NHS
Northern Lincolnshire and Goole
NHS Foundation Trust

AGENDA

A meeting of the Council of Governors
to be held on Thursday, 20 August 2026 at 16:00 – 17:30 hours
To be held via MS Teams - Join the meeting now

For the purpose of transacting the business set out below:

No.	Agenda item	Format	Purpose	Time
1. CORE BUSINESS ITEMS				
1.1	**Welcome and Apologies for absence** Alan Downey, Group Chair	Verbal	Information	**16:00**
1.2	**Staff Charter and Values** Alan Downey, Group Chair	Attached	Information	
1.3	**Declarations of Interest** Alan Downey, Group Chair	Verbal	Information	
1.4	**Minutes of the previous meeting held on 16 July 2026** Alan Downey, Group Chair	CoG(26)070 Attached	Approval	
1.5	**Urgent Matters Arising** Alan Downey, Group Chair	Verbal	Information	
1.6	**Action Tracker – Public** Alan Downey, Group Chair	CoG(26)071 Attached	Approval	
1.7	**Questions submitted from the Public** Alan Downey, Group Chair	Verbal	Information	
2. COG BUSINESS ITEMS				
2.1	**Governor Elections and Lead Governor Update** Alison Hurley, Group Deputy Director of Assurance	CoG(26)072 Attached	Approval	**16:20**
2.2	**Putting Patients First – Accreditation Progress Update** Michelle Drinkell, Lead Nurse Accreditation	CoG(26)073 Attached	Information	**16:30**
2.3	**To consider adoption of a resolution proposed by the Lead Governor on behalf of fellow Governors as follows:** The Council of Governors wholeheartedly supports the submission of proposals for future governance and leadership made by the NLaG consultant body. The Humber Health Partnership Boards-in-Common and NHS England are urged to give serious consideration to the recommended full restoration of NLaG as an independent NHS Foundation Trust. Ian Reekie, Lead Governor	Verbal	Approval	**16:55**
3. OTHER				
3.1	**Questions from Governors** Alan Downey, Group Chair	Verbal	Information	**17:10**
3.2	**Items for Information / To Note (as per Appendix A)** Alan Downey, Group Chair	Verbal	Information	
3.3	**Any Other Urgent Business** Alan Downey, Group Chair	Verbal	Information	

4.	DATE OF THE NEXT MEETING
4.1	The next meeting of the Council of Governors will be: Joint NLaG Council of Governors Annual Members Meeting and HUTH Annual General Meeting Wednesday 14 October 2026 from 14:30 - 17:00 hours Virtual meeting via MS Teams Live

APPENDIX A

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

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

3.2.	**Items for Information**		
3.2.1	Council of Governors and Trust Board Engagement Policy (DCP231)	Alison Hurley, Group Deputy Director of Assurance	CoG(26)074 Attached
3.2.2	Acronyms & Glossary of Terms	Alison Hurley, Group Deputy Director of Assurance	CoG(26)075 Attached

PROTOCOL FOR CONDUCT OF COUNCIL OF GOVERNOR BUSINESS

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

PROTOCOL FOR QUESTION(S) SUBMITTED FROM TRUST MEMBERS AND THE PUBLIC

Please note - Trust members and the public are encouraged to submit any questions requiring information or clarification at least 7 days before the meeting. This ensures sufficient time to gather the necessary details and provide an appropriate response.

Questions received within 7 days of the meeting will be addressed at the next Council of Governors business meeting.

Staff charter

NHS
Humber Health
Partnership

COMPASSION	HONESTY	RESPECT	TEAMWORK
Put the safety and care of patients and colleagues at the heart of everything you do	Take responsibility for your actions, decisions and behaviours	Trust and appreciate your colleagues - say thank you and well done	Meet regularly as a whole team , discuss goals, actions and ideas for improvement. Commit to being good team members
Listen to your colleagues and patients, understand, empathise and take action to help	Report concerns about safety, quality and negative behaviours as quickly as possible	Talk to everyone in a respectful and polite manner and listen when others want to speak	Include all colleagues in key discussions about the team or service
Treat everyone with kindness and support those who need assistance or guidance	Communicate constantly and clearly at all times; create and respond to a constant loop of honest feedback	Understand and appreciate the perspectives, choices and beliefs of others and never discriminate against anyone	Tackle poor behaviours as they arise
Do the right thing, even if this is more difficult to do	Be open about mistakes, apologise, learn and improve	Respect and use each others' strengths; act respectfully by giving, receiving and acting on constructive feedback	Agree high professional standards as a team; give yourselves time to reflect on how to constantly improve

COUNCIL OF GOVERNORS BUSINESS MEETING

Minutes of the meeting held on Thursday, 16 July 2026
at 14:00 to 17:00 hours held in the Chamber, University Campus North Lincolnshire (UCNL), Ashby Road, Scunthorpe, DN16 1BU and via MS Teams

For the purpose of transacting the business set out below:

Present:

Core Members:

Murray Macdonald	Group Vice Chair
Kevin Allen	Public Governor
Mike Bateson	Public Governor
Cllr Anne Handley	Stakeholder Governor
Dietmar Harteveld	Public Governor
Brent Huntington	Public Governor
Wendy Lawtey	Public Governor
Corrin Manaley	Staff Governor
Ian Reekie	Lead Governor
Jackie Weavill	Staff Governor

In Attendance:

