royal Infirmary, and Castle Hill, engaging 658 staff members. Led by an executive director, these sessions highlighted the importance of values in shaping organisational culture and driving performance. Participants reflected on their personal values and how they align with our mission, then brainstormed the core values for the NHS Humber Health Partnership.

Following the sessions, a group-wide survey with 1,416 respondents helped refine the initial set of values. The feedback emphasised the need for values that resonate with both staff and patients, reflecting our commitment to excellence and continuous improvement.

The resulting values—Compassion, Honesty, Respect, and Teamwork—are now central to our organisation. We have created a Staff Charter and a new mission statement: "United by Compassion: Driving for Excellence." A pilot programme is underway to embed these values through educational initiatives, guiding our journey towards excellence and ensuring a positive impact on those we serve.

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 leadership development programmes across the Humber Health Partnership were paused until the autumn of 2024 when we launched our Bite Size Leadership Development Workshops. These are half or full day workshops provided face to face across our hospitals or via Teams. This was the first stage in the consolidation of our programmes across the group. In January 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. In partnership with Trans2Performance we have also provided Personal Mastery workshops and access to the T2 Hub Learning platform for leadership development. In addition, we have supported our colleagues through Leadership and Management Apprenticeships from Level 3 up to Level 7.

Bitesize Leadership Programme:

96 members of staff across the Group have accessed the following workshops since the autumn:

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

Coaching and Mentoring Network

NLAG has 10 trained coaches in the network. All our coaches are offered group and individual supervision as well as Continuous Professional Development (CPD). There have been 23 coaching relationships. Reasons for coaching were: professional development; career coaching; confidence building; and managing change. At NLAG we have been running an apprenticeship program to train more coaches for our network and we have 22 members of staff in training currently.

HHP Care Group and Team Development

We have been supporting the Care Group Directors and the Site Directors with the transition into the new group structure, by providing team coaching for the directors, providing internally and externally run workshops, facilitating a director development programme with our training partner Trans2Performance, and supporting the directors facilitate timeouts for their senior leadership teams. Falling out of, and working in tandem with, the care group development, our Organisational Development Team has been providing support for individual teams across all of the care groups and the corporate functions. These have included restorative practice, team coaching, situational leadership development, and team workforce culture transformation.
This is a snapshot of the teams we have worked with this year:

- Emergency Department (Groupwide)
- Cancer Network admin team
- Digestive Diseases Senior Nursing team
- Ophthalmology
- Intensive care (Groupwide)
- Pre-op (NLAG)
- Cardiology ACPs
- Haematology CNS team and radiotherapy CNS team
- Pharmacy (Groupwide) and Procurement Services
- Immunology
- Clinical Psychology
- Therapies (Groupwide)
- Speech and Language team (NLaG)
- Frailty Team (NLAG) and Site Matrons (NLaG)

Apprenticeships

The trust currently has 245 live enrolments across 43 apprenticeship standards, ranging from Level 2 to Level 7, supporting career development for clinical and non-clinical colleagues across the trust. 134 of these apprentices started their programmes in 2024/25, and we have had more than 1,000 starts in total since the 2017 apprenticeship reforms.

The highest volumes of our current enrolments are in senior leadership and coaching programmes, and the Level 6 Registered Nurse Degree Apprenticeship. The range of Allied Health Profession apprenticeships offered has also expanded in 2024/25, aligning with two key priorities of the NHS Long Term Workforce Plan 2023; providing training opportunities to grow numbers of nurses and AHPs, and, retaining staff through wider opportunities for career development.

The trust has enhanced support for apprenticeships across the local community in 2024/25, actively collaborating with organisations across the Humber and North Yorkshire region through an increased use of levy transfers. Requests are predominantly from local GP practices and health partnerships, and we currently support a range of clinical and non-clinical apprenticeship standards. Plans for 2025/26 include providing funds for Yorkshire Ambulance Service to support growth of their capacity to serve local communities.

The NLaG apprenticeship team continue to work collaboratively across the Humber Health Partnership (HHP) to enhance our groupwide leadership apprenticeship offer in line with the HHP strategic objectives. Further collaborative work has been the introduction of skill scans for leadership programmes, with plans to introduce these across all apprenticeship standards in 2025/26.

The NLaG apprenticeship team will also be working with relevant stakeholders across the trust through 2025/26 to enhance the organisation's entry level apprenticeship offer where opportunity arises in both clinical and non-clinical areas. This will help maximise the use of the apprenticeship levy and provide wider employment opportunities across our local communities.

A notable success has been the introduction of the Level 5 Coaching Professional apprenticeship, supporting the coaching culture across the organisation. Our first cohort, enrolled in September 2023, are now approaching completion, and we are currently planning for our fourth cohort, continuing the positive impact of this programme.

Learning Environments

Over the past year, the group has made significant strides in enhancing the learning environments across all our facilities. The focus has been on creating spaces that foster innovation, collaboration, flexibility, and continuous professional development.

Within Northern Lincolnshire and Goole NHS Foundation Trust (NLAG) learning facilities include:

- Diana Princess of Wales Hospital (DPOW) – Grimsby
  - Post Graduate Medical Education Building – incorporating lecture theatre and seminar room, library facilities, clinical simulation space, resuscitation training room
  - Training and Development Building – incorporating three flexible learning spaces (including space for IT and Moving and Handling training)
- Scunthorpe General Hospital (SGH)
  - Butterwick House – incorporating a range of seminar rooms, lecture theatre, library facilities with IT room and resuscitation training room
- New Beacon House – incorporating a dedicated space for Moving and Handling training and CPD clinical skills room

The Post Graduate Medical Education (PGME) learning facilities have been refurbished, with significant improvements in both training rooms and the reception area. Following a full refurbishment to learning rooms at SGH, the learning space in DPOW has been fully refurbished, with work set to be complete by April 2025. These changes have provided opportunity for all spaces to become multipurpose, equipped for simulation training, large scale presentation events for the Humber Health Partnership (HHP) workforce, and traditional lecture delivery. In addition, the DPOW Training and Development Building has been re-designed to provide further flexible learning spaces, including a dedicated area for IT training and an improved space for Moving and Handling training. A lecture room and two flexible training rooms are available in the Training Department of Goole and District Hospital, allowing trainers to support staff development and deliver required learning to staff based on this site.

New developments and key successes

Required learning programmes

The group is developing a comprehensive education programme for all patient-facing roles, focusing on Resuscitation, Deteriorating Patient, and Sepsis. This role-specific programme aims to enhance clinical knowledge, improve teamwork, and embed human factors awareness in managing deteriorating patients. The final proposal is expected by the end of June 2025. Current training programmes related to resuscitation, deteriorating patients, and sepsis are under review to ensure they meet the desired learning outcomes. In response, a new simulation training initiative, ATHENS (Assessment, Treatment, Human factors, Escalation, News monitoring in Simulation), has been developed.

Teams across the Group have collaborated on a national project with the NHSE Statutory and Mandatory Training Group to alleviate training pressures on NHS staff.
Both HUTH and NLAG are required to align with the Core Skills Training Framework (CSTF), which will be relaunched in Summer 2025. This relaunch will specify the frequency at which core topics must be delivered. The group has received funding through the ICB to recruit a full time Band 5 post to deliver the Oliver McGowan training package, this has helped the organisations to deliver the training and across Group we are on target to meet the years training trajectory by October 31 2025.

Workforce development

A Learning Needs Analysis (LNA) template has been successfully piloted within the AHP teams and maternity services will soon be implemented across NLAG. This LNA process empowers senior leaders to identify skills gaps, plan for career progression, and ensure our workforce is equipped with essential skills and knowledge.

With the opening of the new Learning and Innovation Centre at Castle Hill Hospital, the Learning Team (North) has launched the Train the Trainer 2025 programme. Running throughout 2025, this programme aims to upskill colleagues across the group in areas such as presentation skills, communication, memory and learning, and programme evaluation.

Career engagement and development

The Learning and Development Team at NLAG has launched a dedicated workstream to enhance widening participation and career development across the Trust. This initiative is vital for building strong relationships with the local community and education providers, leading to better outcomes for disadvantaged groups and young people in Northern Lincolnshire, North East Lincolnshire, and Goole. By providing learning opportunities for local people, we aim to address skills shortages and create a pipeline for future healthcare professionals. Our commitment to the social and economic well-being of our communities is reflected in various activities supporting this goal. In 2024/25, the widening participation team expanded their engagement with schools and colleges, offering essential information about NHS

career opportunities to local youth. In April 2024, we partnered with North Lindsey College to offer Functional Skills qualifications in maths and English to staff without a level 2 qualification. This initiative supports personal development and enhances essential skills across our workforce, with over 50 staff members currently enrolled. The team also provides guidance at Career Clinics across the Trust, helping staff navigate their career paths. Additionally, career conversations are now part of the corporate induction, ensuring all new staff have access to key information from the start.

Work experience

In September 2024, the Learning and Development team at NLAG took charge of work experience across the Trust, organising 75 placements in clinical and non-clinical areas.

T Levels

T Levels are Level 3 qualifications for 16–19-year-olds, equivalent to 3 A Levels, focusing on vocational skills. We have enhanced our support for local T Level students this academic year:

- 35 T Level Health students from five local colleges, supported by the CPD team, have completed the required learning for clinical staff before starting their placements in January 2025.
- 10 T Level Media students from Grimsby Institute will produce a video on breaking barriers for internationally educated nurses, led by the CPD team.
- The T Level Business pilot is in its second year, supporting four students from North Lindsey College in developing skills within NHS corporate functions.
- The T Level Health and Business programmes were recently featured as an ICB case study for their innovative support of students in clinical and non-clinical areas.

DFN Project SEARCH

DFN Project SEARCH is a one-year transition programme for young adults with learning disabilities, providing internships, job skills training, and professional development to help them secure meaningful employment. In September 2024, the Learning and Development team took over Project SEARCH at DPOW, supporting seven interns and starting recruitment for the 2025/26 cohort. We are also collaborating with North Lincolnshire Council and Trent View College to introduce DFN Project SEARCH at Scunthorpe General Hospital, aiming to support young people with EHCPs and diversify our workforce. Discussions to expand DFN Project SEARCH across the group will begin in 2025/26.

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:

- A monthly JNCC (Joint Negotiating and Consultation Committee Meeting) for Staffside representatives and a monthly JLNC (Joint Local Negotiating Committee) for medical staff.
- Staff networks, including BAME, Disability and LGBTQ+ Staff Equality Networks.
- A Women's Staff Equality Network has recently been launched and plans are in place to launch a Men's Network.
- 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) 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 appointment of Emma Sayner (Group Chief Financial Officer) and Tom Myers (Group Director of Estates and Facilities) has resulted in the two health and safety functions across NLaG and HUTH working more closely together as a partnership group under the Humber Health Partnership (HHP) group. Within NLaG, occupational safety, fire safety and security strategy are managed through the safety and statutory compliance team with the Estates, Facilities and Development (EFD) Directorate. Performance, risks and policies/procedures and other related issues are monitored across NLaG are monitored through the Health, Fire and Safety Group (HFSG) which comprises of union appointed safety representatives as well as other staff groups and management.

This group currently reports to the Performance, Estates and Finance Committees in Common (PEF CiC) via the EFD Governance Group although some elements are also monitored by other groups (such as Audit, Risk and Governance CiC) as well to ensure that all aspects of safety and health are appropriately overseen and escalated where required. Care groups and other directorates (though not all) have established governance groups which incorporate the safety and health aspects (and fire safety etc.) as well as the sub-board groups and HFSG also has established links with the Security Group as well as being represented on the Joint Negotiating Consultative Committee (JNCC). Regular highlight reports are submitted to the PEF CiC and annual reports relating to Fire and Security are submitted to the trust board via the PEF CiC.

Although part of the EFD Directorate, the team works across all south bank care groups and directorates to ensure a consistent approach is taken in regard to safety management. The team also works closely with the clinical, infection control, procurement and emergency preparedness teams to ensure that appropriate measures are in place both in emergency situations and during operational pressures. This 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 12 incidents during the 2024/25 period. This was an increase from the previous year but is linked to the resumption of normal operational activity levels. The period saw the completion of the replacement of the DPOW automatic fire detection (AFD) system with the interfaces of third parties being fully completed as well as the final commissioning tests being completed for the Scunthorpe AFD replacement system for the system to become fully live across the SGH site in early 2-25/26.

Staff policies and actions

Policy	Action
Polices 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.
Actions taken in the year to provide employees systematically with information on matters of concern to them as employees.	The HR Hub page (intranet) incorporates a suite of information around the HR policies, including further guidance for employees and managers, templates/forms and Q&A documents. Development of this page and its content has continued to be reviewed and developed over the last year. This has been based on analysis of the calls to the HR Helpdesk, questions raised to the Exec and via the Trust Facebook page, feedback from employee relations cases, feedback from Staff Side colleagues, the Staff Network Groups and from the Staff Survey.
Actions taken to consult staff on a regular basis so that the views of staff can be taken into consideration in making decisions which are likely to affect their interests.	• Engagement via Union forums • Engagement through formal consultation processes • Localised team meetings and manager briefs • Group Chief Executive cascade • Ask the Chief Executive • Organisational survey's • A QI approach, empowering staff to own and direct change

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). In 2020 the role of Counter Fraud Champions was introduced across all NHS organisations, with a view to further strengthening counter fraud work by supporting LCFSs in the work they do. A Counter Fraud Champion was duly nominated at the Trust and completed the NHSCFA training, and collaborates as necessary with the 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 branch of medicine focusing on the health of staff in the workplace with specific duties under section 3(1) of the Health and Safety at Work Act 1974. The OH team aims to identify what impact work may on staff health and ensure that staff are fit to undertake the role they are employed to do both physically and emotionally. OH provide impartial advice to staff members, managers, recruitment teams and the organisation as a whole to aid support in sustaining a functional workforce which may be impacted on by temporary or long term health difficulties. In line with the Humber Partnership Group the OH teams have central leadership and continue to build to a standardised OH service across the group in process, policy and delivery.

In line with 'Growing Occupational Health Wellbeing Together' strategy, OH will work in unified partnership with other key stakeholders such as OD, Health and Wellbeing Team, Staff Psychology and counselling services, Staff Physiotherapy and Occupational Therapy support 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 2024	Adjusted FTE days lost to Cabinet Office definitions	Average Sick Days per FTE	FTE - Days Available	FTE - Days recorded Sickness Absence
6,584	77,598	11.8	2,403,301	125,882

Key to table

- Source – NHS Digital: Sickness Absence and Workforce Publications, based on data from the ESR Data Warehouse
- Period covered – April 2024 - March 2025
- 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.

NHS staff survey

The National Staff Survey sets out trust performance against the seven key indicators in the national NHS People Promise, as well as scores for staff engagement and morale. The survey ran between September and December 2024 and was completed by 42% of NLaG staff, lower than the national average of 48%. Overall the results show a deterioration in performance against all of the key indicators. Care Groups and Directorates have been asked to develop local plans for improvement and progress will be measured in our monthly performance meetings.

2024/25 compared to 2023/24 and 2022/23

Indicators (People Promise and themes)

	2024/25		2023/24		2022/23	
	Trust score	Benchmarking group score	Trust score	Benchmarking group score	Trust score	Benchmarking group score
People promise						
We are compassionate and inclusive	**6.9**	**7.2**	7	7.2	6.9	7.2
We are recognised and rewarded	**5.6**	**5.9**	5.7	5.9	5.5	5.7
We each have a voice that counts	**6.3**	**6.7**	6.5	6.7	6.4	6.6
We are safe and healthy	**5.9**	**6.1**	5.99	6	5.7	5.9
We are always learning	**5.3**	**5.6**	5.4	5.6	5.1	5.4
We work flexibly	**5.7**	**6.2**	5.8	6.2	5.6	6.0
We are a team	**6.4**	**6.7**	6.5	6.7	6.4	6.6
Staff engagement	**6.4**	**6.8**	6.65	6.9	6.4	6.8
Morale	**5.6**	**5.9**	5.8	5.9	5.5	5.7

A set of corporate actions to address issues in four main areas – Communication, Health and Wellbeing, Reward and Recognition and Essential needs – is being developed at board level.

Response Rate

NLAG's completion rate decreased from 48% to 42% (3,230 staff responded compared to 3,512 last year)

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: https://www.nlg.nhs.uk/resources/gender-pay-gap-reports/

Trust staff in numbers

Staff costs (subject to audit)

	Group			
	2024/25			2023/24
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	312,010	3,316	**315,326**	289,720
Social security costs	32,442	-	**32,442**	31,024
Apprenticeship levy	1,609	-	**1,609**	1,543
Employer's contributions to NHS pension scheme	56,192	-	**56,192**	44,765
Temporary staff	-	16,416	**16,416**	28,779
Total gross staff costs	**402,253**	**19,732**	**421,985**	**395,831**
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	**402,253**	**19,732**	**421,985**	**395,831**
Of which				
Costs capitalised as part of assets	812	-	**812**	664

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

	Group			
	2024/25			2023/24
	Permanent	Other	Total	Total
	Number	Number	Number	Number
Medical and dental	827	128	**955**	863
Ambulance staff	-	-	**-**	-
Administration and estates	1,424	70	**1,494**	1,488
Healthcare assistants and other support staff	1,312	63	**1,375**	1,360
Nursing, midwifery and health visiting staff	1,939	291	**2,230**	2,248
Scientific, therapeutic and technical staff	1,165	34	**1,199**	1,140
Total average numbers	**6,667**	**586**	**7,253**	**7,099**

Number of people

	2023/24	2024/25
Medical	803	799
Band 9	10	5
Band 8	269	251
Band 7	624	603
Band 6	911	917
Band 5	1,653	1,708
Band 4	425	366
Band 3	1,027	1,032
Band 2	2,141	2,158
Band 1	2	2
Other	15	19
Apprentices	12	2
Total	**7,882***	**7,859***

* includes permanent, fixed term, internal secondment, and maternity leave and Very Senior Managers (VSM)

Age profile of staff

	2023/24	2024/25
< 25	560	594
26 – 35	2,020	2,019
36 – 45	1,834	1,878
46 - 50	785	734
51 – 55	998	931
56 – 60	913	888
61-65	618	644
65 plus	154	171
Unknown	0	0
Total	7,882*	7,859*
Other	15	19
Apprentices	12	2
Total	**7,882***	**7,859***

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

Ethnic minority breakdown of staff

	2023/24		2024/25	
	Number	%	Number	%
Asian	730	9.3	**762**	**9.7**
Black	460	5.8	**456**	**5.8**
Mixed	88	1.1	**81**	**1.0**
Other	114	1.4	**141**	**1.8**
Unknown	219	2.8	**199**	**2.5**
White	6,271	79.6	**6,220**	**79.1**
Total	**7,882***	**100**	**7,859**	**100**

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

Analysis of gender distribution of staff 2024/25*

	Female	Male	Total	Female %	Male %
Directors	11	5	16	69%	31%
Other Senior Managers#	173	83	256	68%	32%
Employees excluding the above	6,163	1,424	7,587	81%	19%
Total	**6347**	**1512**	**7859**	**81**	**19**

* 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	
	2023/24	2024/25
Add prof scientific and technical	108	121
Additional clinical services	1735	1712
Administrative and clerical	1623	1582
Allied health professionals	513	531
Estates and ancillary	711	703
Healthcare scientists	213	226
Medical and dental	803	802
Nursing and midwifery registered	2,170	2,176
Students	6	6
Unknown	0	0
Total	**7,882***	**7,859**

* 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 2024/25

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

Reporting of compensation schemes - exit packages 2023/24

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
	Number	Number	Number
Exit package cost band (including any special payment element)			
<£10,000	-	1	1
£10,000 - £25,000	-	-	-
£25,001 - 50,000	2	1	3
£50,001 - £100,000	-	-	-
£100,001 - £150,000	1	-	1
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	**3**	**2**	**5**
Total resource cost (£)	228,000	42,000	270,000

Exit packages: other (non-compulsory) departure payments

	2023/24		2024/25	
	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Number	£	Number	£
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	3	85,000
Early retirements in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	1	36,143		
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	1	6,000	-	-
Total	**2**	**42,143**	**3**	**85,000**
Of which:				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months of their annual salary	-	-	-	-

NHS 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 2025, 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
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 competed.	Annual Report – Accountability Report
Directors' responsibility for preparing the annual report and accounts.	Annual Report – Accountability Report

NHS England Code of Governance continued

Summary of requirement	Where the information is available
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.

Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

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 four '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 4). 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:
a) 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)
b) Additional considerations focused on the assessment of system leadership and behaviours, and improvement capability and capacity.

An NHS foundation trust will be in segment 3 or 4 only where it has been found to be in breach, or suspected breach, of its licence conditions.

Segmentation
This segmentation information is the trust's position as at 20 June 2024. NHS England has placed the trust in segment 3.

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

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accountable Officer Memorandum.

As an Anchor institution the Trust influences 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 Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) and also refers to the new Group development called Humber Health Partnership (HHP) Group with Hull University Teaching Hospitals NHS Trust (HUTH).

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 NLaG NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in NLaG NHS Foundation Trust for the year ended 31 March 2025 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Foundation Trust's current Governance and Risk Management Strategy sets the overall objective for the Trust to be fully 'risk aware'. The strategy is under review as part of moving to the HPP, and a Group strategy covering both NLaG and HUTH will be presented to the Boards-in-Common in 2025. The strategy includes a risk management

approach which is embedded within the organisation's culture and working practices, where open reporting of mistakes made is encouraged and lessons are learned, and there is an acceptance that Risk Management is everyone's responsibility. In line with establishing a Group strategy the two Risk Teams are now joint and are working towards common processes and procedures.

The Strategy sets the Policy for Developing and Maintaining the Foundation Trust's Risk Register which details 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 Foundation Trust. 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 a responsibility for the identification and reporting of risks and incidents.

The Board Committees-in-Common (CiC) structure provides assurance on, and challenge to, the Trust'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 then 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 Foundation Trust continues 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 Policy for Developing and Maintaining the Trust Risk Register describes the organisation's approach to risk and risk management. It defines the leadership roles within the Trust for risk management. In addition, staff across the Trust receive risk management training, in order to identify and report risks. The Trust's mandatory training programme included training on specific risk topics such as fire safety, safeguarding, counter fraud, 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 Trust's arrangements for investigating and managing incidents. The Trust has a well-established process for entering risks onto its risk register and the regular review of risks, which is described below. The Trust also strengthened its approach to escalating risks at corporate level and the way in which this informs the strategic risk managed by the Trust Board. This is also described in more detail below.

The risk and control framework

The management of risk

The Trust is committed to the clinical and non-clinical management of 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 Trust 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 on-going investigation and assessment of risks and the central Risk Team are available to support.

This process has been reviewed in 2024/25 in line with the Group development of the new Care Group structures across the two Trusts and lack of timely review.

At Trust Board level, the Boards-in-Common assess their performance and discuss associated risks at each meeting, through the presentation of the Performance Report, which includes NHS Improvement Single Operating Framework metrics. An exception report on these measures is discussed in more detail at the Board's 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.

From December 2024, the Group Risk and Assurance Committee was established with the purpose of strengthening risk management across the Group and addressing reported weaknesses. This is in alignment with the monthly Care Group Performance meetings where risks are monitored and challenged by the Executive Team. New high-scoring risks are notified to the Group Risk and Compliance Committee whilst lower-scoring risks are discussed at the Care Group / Corporate team meetings. All Board Assurance Framework risks and the high-scoring risks are now s crutinised at the Group Cabinet 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 Trust's incident reporting system records near misses as well as actual incidents. The Trust transitioned from the serious incident framework to the Patient Safety Incident Response Framework (PSIRF) in 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 / responsibility of that domain, such issues were escalated to the Executive Group meeting or Trust Boards-in-Common for a decision to be made.

The Trust's / Group'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 Trust has developed a themes and trends report from this, reported to the Trust Boards and the Quality and Safety Committees-in-Common (Quality and Safety Committees-in-Common) on a quarterly basis. The Quality and Safety Committees-in-Common has also kept oversight of compliance with the national guidance requirements on Learning from Deaths and is satisfied that the Trust has 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 Trust provides its submission 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 Trust activity. The Trust 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.

Freedom to Speak Up Guardians

The role of the Freedom to Speak Up (FTSU) Guardians and promotion of these roles to staff continued to be of great importance across the Group. The Group have adopted and follows National Guardian Office recommendations. The FTSU Guardians continued to attend both national and regional conferences and meetings to ensure that FTSU was being delivered in line with current guidelines and the Guardians continued to work in partnership with the Foundation Trust and Unions to promote 'Speaking Up' as business as usual. The Group has a FTSU strategy which includes the following objectives:

- Encourage Everyone to Speak Up Better
- Create a Culture where staff were listened to
- Use information provided by Freedom to Speak Up concerns to help develop a 'learning culture' within the organisation.

Principal risks to compliance with the NHS Provider Licence Conditions

The following section provides oversight of the Trust'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 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 performance.

All Trust 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 risk having a score of 25 (almost certain and catastrophic) and the lowest risk of 1 (rare and negligible). The Trust uses a web-based incident reporting and risk management system (Ulysses) and has a 'bottom up' approach to identifying risks.

- 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-rated operational risks from each area are reviewed by the Group Risk and Compliance Committee. The Committees will escalate any high-rated risk that they feel cannot be managed within an individual care group or corporate service and represent a corporate risk across the organisation.
- This process has been reviewed in 2024/25 as part of the developing Group model and changes to governance structures.
- The Group Cabinet Risk and Assurance Committee review the Board Assurance Framework (BAF) and high-level risks on a monthly basis. This Committee consists of the Group Chief Executive and Executive Board members.
- The high-level 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 Trust from achieving its strategic aims. This consideration of corporate risk helps the Trust Board identify the corporate risk burden being carried by the Trust and whether this impacts on achieving the Trust's strategic goals.

Risk Reporting 2024/25

The Risk Teams at HUTH and NLaG have now harmonised and the risk process has been aligned. The Care Group triumvirates and Site Directors received risk register reports on a monthly basis for oversight and management of risks including consistency of scoring. In 2025 risk register Key Performance Indicators (KPIs) would be developed for Care Groups and Site Integrated Performance Reviews would be held to support monitoring and compliance requirements.

The table highlights the Care Groups and their high-level risks by rating as at March 2025:

Care Group / Corporate Directorate	15	16	20	25	Total
Acute And Emergency Medicine		7	2	1	10
Cancer Network		2			2
Cardiovascular	3	2			5
Chief Nurse	1	3	1		5
Digestive Diseases		1			1
Digital	2	2			4
Estates and Facilities		3	7		10
Family Services		3	1		4
Head And Neck	3	1			4
Major Trauma		1			1
Pathology Network	1				1
Specialist Cancer and Support Services	8	4	3		15
Specialist Medicine Care Group	1	1	2		4
Specialist Surgery	2	3	1		6
Theatres, Anaesthetics and Critical Care	2	3			5
Transformation	1	1			2
Total	**24**	**37**	**17**	**1**	**79**

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

Board Assurance Framework (BAF)

The Group BAF covers all the strategic risks for HUTH and NLaG. The table below shows the BAF strategic risks and their ratings as at March 2025:

Risk Category	Strategic Risk	Risk Rating
Group culture and leadership	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 not improve.	20
Achieving upper quartile performance	We aim to achieve upper quartile performance through transformational change and by harnessing the energy of the organisation and creating a culture of improvement.	20
Listening to our patients and keeping them safe	We aim to listen to our patients and keep them safe by learning from mistakes. However, if we do not listen actively, we will give patients a poor experience, sustain avoidable harm and the Group will attract regulatory sanctions.	20
Developing research and innovation capabilities	We aim to expand our research and innovation capabilities by developing a strong brand. However, if we fail to develop sufficient skill sets and resources, we will not be able to exploit all the income sources to achieve this and attract high calibre staff into research posts	12
Playing an active role in our health and care system	We aim to play a leading role in our health and care system, by being a prominent advocate for the Humber region, outward facing with a clear, consistent case for its investment and regeneration. However, if we fail to unite internally and attract investment, we will experience little progress towards addressing our health inequality challenges.	12
Developing our digital infrastructure	We aim to develop our digital infrastructure and wider connectivity through a robust digital delivery function that matches Group needs with adequate capital and revenue funds. However, if the Board fails to commit to the digital benefits and we have an unclear line of sight to the benefits sought, we will own a weak plan to deliver and to monitor transformation, resulting in insufficient transformation of our operations.	16
Using major capital effectively	We aim to use major capital infrastructure and investment effectively. However, if we fail to identify sufficient capital sources for equipment, digital and estates, and to address estate deficiencies, and produce a weak capital plan, and then experience unexpected capital growth or plan ineffectively across schemes in-year, we will face unpredictable capital demands, access issues for our patients and not deliver transformational change for the benefit of our patients.	15
Achieving financial sustainability	We aim to achieve financial sustainability through strong financial stewardship. However, if we fail to agree and communicate clear, balanced finance plans that are mutually beneficial to the Group and system partners, with aligned activity and workforce actions, then a failure to engage with teams and to set controls that are consistent and / or appropriately delegated, will result in overspent budgets and little change in practice.	16

In respect of any principal risks to compliance with the NHS provider licence conditions, particularly the effectiveness of governance structures, responsibilities of directors and sub-committees, reporting lines and accountabilities to and from the Trust Boards, submission of timely and assurance information to assess compliance with the licence conditions or any associated with the oversight the Board has on Trust performance, the Board's assessment was as follows:

At the end of the year, whilst all risk areas on the Board Assurance Framework received some positive assurance throughout the year, one risk area made sufficient progress which was the Achieving Financial Stability risk. This was downgraded from a 25 (5 likelihood x 5 impact) to 16 (4 likelihood x 4 impact) due to mitigations such as development of a financial strategy, Care Group transformation and the assistance of PA Consultancy (external company assisting the Trust with its Cost Improvement Programme (CIP).

In 2024/25 as part of this strategic approach to risk management through the BAF, each of the newly formed Committees-in-Common received the BAF at every meeting and any risk movements in month were highlighted and escalated to the Boards-in-Common.

Group People Strategy

The Group updated its 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 shows a decline to the lower quartile nationally and the strategy responds to these results.

The strategy will 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 Foundation Trust complies with the Developing Workforce Safeguards recommendations using existing staffing data to make an assessment of staffing levels in each Care Group and against vacancies, which are reviewed annually as part of operational planning for capacity and demand in respect of clinical services and the staffing requirements that make up an effective service. Workforce metrics are received and reviewed on behalf of the Trust Board by the Workforce, Education and Culture Committees-in-Common.

Equality, Diversity and Inclusion

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 2024/25 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
- Group recruitment practices will align with Disability Confident standards, offering EDI panel representation
- Zero Tolerance to Racism policy is 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.

Care Quality Commission

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

The Trust continues to work closely with the CQC, ICB and NHS England. 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.

Conflicts of Interest

The Foundation 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 Trust with reference to the guidance) within the past twelve months as required by the Managing Conflicts of Interest in the NHS guidance. The Trust's Register of Directors' interests is 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

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.

Environmental Sustainability

The Trust has a Board-approved Green Plan 2022/25. This plan demonstrated the Trusts commitment to sustainability, incorporating the requirements of the NHS Delivering a Net Zero NHS report and the NHS Long Term Plan.

The Foundation Trust 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 and taken account of the 'Delivering a Net Zero Health Service' report. The Trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Green Plan incorporated a working action plan to address our progress towards Net Zero, a document which will grow as the impact of our work, projects and capital investments develop. Our reporting processes were robust and ensured the Trust complied with the UK Climate Change Act (2008) projections for the reduction of carbon. In addition to this, working with partners to reduce energy consumption, the Trust will be supported in the development of a road map to Net Zero, ensuring we comply with the targets set within the Net Zero report, which is now incorporated into the Green Plan advancing from 2022/25. The trust 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 trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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 below.

Information Governance

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

- The Group Director of Strategy and Partnerships as the Caldicott Guardian
- The Group has a dedicated Data Protection Officer 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
- 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)
- For NLaG and HUTH the Group Chief Strategy and Partnership Officer serves as the Senior Information Risk Owner (SIRO)
- 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.

The Trust reported 5 Data Security and Protection Breaches in 2024/25 to the Information Commissioners Office (ICO) as classified in the DSP Toolkit Incident Reporting Guidelines. The ICO were satisfied with the way in which the Group investigated and handled the incidents and resulted in no action being taken.

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 Trust and on a system level. Quality data requires consistency, accuracy, completeness and needs to be processed efficiently and in a timely manner.

Both Trusts within the Group have data quality strategies with over-arching governance. As part of the migration to Group integration these have been amalgamated in 2024/25 into a single strategy with oversight from an integrated Data Quality Steering Group. This Steering Group will commission, design and conduct a regular review 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 sovereign Trusts are in line with, or exceeding, national valid percentage rates in all but one of the data items routinely monitored nationally.

The Trusts participate in a commissioning Activity Recording Panel that ensures any proposed changes to the recording of Trust 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 the number of 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.

An Integrated Performance Report which outlined the Trust'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.

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.

Review of Effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS Foundation 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 and Finance Committees-in-Common and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The Boards-in-Common

The Trust Board is accountable for all aspects of the performance of the Trust. The Boards-in-Common met in public on six occasions during 2024/25 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 six committees in 2024/25 which discharged their responsibilities. In addition to the statutory requirement for an Audit Committee, 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 the 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). An attendance record is kept for the Board and each of its Committees-in-Common.

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

The Audit, Risk and Governance Committees-in-Common met five times during 2024/25, which is the required number as set by its Terms of Reference and was quorate for all meetings. The Audit, Risk and Governance Committee became a Committees-in-Common from January 2024 in shadow form and in an official capacity from April 2024 and both the new terms of reference and workplan were approved by the Boards-in-Common and reviewed at the first meeting. 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 for any governance or internal control issues that require further examination by the Audit, Risk and Governance Committees-in-Common. There are standing agenda sections for external audit, internal audit and counter-fraud. Other agenda items are scheduled at regular intervals during the year and these include the draft and audited Annual Accounts, Going Concern status, review of the Board Assurance Framework, a number of routine management reports in line with its agreed annual work plan.

The Trust's local Counter-Fraud specialist did not raise any issues of internal control or gaps in assurance in 2024/25.
The Audit, Risk and Governance Committee escalated several serious gaps in control during the year to the Group Chief Executive and Board and received additional assurance from management in mitigation.

Head of Internal Audit Opinion

The internal audit programme for 2024/25 was informed by the Trust's own risk and assurance framework, discussion with a wide range of officers and the broader context of the NHS. It was developed around the Trust's strategic objectives and its business-critical systems and was risk based. The Head of Audit Opinion and Annual Report 2024/25 gave an overall opinion that significant assurance could be given as there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

Board Committees with a Role of Risk Management including Clinical Audit

The Performance, Estates and Finance Committees-in-Common met on 11 occasions in 2024/25 which is in line with their Terms of Reference. All meetings were quorate. The focus of each meeting was on the detailed Performance exception report, specifically the Trust's underlying performance against the key NHS Constitution standards and the Trust's financial plan, which are standing agenda items discussed at each meeting. Other substantive agenda items have also been the financial position of the Trust, particularly the financial performance of the Trust's Care Groups and their contribution to the Trust's underlying run-rate issues. 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 11 occasions, in line with their Terms of Reference. Key issues discussed related to the compliance with the Learning from Deaths national requirements, Research and Innovation and Mental Health patient updates. Maternity Services, in particular CQC actions and CNST compliance have been a priority throughout the year. CQC actions were also monitored at the Committees-in-Common. The Committees-in-Common received annual reports relating to Safeguarding, Infection Control, Research, Innovation and Development, Patient Experience, Medicines Management, Patient Reported Outcome Measures (PROMS), Medication Safety, End of Life, Organ Donation, Clinical Audit and Patient Safety Incident Response Framework (PSIRF). 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 Capital and Major Projects Committees-in-Common met on six occasions, in line with their Terms of Reference, during 2024/25. All of the meetings were quorate in 2024/25. Agenda items included the Community Diagnostics Centre developments, major developments such as the Castle Hill Day Surgery, the Humber Acute Services Review, the Digital Plan, the EPR business case review and the Public Sector Decarbonisation Scheme.

The Remuneration Committees-in-Common met six times during 2024/25. The Committees-in-Common was quorate for all meetings. Agenda items included annual Group Executive Director Appraisals, recruitment and succession plans, new recruit reports and a review of the Terms of Reference.

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, 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 in to each Health 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 and plan is being undertaken in 2025 and the 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 Committee monitors and provides assurance to the Trust Board by way of a highlight report.

The Workforce, Education and Culture Committees-in-Common receive a Nursing and Midwifery staffing report and any issues are escalated to the Trust Board. The report includes the Trust's fill rates (number of nurses in post and hours of care delivery compared with planned levels) and the Trust's plans in nursing recruitment. I am pleased that the significant efforts from the Trust have paid off in nursing recruitment during this year.

In 2024/25, the Foundation Trust declared 1 Never Event, this is compared to 2023/24 when the Trust declared 0 Never Events.

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.

Audit Yorkshire currently provide Internal Audit services for NLaG. This 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 usually attends the Audit, Risk and Governance Committees-in-Common meetings. Further details are captured in the Annual Report.

Significant Internal Control Issues

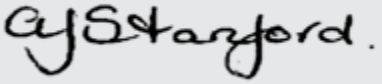
Having reviewed the areas of risk I consider that the following are significant issues:

- The Foundation Trust did not meet all of the NHS Constitutional standards and further improvements to flow are required
- The Foundation Trust is in Tier 1 for cancer delivery. Work is ongoing with the Regional Office on recovery
- NLaG NHS Foundation Trust's Accident and Emergency (A&E) 4 hour standard (all types) delivery remains under target. Three critical front door actions have been identified which are, reducing non-admitted breaches, time to first clinician and improving frailty assessment. A robust action plan and flow programme are in place to address the issues
- The waiting list volume continues to increase mainly due to an increase in referrals. An automated waiting list validation product has been commissioned and will be trialed in 2025
- Addressing the Foundation Trust's / Group's underlying financial position as part of a system financial plan. A challenging CIP programme will be in place in 2025-26 and support will be given to the Care Groups to reduce the unidentified gap and achieve a balanced plan
- Securing capital funding to address all critical and long-term infrastructure requirements
- The Group is committed to developing a culture that values, protects and prioritised colleagues inclusively whilst promoting excellence in patient care. The People Strategy 2025–28 sets out how this will be achieved
- The 2024/25 Staff Survey results were in the lower quartile with staff engagement requiring further work. Actions are underway to improve staff engagement with each quarter focusing on a different area of improvement. Quarter 1 of 2025-26 focuses on Communication and Engagement.

The Group acknowledges that 2025-26 will be another challenging year that staff will experience. The resilience of our staff is being particularly tested and we seek to maintain the highest standards of care we can, for as many patients as possible, in 2025-26.

Conclusion

This annual governance statement has identified the following significant internal control issues/ risks and set these out in the previous section. In conclusion, there remains an understood level of risk to the volume of clinical activity that the organisation and Group structure can deliver, and the achievement of constitutional and regulatory performance requirements. However, I am confident that the internal control systems are operating well and that the work we have done to maintain and develop our risk management systems will help us to consolidate this position in the future. The Foundation Trust is committed to the continuous improvement of processes of internal control and assurance. This includes the effective tracking of action to mitigate significant control issues through the Board Assurance Framework.



Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

Appendix A:

Head of Internal Audit opinion on the effectiveness of the system of internal control at the Northern Lincolnshire and Goole NHS Foundation Trust for the year ended 31 March 2025

Introduction from the Head of Internal Audit

As NHS organisations continue to face unprecedented challenges in this ever more demanding environment, the provision of independent and objective assurance regarding governance, risk and internal control is critical to supporting successful outcomes.

Northern Lincolnshire and Goole NHS Foundation Trust's Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives and is also responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system. A key element in that flow of assurance is the overall opinion from the Head of Internal Audit. This report sets out the Head of Internal Audit Opinion (HoIAO) together with the summarised results of the internal audit work performed during the year. The report also includes a summary of audit performance and an assessment of conformance with the Public Sector Internal Audit Standards (PSIAS). We have been able to complete the plan enabling delivery of a balanced HoIAO for 2024/25.

Head of Internal Audit Opinion

The provision of the HoIAO is a requirement of PSIAS. It must be provided annually to support the organisation's Annual Governance Statement and inform and comment on the adequacy of the organisation's assurance framework. This opinion is based on a combination of the assurance work that we deliver during the year (as set out in the annual audit plan) and our assessment of other available evidence and assurances about the organisation's arrangements for internal control and managing risk.

Conformance with PSIAS

The provision of professional, quality internal audit is a fundamental aim of our service methodology and compliance with PSIAS is central to our approach. Quality is controlled on an ongoing basis and monitored by the Head of Internal Audit.
The outcome of our annual Internal Quality Assessment has been reported to the Audit Yorkshire Board where areas identified for improvement are monitored.
Our independent External Quality Assessment undertaken by CIPFA and reported in October 2024 concluded that we fully comply with all aspects of the Public Sector Internal Audit Standards. This achievement is testament to the professionalism of our dedicated team together with the support we receive from our clients. Audit Yorkshire can assure the Audit, Risk and Governance Committees in Common that it has conducted its work at Northern Lincolnshire and Goole NHS Foundation Trust in conformance with the PSIAS for 2024/25.

We would like to acknowledge the time and co-operation given by Directors and staff at Northern Lincolnshire and Goole NHS Foundation Trust to support delivery of the Internal Audit Plan during 2024/25.

Helen Higgs
Head of Internal Audit

Danielle Hodson
Internal Audit Manager

Delivery of the plan

The scope of the work was defined in the Group Internal Audit Plan for 2024/25 which was approved by the Audit, Risk and Governance Committees in Common on 25th April 2024, following consultation with the Executive Team and Non-Executive Directors/Members. This set out details of audit coverage in the following areas:

Internal Audit Plan

- Board Assurance Framework; Risk Management;
- Cinical Governance and Quality
- Financial Sustainability
- Performance Monitoring and Management
- Workforce and Organisational Development
- Digital, information Management and Technology
- Estates and Facilities Management

Resource was also provided for assurance on other emerging issues/risks as prioritised by the Trust. The plan was derived from a risk assessment of the Trust's strategic risks and related assurances, as detailed in the Board Assurance Framework, risk areas identified from discussions with Executive and Non-Executive Directors and any statutory requirements. The agreed audit plan included provision for 200 Internal Audit days for 2024/25. No amendments were made to the plan. The plan provided for the delivery of 200 Internal Audit days. A summary of all audits completed together with the level of assurance we were able to provide on the controls reviewed, is provided at Appendix 2. We have provided the main findings and recommendations from all these reports to the Audit, Risk and Governance Committees in Common during the year. We have reported to the Audit, Risk and Governance Committees in Common on the implementation of agreed Internal Audit recommendations.

Roles and responsibilities

Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation's operations. It can help an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control, and governance processes. Internal auditing enhances the organisation's success by providing the Board and management with objective assurance and advice.

The Audit, Risk and Governance Committees in Common is responsible for monitoring the quality of the Internal Audit service delivered, including the evaluation of its compliance with mandatory PSIAS and for monitoring the organisation's response to Internal Audit's findings. The Trust's Board is accountable for maintaining a sound system of internal control that supports the achievement of the organisation's objectives. This should be based on an ongoing risk management process that is designed to identify the principal risks to the organisation's objectives, to evaluate the nature and extent of those risks, and to manage them efficiently, effectively, and economically.

The Board is responsible for putting in place arrangements for gaining assurance about the effectiveness of the organisation's system of internal control. To achieve this, the Board should identify the principal risks to the organisation meeting its corporate objectives and map out the key controls in place to manage these risks. The Board should also identify how they have gained sufficient assurance about the effectiveness of these key controls.

The Internal Audit service provides independent assurance to the Board via the Audit, Risk and Governance Committees in Common. Assurances may be derived from a number of sources, and it is the responsibility of the Board to determine how much reliance can be placed on each of them. Accounting Officers must make sure that their arrangements for delegation promotes good management and that they are supported by the necessary staff with an appropriate balance of skills. Arrangements for Internal Audit should accord with the objectives, standards and practices set out in the PSIAS. All work conducted at the organisation in 2024/25 has been undertaken in compliance with these standards.

The Standards state that Internal Auditors must be objective in performing their work and avoid any conflict of interest. All Internal Auditors working for the NHS must complete an annual declaration of interest identifying possible conflicts of interest and the actions taken to mitigate them. At the start of the financial year, or on commencement of employment with Audit Yorkshire, all Internal Auditors completed a declaration and certified that they had no conflicts of interest which might compromise their independence as an auditor working for Audit Yorkshire. The register of interests is kept under regular review to ensure no conflicts arise during the year. No conflicts have arisen in 2024/25 that has impacted on the independence of an auditor.

In line with the PSIAS the Head of Internal Audit can also confirm that there have been no circumstances in 2024/25 that have impacted on the organisational independence of Internal Audit. This independence has been maintained in delivering the Internal Audit plan to the Trust in 2024/25. Throughout the year we have maintained an effective relationship with the organisation's External Auditors, Sumer NI.

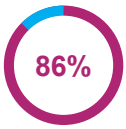
Summary of Performance against 2024/25 Plan

During 2024/25 we have delivered 100% of the Internal Audit plan.

Note: A number of agreed changes were made to the Internal Audit plan in respect of audits that could not be delivered as planned. All changes have been agreed with the Audit, Risk and Governance Committees in Common throughout the year.

Performance of the Internal Audit Service

This report provides the Audit, Risk and Governance Committees in Common with the latest available statistics at the time of producing the annual report and provides the latest picture possible for the full year 2024/25.

KPI Ref.	2024/25	Performance Indicator	Comments
1		Draft reports issued within 3 weeks of completion of fieldwork (2023/24 = 100%)	All reports met the target
2		Management responses received within 3 weeks of the issue of the draft report (2023/24 = 74%)	Two reports missed the target
3		Final reports issued within 1 week of the receiving management responses (2023/24 = 91%)	All reports met the target
4		Feedback received was 'good' or 'very good' (2023/24 = 100%)	All feedback was positive
5		Audit reports with SMART recommendations for improvement	
6		Audits where fully qualified staff have provided their expertise as part of the Audit	
7		Audits where all staff involved have certified their objectivity and confirmed their independance	

Conclusion

The Internal Audit plan for 2024/25 has been completed as expected subject to the amendments reported and has been delivered in line with our quality manual and processes that are designed to comply with the PSIAS.

In accordance with PSIAS, the Head of Internal Audit is required to provide an annual opinion, based upon, and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e., the organisation's system of internal control).

Significant assurance can be given that there is a good system of governance, risk management and internal control designed to meet the organisation's objectives and that controls are generally being applied consistently.

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

THE INDEPENDENT AUDITOR'S REPORT

ANNUAL
REPORT & ACCOUNTS
2024/25

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 2025, 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 2024-25 Government Financial Reporting Manual as contained in the Department of Health and Social Care Group Accounting Manual 2024-25, and the NHS Foundation Trust Annual Reporting Manual 2024-25 issued by NHS Improvement.

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 2025 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 2024-25; 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 2024-25.

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 2025.

We have nothing to report in this regard.

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.

Author's responsibilities for the Audit of the financial statements

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.

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 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, valuation of land and buildings 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 NHS group consolidation is complete. We are satisfied that our remaining work in respect of the NHS group consolidation is unlikely to have a material impact on the financial statements. 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 2025

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

ANNUAL ACCOUNTS

for the year ended 31 March 2025

ANNUAL
REPORT & ACCOUNTS
2024/25

Foreword to the Accounts

Northern Lincolnshire and Goole NHS Foundation Trust

These accounts, for the year ended 31 March 2025, 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.

Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025

Consolidated Statement of Comprehensive Income

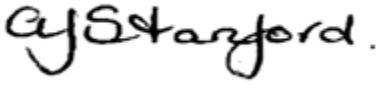
		Group	
		2024/25	2023/24
	Note	£000	£000
Operating income from patient care activities	3	559,651	524,856
Other operating income	4	54,956	49,335
Operating expenses	7,9	(623,809)	(588,176)
Operating surplus/(deficit) from continuing operations		**(9,202)**	**(13,986)**
Finance income	11	2,869	2,288
Finance expenses	12	(516)	(491)
PDC dividends payable		(6,446)	(6,584)
Net finance costs		**(4,093)**	**(4,786)**
Other gains / (losses)	13	56	158
Surplus / (deficit) for the year from continuing operations		**(13,239)**	**(18,614)**
Surplus / (deficit) on discontinued operations and the gain / (loss) on disposal of discontinued operations	15	-	-
Surplus / (deficit) for the year		**(13,239)**	**(18,614)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(2,014)	(199)
Revaluations	13	1,841	2,707
Total comprehensive income / (expense) for the period		**(13,412)**	**(16,106)**
Surplus / (deficit) for the period attributable to:			
Non-controlling interest, and		-	-
Northern Lincolnshire and Goole NHS Foundation Trust		(13,239)	(18,614)
TOTAL		**(13,239)**	**(18,614)**
Total comprehensive income/ (expense) for the period attributable to:			
Non-controlling interest, and		-	-
Northern Lincolnshire and Goole NHS Foundation Trust		(13,412)	(16,106)
TOTAL		**(13,412)**	**(16,106)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(13,239)	(18,614)
Remove impact of consolidating NHS charitable fund		(232)	(11)
Remove net impairments not scoring to the Departmental expenditure limit		15,545	17,632
Remove I&E impact of capital grants and donations		(2,073)	953
Remove net impact of DHSC centrally procured inventories		-	165
Adjusted financial performance surplus / (deficit)		**1**	**125**

Statements of Financial Position

		Group		Trust	
		31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	Note	£000	£000	£000	£000
Non-current assets					
Intangible assets	16	13,283	9,561	13,283	9,561
Property, plant and equipment	17	276,388	271,206	276,388	271,207
Right of use assets	20	11,000	13,366	11,000	13,366
Other investments / financial assets	21	1,146	1,297	-	-
Receivables	24	751	740	751	740
Total non-current assets		**302,568**	**296,170**	**301,422**	**294,874**
Current assets					
Inventories	23	4,226	4,057	4,226	4,057
Receivables	24	20,872	22,009	20,311	21,900
Cash and cash equivalents	28	32,648	41,274	32,619	41,224
Total current assets		**57,746**	**67,340**	**57,156**	**67,181**
Current liabilities					
Trade and other payables	29	(74,291)	(80,020)	(74,211)	(79,988)
Borrowings	31	(3,685)	(3,806)	(3,685)	(3,806)
Provisions	32	(4,523)	(808)	(4,523)	(808)
Other liabilities	30	(194)	(461)	(194)	(461)
Total current liabilities		**(82,692)**	**(85,095)**	**(82,613)**	**(85,063)**
Total assets less current liabilities		**277,622**	**278,415**	**275,965**	**276,992**
Non-current liabilities					
Borrowings	31	(12,812)	(16,199)	(12,812)	(16,199)
Provisions	32	(3,601)	(3,590)	(3,601)	(3,590)
Total non-current liabilities		**(16,413)**	**(19,788)**	**(16,413)**	**(19,789)**
Total assets employed		**261,208**	**258,627**	**259,552**	**257,203**
Financed by					
Public dividend capital		479,620	463,627	479,620	463,627
Revaluation reserve		20,229	23,136	20,229	23,136
Income and expenditure reserve		(240,297)	(229,560)	(240,297)	(229,560)
Charitable fund reserves	22	1,656	1,424	-	-
Total taxpayers' equity		**261,208**	**258,627**	**259,552**	**257,203**

The notes in the rest of this chapter form part of these accounts.

Amanda Stanford
Acting Group Chief Executive
Date: 20 June 2025



Consolidated Statement of Changes in Equity for the year ended 31 March 2025

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£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**

Consolidated Statement of Changes in Equity for the year ended 31 March 2024

Group	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Charitable fund reserves	Total
	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2023 - brought forward	431,655	20,628	(210,935)	1,413	242,761
Surplus / (deficit) for the year	-	-	(19,334)	720	(18,614)
Impairments	-	(199)	-	-	(199)
Revaluations	-	2,707	-	-	2,707
Public dividend capital received	31,972	-	-	-	31,972
Other reserve movements	-	-	709	(709)	-
Taxpayers' and others' equity at 31 March 2024	**463,627**	**23,136**	**(229,560)**	**1,424**	**258,627**

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 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

		Group		Trust	
		2024/25	2023/24	2024/25	2023/24
	Note	£000	£000	£000	£000
Cash flows from operating activities					
Operating surplus / (deficit)		(9,202)	(13,986)	(9,448)	(13,845)
Non-cash income and expense:					
Depreciation and amortisation	7.1	20,377	18,875	20,377	18,875
Net impairments	8	15,545	17,632	15,545	17,632
Income recognised in respect of capital donations	4	(3,095)	(84)	(3,095)	(84)
Decrease in receivables and other assets		2,375	3,815	2,328	3,755
Increase in inventories		(169)	(84)	(169)	(84)
Decrease in payables and other liabilities		(2,443)	(9,893)	(2,397)	(9,744)
Increase / (decrease) in provisions		3,648	(440)	3,648	(440)
Movements in charitable fund working capital		(406)	(128)	-	-
Net cash flows from / (used in) operating activities		**26,629**	**15,707**	**26,789**	**16,065**
Cash flows from investing activities					
Interest received		2,914	2,128	2,914	2,128
Purchase of intangible assets		(4,817)	(3,891)	(4,817)	(3,891)
Purchase of PPE and investment property		(40,479)	(36,215)	(40,479)	(36,215)
Sales of PPE and investment property		109	60	109	60
Initial direct costs or up front payments in respect of new right of use assets (lessee)		(200)	(257)	(200)	(257)
Receipt of cash donations to purchase assets		3,022	84	3,022	84
Net cash flows from charitable fund investing activities		138	238	-	-
Net cash flows from / (used in) investing activities		**(39,312)**	**(37,853)**	**(39,451)**	**(38,091)**
Cash flows from financing activities					
Public dividend capital received		15,993	31,972	15,993	31,972
Movement on loans from DHSC		(1,329)	(1,329)	(1,329)	(1,329)
Capital element of lease liability repayments		(2,321)	(2,454)	(2,321)	(2,454)
Interest on loans		(145)	(176)	(145)	(176)
Other interest		-	(0)	-	(0)
Interest paid on lease liability repayments		(303)	(267)	(303)	(267)
PDC dividend (paid) / refunded		(7,838)	(5,970)	(7,838)	(5,970)
Net cash flows from / (used in) financing activities		**4,057**	**21,776**	**4,057**	**21,776**
Increase / (decrease) in cash and cash equivalents		**(8,626)**	**(370)**	**(8,605)**	**(250)**
Cash and cash equivalents at 1 April - brought forward		**41,274**	**41,644**	**41,224**	**41,474**
Cash and cash equivalents at 31 March	28	**32,648**	**41,274**	**32,619**	**41,224**

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 2024/25 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 finanical 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 onditions 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 2025 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.

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 2024/25 with a valuation date of 31 March 2025, using the RICS Valuation Global Standards 2020 (Red Book).
Of the £225.9m net book value of land and buildings subject to valuation, £199.7m 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 £276.4m.

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 £14.2m.

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 £0.14m to support payments in line with the Trust pay protection policy.

The total value of provisions included within these accounts is £8.1m.

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.

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 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.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and 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 CQUIN and 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.

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.

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.

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 15 years
	Furniture and fittings	5 to 10 years
	IT equipment	Up to 5 years
Vehicles/transport equipment		Up to 7 years
Intangible		Up to 10 years

Valuations are carried out in accordance with the current Valuation Standards and UK Valuation Standards contained within the Royal Institute of Chartered Surveyors (RICS) Valuation Standards – The Red Book, which are consistent with the agreed requirements of the DHSC and HM Treasury.

Property assets have been valued primarily by using the Depreciated Replacement Cost (DRC) approach. In accordance with VS6.6, the DRC will be subject to the prospect and viability of the continued occupation and use by the 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.

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."

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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.

Between 2020/21 and 2023/24 the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department. Distribution of inventories by the Department ceased in March 2024.

Note 1.13 Private Finance Initiative (PFI) Transactions

At the 31 March 2025, the Trust did not have any PFI transactions.

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 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

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.

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 2.40% in real terms (prior year: 2.45%).

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 £0.14m 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.

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

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 and Improvement, 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 28.2) 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.

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 24.45% (2023/24: 23.07%) 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.

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 2024/25.

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 2024/25:

IFRS 17 Insurance Contracts

The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025/26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025/26 is not expected to have a material impact on the financial statements.

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.

Changes to non-investment asset valuation

Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- Withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.
- Removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- A mandated quinquennial revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- Removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

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 2024/25, 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) Car Parking Services

	Trust 2024/25	Trust 2023/24
	£000	£000
Income	2,327	2,048
Direct costs	(1,624)	(1,548)
Surplus before indirect costs	703	500
Indirect Costs	(781)	(774)
(Deficit) / Surplus	(78)	(274)

ii) Staff Accommodation

Staff accommodation amounted to £2.3m (2023/24: £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.

Note 3 Operating Income from Patient Care Activities (Group)

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)

	Trust 2024/25	Trust 2023/24
	£000	£000
Acute services		
Income from commissioners under API contracts - variable element*	84,742	81,000
Income from commissioners under API contracts - fixed element*	406,040	389,652
High cost drugs income from commissioners	11,207	11,542
Other NHS clinical income	6,493	2,339
Community services		
Income from commissioners under API contracts*	23,316	22,792
Income from other sources (e.g. local authorities)	2,288	1,757
All services		
Private patient income	316	286
National pay award central funding**	1,074	168
Additional pension contribution central funding***	22,208	13,609
Other clinical income	1,967	1,711
Total income from activities	**559,651**	**524,856**

*Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the 2023/25 NHS Payment Scheme documentation. https://www.england.nhs.uk/pay-syst/nhs-payment-scheme/

**Additional funding was made available directly to providers by NHS England in 2024/25 and 2023/24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

***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 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023/24: 20.6%) and related NHS England funding (9.4%, 2023/24: 6.3%) have been recognised in these accounts.

Note 3.2 Income from Patient Care Activities (by source)

	Trust 2024/25	Trust 2023/24
Income from patient care activities received from:	**£000**	**£000**
NHS England	51,721	40,249
Integrated care boards	505,351	482,276
Department of Health and Social Care	46	42
Other NHS providers	280	292
NHS other	4	-
Non-NHS: private patients	316	286
Non-NHS: overseas patients (chargeable to patient)	1,286	878
Injury cost recovery scheme	647	833
Total income from activities	**559,651**	**524,856**
Of which:		
Related to continuing operations	559,651	524,856

Note 3.3 Overseas Visitors (relating to patients charged directly by the provider)

	Trust 2024/25	Trust 2023/24
	£000	**£000**
Income recognised this year	1,286	878
Cash payments received in-year	143	122
Amounts written off in-year	618	183

Note 4 Other Operating Income (Group)

	2024/25			2023/24		
	Contract income	Non-contract income	Total	Contract income	Non-contract income	Total
	£000	£000	£000	£000	£000	£000
Research and development	740	-	740	677	-	677
Education and training	21,472	1,144	22,616	19,051	771	19,822
Non-patient care services to other bodies	21,914	-	21,914	22,333	-	22,333
Receipt of capital grants and donations and peppercorn leases	-	3,095	3,095	-	84	84
Charitable and other contributions to expenditure	-	-	-	-	150	150
Revenue from operating leases	-	179	179	-	260	260
Amortisation of PFI deferred income / credits	-	-	-	-	-	-
Charitable fund incoming resources	-	930	930	-	624	624
Other income*	5,482	-	5,482	5,385	-	5,385
Total other operating income	**49,608**	**5,348**	**54,956**	**47,446**	**1,889**	**49,335**
Of which:						
Related to continuing operations			54,956			49,335
Related to discontinued operations			-			-

* Other income included £2.3m (2023/24: £2.0m) for car parking and £2.3m (2023/24: £2.3m) for staff accommodation.

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:

	Trust 2024/25	Trust 2023/24
	£000	£000
Income from services designated as commissioner requested services	534,945	507,622
Income from services not designated as commissioner requested services	24,706	17,234
Total	**559,651**	**524,856**

Note 5.2 Profits and Losses on Disposal of Property, Plant and Equipment

	Trust 2024/25	Trust 2023/24
	£000	£000
Gains on disposal of other property plant and equipment	109	61
Gains on disposal of right of use assets (lease termination - lessee)	-	5
Losses on disposal of other property plant and equipment	(2)	(22)
Total gain / (loss) on disposal of assets	**107**	**44**

Note 5.5 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.

	Trust 2024/25	Trust 2023/24
	£000	£000
Income	2,327	2,048
Full cost	(2,406)	(2,322)
Surplus / (deficit)	**(79)**	**(274)**

The fees and charges above relate to Car Parking Services.

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

	Trust 2024/25	Trust 2023/24
	£000	£000
Lease receipts recognised as income in year:		
Minimum lease receipts	179	260
Variable lease receipts / contingent rents	-	-
Total in-year operating lease income	179	260

Note 6.2 Future Lease Receipts

	Trust	Trust
	31 March 2025	31 March 2024
	£000	£000
Future minimum lease receipts due in:		
- not later than one year	179	260
- later than one year and not later than two years	179	260
- later than two years and not later than three years	179	260
- later than three years and not later than four years	179	260
- later than four years and not later than five years	179	260
- later than five years	-	-
Total	**895**	**1,300**

Note 7

Note 7.1 Operating Expenses (Group)

	2024/25	2023/24
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	4,444	4,556
Purchase of healthcare from non-NHS and non-DHSC bodies	12,177	12,433
Staff and executive directors costs	419,881	393,908
Remuneration of non-executive directors	150	151
Supplies and services - clinical (excluding drugs costs)	49,468	45,028
Supplies and services - general	6,189	6,399
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	39,781	37,949
Inventories written down	98	-
Consultancy costs	1,375	658
Establishment	4,219	4,630
Premises	23,085	20,444
Transport (including patient travel)	3,085	3,265
Depreciation on property, plant and equipment	18,695	18,073
Amortisation on intangible assets	1,682	802
Net impairments	15,545	17,632
Movement in credit loss allowance: contract receivables / contract assets	533	294
Change in provisions discount rate(s)	11	(249)
Fees payable to the external auditor		
audit services- statutory audit	174	178
Internal audit costs	74	74
Clinical negligence	15,781	14,429
Legal fees	386	183
Insurance	460	430
Research and development	622	615
Education and training	2,733	2,766
Expenditure on low value leases	181	80
Redundancy	135	228
Car parking & security	1,624	1,588
Hospitality	13	44
Losses, ex gratia & special payments	18	15
Other NHS charitable fund resources expended	101	56
Other	1,089	1,517
Total	**623,809**	**588,176**
Of which:		
Related to continuing operations	623,809	588,176

* Other includes; £0.2m of patient welfare, £0.09m professional fees & £0.08m interpreting services.

Note 7.2 Other Auditor Remuneration

	Group 2024/25	Group 2023/24
	£000	£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 (2023/24: £179k).

Note 8 Impairment of Assets

	Group 2024/25	Group 2023/24
	£000	£000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	15,545	17,632
Total net impairments charged to operating surplus / deficit	15,545	17,632
Impairments charged to the revaluation reserve	2,014	199
Total net impairments	17,559	17,831

The impairment losses in 2024/25 were as a result of bringing into use the new Acute Assessment Unit at Scunthorpe together with the new fire alarm system (£11m). Scunthorpe Community Diagnostic Centre has also been impaired (£3m). The Grimsby boilerhouse block incurred impairments of £1m.

Note 9 Employee Benefits

	Group 2024/25	Group 2023/24
	£000	£000
Salaries and wages	315,326	289,720
Social security costs	32,442	31,024
Apprenticeship levy	1,609	1,543
Employer's contributions to NHS pensions	56,192	44,765
Temporary staff (including agency)	16,416	28,779
Total gross staff costs	**421,985**	**395,831**
Recoveries in respect of seconded staff	-	-
Total staff costs	**421,985**	**395,831**
Of which		
Costs capitalised as part of assets	812	664

Note 9.1 Retirements due to Ill-health

During 2024/25 there were 3 early retirements from the Trust agreed on the grounds of ill-health (6 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £189k (£327k in 2023/24).

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 2024/25	Group 2023/24
	£000	£000
Salary	1,011	1,224
Employer's National Insurance	122	136
Employer's pension contributions	102	123
Total	**1,235**	**1,483**

Note 9.3 Management Costs

	Group 2024/25	Group 2023/24
	£000	£000
Management Costs	27,865	25,401
Income	617,092	576,526
Management Costs as a % of income	4.52%	4.41%

The above is excluding Charitable income and costs.

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 Socail 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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 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 to 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.

Note 11 Finance Income

Finance income represents interest received on assets and investments in the period.

	Group 2024/25	Group 2023/24
	£000	£000
Interest on bank accounts	2,832	2,250
NHS charitable fund investment income	37	38
Total finance income	**2,869**	**2,288**

Note 12.1 Finance Expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money or asset financing.

	Group 2024/25	Group 2023/24
	£000	£000
Interest expense:		
Interest on loans from the Department of Health and Social Care	134	165
Interest on lease obligations	303	267
Interest on late payment of commercial debt	-	-
Total interest expense	**437**	**432**
Unwinding of discount on provisions	79	58
Total finance costs	**516**	**490**

Note 12.2 The Late Payment of Commercial Debts (interest) Act 1998

	Group 2024/25	Group 2023/24
	£000	£000
Amounts included within interest payable arising from claims made under this legislation	-	-

Note 12.3 Other Gains / (Losses)

	Group 2024/25	Group 2023/24
	£000	£000
Gains on disposal of assets	109	66
Losses on disposal of assets	(2)	(22)
Total gains / (losses) on disposal of assets	107	44
Fair value gains / (losses) on charitable fund investments & investment properties	(51)	114
Total other gains / (losses)	**56**	**158**

Note 13 Revaluation of Assets (Property, Plant and Equipment) Cushman & Wakefield Valuations Summary

	Group 2024/25	Group 2023/24
	£000	£000
Impairments		
Impairments charged to Revaluation Reserve	(2,014)	(199)
Impairments charged to Statement of Comprehensive Income	(16,972)	(20,518)
Total Impairments due to Market Changes	(18,986)	(20,717)
Revaluation gains		
Revaluation gains credited to Revaluation Reserve	1,841	2,707
Revaluation gains relating to previous impairments credited to Statement of Comprehensive Income	1,427	2,885
Total Revaluation gains due to Market Changes	3,268	5,592

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 £13.7 million (2023/24: £18.6 million). The Trust's total comprehensive income/(expense) for the period was £13.9 million (2023/24: £16.1 million).

Note 15 Discontinued Operations

	Group 2024/25	Group 2023/24
	£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	**-**	**-**

Note 16.1 Intangible Assets - 2024/25

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**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 - brought forward	**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 16.1 Intangible Assets - 2024/25

Group	Software licences	Intangible assets under construction	Total
	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**9,412**	**1,429**	**10,841**
Additions	2,579	3,069	**5,648**
Reclassifications	2,803	(1,429)	**1,374**
Valuation / gross cost at 31 March 2024	**14,794**	**3,069**	**17,863**
Amortisation at 1 April 2023 - as previously stated	7,500	-	**7,500**
Provided during the year	802	-	**802**
Amortisation at 31 March 2024	**8,302**	**-**	**8,302**
Net book value at 31 March 2024	**6,492**	**3,069**	**9,561**
Net book value at 1 April 2023	**1,912**	**1,429**	**3,341**

Note 17.1 Property, Plant and Equipment - 2024/25

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2024 - brought forward	**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 - brought forward	**-**	**0**	**-**	**-**	**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 17.2 Property, Plant and Equipment - 2023/24

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2023 - as previously stated	**9,351**	**176,761**	**17,078**	**30,563**	**56,744**	**186**	**22,729**	**1,326**	**314,738**
Additions	-	5,936	11	30,728	3,778	-	1,926	128	**42,507**
Impairments	(18)	(175)	(6)	-	-	-	-	-	**(199)**
Revaluations	48	(22,024)	112	-	-	-	-	-	**(21,864)**
Reclassifications	-	14,238	-	(17,858)	1,700	-	465	81	**(1,374)**
Disposals / derecognition	-	-	-	-	(2,703)	-	(1)	(24)	**(2,728)**
Valuation / gross cost at 31 March 2024	**9,381**	**174,736**	**17,195**	**43,433**	**59,519**	**186**	**25,119**	**1,511**	**331,080**
Accumulated depreciation at 1 April 2023 - as previously stated	**-**	**-**	**-**	**-**	**38,578**	**157**	**14,443**	**961**	**54,139**
Provided during the year	-	6,592	347	-	5,409	14	2,885	133	**15,380**
Impairments	-	20,518	-	-	-	-	-	-	**20,518**
Reversals of impairments	-	(2,575)	(310)	-	-	-	-	-	**(2,885)**
Revaluations	-	(24,535)	(37)	-	-	-	-	-	**(24,572)**
Disposals / derecognition	-	-	-	-	(2,681)	-	(1)	(24)	**(2,706)**
Accumulated depreciation at 31 March 2024	**-**	**0**	**-**	**-**	**41,306**	**171**	**17,327**	**1,070**	**59,874**
Net book value at 31 March 2024	**9,381**	**174,736**	**17,195**	**43,433**	**18,213**	**15**	**7,792**	**441**	**271,206**
Net book value at 1 April 2023	**9,351**	**176,761**	**17,078**	**30,563**	**18,166**	**29**	**8,286**	**365**	**260,599**

Note 17.3 Property, Plant and Equipment Financing - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
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 17.4 Property, Plant and Equipment Financing - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Owned - purchased	9,381	171,422	17,195	34,818	15,221	15	7,776	371	**256,199**
Owned - donated / granted	-	3,314	-	8,615	2,992	-	16	70	**15,007**
NBV total at 31 March 2024	**9,381**	**174,736**	**17,195**	**43,433**	**18,213**	**15**	**7,792**	**441**	**271,206**

Note 17.5 Property, Plant and Equipment Assets subject to an Operating Lease (Trust as a lessor) - 31 March 2025

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
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 17.6 Property, Plant and Equipment Assets subject to an Operating Lease (Trust as a lessor) - 31 March 2024

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Subject to an operating lease	-	1,492	-	-	-	-	-	-	**1,492**
Not subject to an operating lease	9,381	173,244	17,195	43,433	18,213	15	7,792	441	**269,714**
NBV total at 31 March 2024	**9,381**	**174,736**	**17,195**	**43,433**	**18,213**	**15**	**7,792**	**441**	**271,206**

Note 18 Donations and Grants of Property, Plant and Equipment

The Trust received donations and grants to support capital purchases as follows;

	2024/25	2023/24
	£000	£000
Buildings ex Dwellings	2,803	-
Assets under Construction	-	-
Plant and machinery	220	84
Intangible	-	-
Total	**3,022**	**84**

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 2025, the NHS Foundation 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 2025, using the Royal Institue 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 £225.9m net book value of land and buildings subject to valuation, £199.7m 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 2025 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.

Site	Description	Net Change in Valuation (increase) Decrease £000	Charged to Expenses £000	Impairment Reversals Credited to Expenses £000	Changes to Revaluation Reserves £000
Diana, Princess of Wales Hospital, Grimsby		(212)	1,891	(1,394)	(709)
Scunthorpe General Hospital		16,848	15,081	-	1,767
Goole District Hospital		(918)	-	(33)	(885)
Other		-	-	-	-
Total		**15,718**	**16,972**	**(1,427)**	**173**

All the above changes relate to properties in the Trust's main healthcare segment.

Note 20 Leases - Northern Lincolnshire and Goole NHS Foundation Trust as 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.

Note 20.1 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 20.2 Right of Use Assets - 2023/24

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 2023 - brought forward	**15,494**	**1,302**	**919**	**17,715**	**12,790**
Additions	480	13	707	**1,200**	123
Remeasurements of the lease liability	213	(124)	(2)	**87**	32
Disposals / derecognition	(231)	(276)	(225)	**(732)**	(177)
Valuation / gross cost at 31 March 2024	**15,956**	**915**	**1,399**	**18,270**	**12,768**
Accumulated depreciation at 1 April 2023 - brought forward	**1,905**	**572**	**311**	**2,788**	**1,324**
Provided during the year	1,967	266	460	**2,693**	1,335
Disposals / derecognition	(76)	(276)	(225)	**(577)**	(22)
Accumulated depreciation at 31 March 2024	**3,796**	**562**	**546**	**4,904**	**2,637**
Net book value at 31 March 2024	**12,160**	**353**	**853**	**13,366**	**10,132**
Net book value at 1 April 2023	**13,589**	**730**	**608**	**14,927**	**11,466**
Net book value of right of use assets leased from other NHS providers					6,417
Net book value of right of use assets leased from other DHSC group bodies					3,714

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 3

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April	**13,066**	**14,651**	**13,066**	**14,651**
Lease additions	381	942	381	942
Lease liability remeasurements	(228)	87	(228)	87
Interest charge arising in year	303	267	303	267
Early terminations	-	(160)	-	(160)
Lease payments (cash outflows)	(2,624)	(2,721)	(2,624)	(2,721)
Carrying value at 31 March	**10,898**	**13,066**	**10,898**	**13,066**

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 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 Mar 2025	31 Mar 2025	31 Mar 2025	31 Mar 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 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

Note 20.5 Maturity Analysis of Future Lease Payments at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 Mar 2025	31 Mar 2025	31 Mar 2025	31 Mar 2025
	£000	£000	£000	£000
Undiscounted future lease payments payable in:				
- not later than one year;	2,671	1,461	2,671	1,461
- later than one year and not later than five years;	6,858	5,553	6,858	5,553
- later than five years.	4,527	3,980	4,527	3,980
Total gross future lease payments	**14,056**	**10,994**	**14,056**	**10,994**
Finance charges allocated to future periods	(990)	(751)	(990)	(751)
Net lease liabilities at 31 March 2025	**13,066**	**10,243**	**13,066**	**10,243**
Of which:				
Leased from other NHS providers		6,456		6,456
Leased from other DHSC group bodies		3,787		3,787

Note 21 Other Investments / Financial Assets (non-current)

	Group		Trust	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Carrying value at 1 April - brought forward	**1,297**	**1,383**	**-**	**-**
Movement in fair value through income and expenditure	(51)	114	-	-
Disposals	(100)	(200)	-	-
Carrying value at 31 March	**1,146**	**1,297**	**-**	**-**

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 2024/25, the NHS Charitable Funds balances are as follows:

	31 March 2025	31 March 2024
	£000	£000
Unrestricted funds:		
Unrestricted income funds	1,656	1,424
	1,656	**1,424**

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 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Drugs	1,233	1,101	1,233	1,101
Consumables	2,491	2,370	2,491	2,370
Energy	62	160	62	160
Other	440	426	440	426
Total inventories	**4,226**	**4,057**	**4,226**	**4,057**

Inventories recognised in expenses for the year were £43,581k (2023/24: £41,688k). Write-down of inventories recognised as expenses for the year were £98k (2023/24: £0k).

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2023/24 the Trust received £150k of items purchased by DHSC. Distribution of inventory by the Department ceased in March 2024.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

Note 24.1 Receivables

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Current				
Contract receivables*	14,595	15,396	14,603	15,403
Allowance for impaired contract receivables / assets	(1,002)	(1,105)	(1,002)	(1,105)
Prepayments (non-PFI)	4,726	5,810	4,726	5,810
Interest receivable	224	306	224	306
PDC dividend receivable	879	-	879	-
VAT receivable	860	1,462	860	1,462
Other receivables**	21	24	21	24
NHS charitable funds receivables	569	116	-	-
Total current receivables	**20,872**	**22,009**	**20,311**	**21,900**
Non-current				
Other receivables***	751	740	751	740
Total non-current receivables	**751**	**740**	**751**	**740**
Of which receivable from NHS and DHSC group bodies:				
Current	8,200	8,658	8,200	8,658
Non-current	751	740	751	740

* Contract receivables for 2024/25 includes £0m relating to pay award funding, (2023/24 includes £0.17m).
** 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.

Note 24.2 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 - brought forward	**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**	**-**

Note 24.3 Allowances for Credit Losses - 2023/24

	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 2023 - as previously stated	**1,007**	**-**	**1,007**	**-**
New allowances arising	454	-	454	-
Reversals of allowances	(160)	-	(160)	-
Utilisation of allowances (write offs)	(196)	-	(196)	-
Allowances as at 31 Mar 2024	**1,105**	**-**	**1,105**	**-**

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	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
Finance lease receivables at 1 April	**-**	**-**	**-**	**0**
Prior period adjustments	-	-	-	-
Finance lease receivables at 1 April - restated	-	-	-	-
Transfers by absorption	-	-	-	0
Additions	-	-	-	0
Interest arising (unwinding of discount)	-	-	-	0
Remeasurements of lease receivables	-	-	-	0
Lease receipts (cash payments received)	-	-	-	0
Derecognition due to early termination	-	-	-	0
Finance lease receivables at 31 March	**-**	**-**	**-**	**-**

Note 25.2 Finance Lease Receivables Maturity Analysis as at 31 March 2025

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 Mar 2025	31 Mar 2025	31 Mar 2025	31 Mar 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		-		-

Note 25.3 Finance Lease Receivables Maturity Analysis as at 31 March 2024

	Group		Trust	
	Total	Of which leased from DHSC group bodies:	Total	Of which leased from DHSC group bodies:
	31 Mar 2024	31 Mar 2024	31 Mar 2024	31 Mar 2024
	£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 26 Other Assets

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Current				
Other assets	-	-	-	-
Total other current assets	**-**	**-**	**-**	**-**
Non-current				
Net defined benefit pension scheme asset	-	-	-	-
Other assets	-	-	-	-
Total other non-current assets	**-**	**-**	**-**	**-**

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.

Note 27 Liabilities in Disposal Groups

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Categorised as:				
Provisions	-	-		
Trade and other payables	-	-		
Other	-	-		
Total	**-**	**-**	**-**	**-**

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	
	2024/25	2023/24	2024/25	2023/24
	£000	£000	£000	£000
At 1 April	41,274	41,644	41,224	41,474
Net change in year	(8,626)	(370)	(8,605)	(250)
At 31 March	32,648	41,274	32,619	41,224
Broken down into:				
Cash at commercial banks and in hand	614	319	585	269
Cash with the Government Banking Service	32,034	40,955	32,034	40,955
Total cash and cash equivalents as in SoFP	32,648	41,274	32,619	41,224
Total cash and cash equivalents as in SoCF	32,648	41,274	32,619	41,224

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 Mar 2025	31 Mar 2024
	£000	£000
Monies on deposit	6	6
Total third party assets	**6**	**6**

Note 29.1 Trade and Other Payables

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Current				
Trade payables	21,135	13,097	21,135	13,097
Capital payables	19,757	22,845	19,757	22,845
Accruals	14,357	24,410	14,357	24,410
Social security costs	8,757	8,531	8,757	8,531
PDC dividend payable	-	513	-	513
Pension contributions payable	4,609	4,308	4,609	4,308
Other payables	5,596	6,284	5,596	6,284
NHS charitable funds: trade and other payables	80	32	-	-
Total current trade and other payables	**74,291**	**80,020**	**74,211**	**79,988**
Non-current				
Total non-current trade and other payables	**-**	**-**	**-**	**-**
Of which payables from NHS and DHSC group bodies:				
Current	9,122	5,182	9,122	5,182
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 Mar 2025	31 Mar 2025	31 Mar 2024	31 Mar 2024
	£000	£000	£000	£000
- to buy out the liability for early retirements over 5 years	-	-	-	-
- number of cases involved	-	-	-	-

Note 30 Other Liabilities

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Current				
Deferred income: contract liabilities	194	461	194	461
Total other current liabilities	**194**	**461**	**194**	**461**
Non-current				
Total other non-current liabilities	**-**	**-**	**-**	**-**

Note 31 Borrowings

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Current				
Loans from DHSC	1,374	1,385	1,374	1,385
Lease liabilities	2,311	2,421	2,311	2,421
Total current borrowings	**3,685**	**3,806**	**3,685**	**3,806**
Non-current				
Loans from DHSC	4,225	5,554	4,225	5,554
Lease liabilities	8,587	10,645	8,587	10,645
Total non-current borrowings	**12,812**	**16,199**	**12,812**	**16,199**

Note 31.1 Reconciliation of Liabilities Arising from Financing Activities

Group - 2024/25	Loans from DHSC	Lease liabilities	Lease liabilities
	£000	£000	£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**

Group - 2023/24	Loans from DHSC	Lease liabilities	Lease liabilities
	£000	£000	£000
Carrying value at 1 April 2023	**8,279**	**14,651**	**22,930**
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,329)	(2,454)	(3,783)
Financing cash flows - payments of interest	(176)	(267)	(443)
Non-cash movements:			
Additions	-	942	942
Lease liability remeasurements	-	87	87
Application of effective interest rate	165	267	432
Early terminations	-	(160)	(160)
Carrying value at 31 March 2024	**6,939**	**13,066**	**20,005**

Note 32 Provisions for Liabilities and Charges Analysis

Group	Pensions: early departure costs	Pensions: injury benefits	Legal claims	Re-structuring	Equal Pay (including Agenda for Change)	Other	Total
	£000	£000	£000	£000	£000	£000	£000
At 1 April 2024	**1,050**	**2,161**	**242**	**181**	**-**	**764**	**4,397**
Change in the discount rate	1	10	-	-	-	(7)	**4**
Arising during the year	124	178	136	140	3,782	2	**4,362**
Utilised during the year	(213)	(170)	(70)	(159)	-	(24)	**(636)**
Reversed unused	-	-	(97)	(23)	-	-	**(120)**
Unwinding of discount	24	55	-	-	-	38	**117**
At 31 March 2025	**986**	**2,234**	**211**	**139**	**3,782**	**772**	**8,124**
Expected timing of cash flows:							
not later than one year;	204	166	211	139	3,782	21	**4,523**
later than one year and not later than five years;	669	626	-	-	-	70	**1,365**
later than five years.	113	1,442	-	-	-	681	**2,236**
Total	**986**	**2,234**	**211**	**139**	**3,782**	**772**	**8,124**

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 provision for legal claims are permanent injury benefits and employer's liability claims, the provision is based on claims information received from NHS Resolution. All claims are handled by NHS Resolution on behalf of the Trust and they advise on likelihood and value of settlement. The timing and value of settlements are subject to both local negotiation and the judgement of NHS Resolution.

The Trust's liability in respect of each claim is limited to the level of excess determined by NHS Resolution. 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 £772k relating to clinician pension tax reimbursement. A reimbursement has been recognised within non current debtors.

Note 33 Clinical Negligence Liabilities

At 31 March 2025, £144,175k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northern Lincolnshire and Goole NHS Foundation Trust (31 March 2024: £144,911k).

Note 34 Contingent Assets and Liabilities

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Value of contingent liabilities				
NHS Resolution legal claims	(48)	(58)	(48)	(58)
Other	-	(745)	-	(745)
Gross value of contingent liabilities	**(48)**	**(803)**	**(48)**	**(803)**
Amounts recoverable against liabilities	-	-		
Net value of contingent liabilities	**(48)**	**(803)**	**(48)**	**(803)**
Net value of contingent assets	**-**	**-**		

Other contingent liabilities in 2023/24 relates to the cost to remove and replace Reinforced Autoclave Aerated Concrete (RAAC) found at the Scunthorpe General Hospital site. This work was completed during 2024/25.

Note 35 Contractual Capital Commitments

	Group		Trust	
	31 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
Value of contingent liabilities				
Property, plant and equipment	5,565	4,098	5,565	4,098
Intangible assets	-	2,177	-	2,177
Total	**5,565**	**6,275**	**5,565**	**6,275**

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 2025.

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 2025.

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 Intergrated 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 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 £5.554m (£6.883m 2023/24), (excluding interest), 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.

Loan - Purpose	Interest Rate	Balance at 31 Mar 2025
	%	£000
Residential Accommodation DPoW Phase 1	2.06%	2,954
Energy Performance Contract	2.39%	2,600
Total		**5,554**

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 2025 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.

Note 39.2 Carrying Values of Financial Assets (Group)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
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**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	15,360	-	-	**15,360**
Cash and cash equivalents	41,224	-	-	**41,224**
Consolidated NHS Charitable fund financial assets	1,463	-	-	**1,463**
Total at 31 March 2024	**58,047**	**-**	**-**	**58,047**

Note 39.3 Carrying Values of Financial Assets (Trust)

Carrying values of financial assets as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	14,528	-	-	**14,528**
Cash and cash equivalents	32,619	-	-	**32,619**
Total at 31 March 2025	**47,147**	**-**	**-**	**47,147**

Carrying values of financial assets as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	15,360	-	-	**15,360**
Cash and cash equivalents	41,224	-	-	**41,224**
Total at 31 March 2024	**56,584**	**-**	**-**	**56,584**

Note 39.4 Carrying Values of Financial Liabilities (Group)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£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**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	6,939	-	**6,939**
Obligations under leases	13,066	-	**13,066**
Trade and other payables excluding non financial liabilities	60,512	-	**60,512**
Provisions under contract	4,397	-	**4,397**
Consolidated NHS charitable fund financial liabilities	32	-	**32**
Total at 31 March 2024	**84,946**	**-**	**84,946**

Note 39.5 Carrying Values of Financial Liabilities (Trust)

Carrying values of financial liabilities as at 31 March 2025	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£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**

Carrying values of financial liabilities as at 31 March 2024	Held at amortised cost	Held at fair value through I&E	Total book value
	£000	£000	£000
Loans from the Department of Health and Social Care	6,939	-	**6,939**
Obligations under leases	13,066	-	**13,066**
Trade and other payables excluding non financial liabilities	60,512	-	**60,512**
Provisions under contract	4,397	-	**4,397**
Total at 31 March 2024	**84,914**	**-**	**84,914**

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.

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 Mar 2025	31 Mar 2024	31 Mar 2025	31 Mar 2024
	£000	£000	£000	£000
In one year or less	69,547	65,497	69,547	69,497
In more than one year but not more than five years	11,943	12,432	11,943	12,432
In more than five years	5,273	8,388	5,273	8,388
Total	**86,763**	**86,317**	**86,763**	**90,317**

Note 40 Losses and Special Payments

	2024/25		2023/24	
Group and Trust	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	18	13	28	13
Bad debts and claims abandoned	261	623	241	185
Stores losses and damage to property	19	25	13	39
Total losses	**298**	**661**	**282**	**237**
Special payments				
Compensation under court order or legally binding arbitration award	1	1	-	-
Ex-gratia payments	20	17	24	15
Special severance payments	-	-	1	6
Total special payments	**21**	**18**	**25**	**21**
Total losses and special payments	**319**	**679**	**307**	**258**
Compensation payments received				

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.

	2024/25 Income	2024/25 Expenditure	2024/25 Receivables	2024/25 Payables
	£000	£000	£000	£000
Care Quality Commission	-	308	-	-
Department of Health and Social Care	46	487	-	-
Doncaster & Bassetlaw Teaching Hospitals NHS Foundation Trust	87	53	138	53
Harrogate & District NHS Foundation Trust	129	8	105	9
Hull University Teaching Hospitals NHS Trust	3505	4727	4143	5611
Humber Teaching NHS Foundation Trust	-	112	-	-
Lancashire Teaching Hospitals NHS Foundation Trust	2	433	-	72
Leeds and York Partnership NHS Foundation Trust	-	-	-	-
Leeds Teaching Hospitals NHS Trust	285	610	191	204
Lincolnshire Community Health Services NHS Trust	415	-	211	-
Lincolnshire Partnership NHS Foundation Trust	161	-	-	-
NHS Blood & Transplant	-	1856	-	191
NHS Business Services Authority	2	90	2	99
NHS Derby & Derbyshire ICB	130	-	-	-
NHS England	48564	66	603	443
NHS Greater Manchester ICB	141	-	-	-
NHS Humber & North Yorkshire ICB	433331	86	465	459

	2024/25 Income £000	2024/25 Expenditure £000	2024/25 Receivables £000	2024/25 Payables £000
NHS Leicester, Leicestershire and Rutland ICB	87	9	-	-
NHS Lincolnshire ICB	71124	-	266	-
NHS North East and North Cumbria ICB	114	-	-	-
NHS Nottingham and Nottinghamshire ICB	380	-	-	-
NHS Pension Scheme	-	56192	-	4609
NHS Property Services	-	1560	-	534
NHS Resolution	-	16044	-	3
NHS South Yorkshire ICB	1622	-	-	-
NHS West Yorkshire ICB	488	-	-	-
Norfolk and Norwich University Hospitals NHS Foundation Trust	72	-	13	-
North Cumbria Integrated Care NHS Foundation Trust	139	-	43	-
North East Lincolnshire Council	-	31	-	15
North Lincolnshire Council	-	105	138	-
North Tees and Hartlepool NHS Foundation Trust	-	209	-	81
North West Anglia NHS Foundation Trust	44	-	6	-
Northampton General Hospital NHS Trust	635	-	53	-
Nottingham University Hospitals NHS Foundation Trust	122	308	54	79
Oxford Health NHS Foundation Trust	-	126	-	5
Oxford University Hospitals NHS Foundation Trust	-	66	-	18
Portsmouth Hospitals University NHS Trust	-	122	-	5
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	172	248	201	46
Sheffield Children's NHS Foundation Trust	2	209	56	188
Sheffield Teaching Hospitals NHS Foundation Trust	329	434	27	191
UK Health Security Agency	-	208	-	87
United Lincolnshire Hospitals NHS Trust	12633	896	601	174

	2024/25 Income	2024/25 Expenditure	2024/25 Receivables	2024/25 Payables
	£000	£000	£000	£000
University Hospitals Birmingham NHS Foundation Trust	-	846	-	518
University Hospitals of Leicester NHS Trust	180	138	6	45
York and Scarborough Teaching Hospitals NHS Foundation Trust	1	368	9	99
Yorkshire Ambulance Service NHS Trust	58	-	13	-
Other (Total)	963	454	974	143
Total Related Parties	**575,963**	**87,409**	**8,318**	**13,981**
HM Revenue and Customs (Taxes and Duties)	-	34,051	-	8,757
Other Government Departments	**-**	**34,051**	**-**	**8,757**
Comparatives 2023/24				
Total Related Parties	**548,209**	**72,151**	**9,145**	**9,879**
Other Government Departments	**-**	**32,567**	**1,462**	**8,531**

Related Party Transactions with bodies outside of the whole of government accounting were are follows:

	2024/25 Income	2024/25 Expenditure	2024/25 Receivables	2024/25 Payables
	£000	£000	£000	£000
Health Service Journal - Chief Executive / Hospitality	-	21	-	-
Healthcare Financial Management Association Ltd - Chief Financial Officer / Vice President	-	18	-	11
NHS Providers - Chief Executive / Hospitality	-	33	-	5
University of Lincoln - Non-Executive Director / Deputy Vice Chancellor	2	5	-	2

NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

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