Julie Beilby	Group Non-Executive Director
Alison Drury	Deputy Director (Finance)
Jane Hawkard	Group Non-Executive Director
Keith Haynes	Interim Board Secretary
Alison Hurley	Deputy Director of Assurance
Lyn Simpson	Group Chief Executive
Suzanne Maclennan	Corporate Governance Officer (minutes)

Public Members and other attendees:
Henry Anderson (virtual), John Palmer and Kevin Woolass

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

1. CORE BUSINESS ITEMS

1.1 Welcome and Apologies for Absence

The Group Vice Chair, Murray Macdonald, welcomed those present to the Council of Governors (CoG) Business Meeting. A particular welcome was extended to Jane Hawkard, a newly appointed Group Non-Executive Director (NED) having been a HUTH NED and Keith Haynes as Interim Board Secretary.

Alison Hurley provided details of apologies for absence for Governors, Ahmed Aftab, Cheryl George, David James, Emma Mundey, Cllr Nigel Oliver, Caroline Ridgway, Dr Vijay and Clare Woodard.

Apologies were also received from Alan Downey, Group Chair, David Sulch, Group Non-Executive Director, Paul Bunyan, Covering Group Chief People Officer, Jo Ledger, Covering Group Chief Nurse, Sam Peate, Group Chief Delivery Officer, Emma Sayner, Group Chief Finance Officer, Dr Pete Sedman, Group Deputy Chief Medical Officer, David Sharif, Group Director of Assurance and Dr Kate Wood, Group Chief Medical Officer.

1.2 **Staff Charter and Values**

Murray Macdonald reminded those present of the Staff Charter and Values and highlighted that everyone should adhere to these in terms of behaviours during the meeting.

1.3 **Declarations of Interest**

Murray Macdonald requested any declarations of interests in respect of any of the agenda items. None were received.

1.4 **Minutes of the Previous Council of Governors Business Meetings**

The minutes of the business meeting held on the 15 April 2026 were reviewed and accepted as a true and accurate record.

The minutes of the extra-ordinary meeting held on the 6 May 2026 were reviewed and accepted as a true and accurate record.

1.5 **Urgent Matters Arising**

Murray Macdonald invited members to raise any matters requiring discussion not captured on the agenda. None were received.

1.6 **Action Tracker**

The Council reviewed the Action Tracker and agreed the five completed actions could be moved to the closed section following the meeting. Murray Macdonald provided an overview of the outstanding actions and their progress updates highlighting that the Model Hospital Data would be covered later on the agenda at item 4.1. The Improvement Plan and Cost Improvement Plan Governor briefing had taken place on 14 July 2026 and the Putting Patients First Ward Accreditation Scheme update was scheduled for the August CoG meeting.

These updates left one outstanding item which was regarding patient transport. Lyn Simpson advised that within the Group Chief Executive's Update there was an update on patient transport services and requested clarification of what aspect of transport the update was required for. Alison Hurley confirmed that it was in relation to patient transport for patients required to attend early morning appointments at hospitals some distance from their home, especially when they may be reliant on public transport.

Mike Bateson requested that all contacts details for transport services were readily available to patients in one place, such as the Trust website. Lyn Simpson agreed this was a reasonable request and agreed to take this as an action as it was easy to assume that families and carers know who to contact. Lyn Simpson confirmed that patient requirements should always be taken into consideration to manage to appointments available. It was noted that transport for patient discharges was managed by senior nurses and matrons and scheduled 24 hours in advance.

Mike Bateson shared his personal experience of travelling from North East Lincolnshire to Castle Hill Hospital for early morning appointments and observed that, on those occasions, the suitability of the arrangements for the patient had not been checked. Lyn Simpson agreed to take an action to discuss this with the nursing and administration services staff to ensure consideration was given to patients to ensure they were able to attend and not assume they could. Kev Allen was also able to provide a similar account from a patient who was repeatedly unable to attend appointments due to transport issues. Lyn Simpson was sorry to hear that the patient's requirements had not been listened to.

Following a meeting between Alan Downey, Paul Bellotti (Chief Executive of East Ridng of Yorkshire Council) and Cllr Anne Handley it had been suggested that a free shuttle service could be a solution to the patient transport issues. Reference was made to a similar service operating between Doncaster and Sheffield hospitals. Given that the two Combined Mayoral Authorities would receive transport funding for the area, including the north bank, opportunities for partnership working were suggested. Brent Huntington supported Cllr Anne Handley's suggestion and noted the existence of a shuttle service between Doncaster Racecourse and Doncaster Infirmary. Murray Macdonald confirmed that it was a very good suggestion that would be considered and discussed further. It was noted that Cllr Anne Handley would be willing to support this as required.

Actions:

- Ensure that patient transport contact details are easily accessible
- Provide feedback to Patient Experience regarding suitability of appointment time and distance/travel to appointments
- Investigate possible shuttle bus services working alongside local authorities and the Integrated Care Board (ICB)

1.7 **Questions submitted from the Public**

Murray Macdonald advised that there had been no questions submitted by the public in advance of the meeting.

2. REPORTS AND UPDATES

2.1 **Group Vice Chair's Update**

Murray Macdonald provided a brief summary of the report and welcomed any questions. None were received.

2.2 **Group Chief Executive's Update**

Lyn Simpson provided an overview of the report which was taken as read and covered the following four areas:

- Improving discharge and patient flow
- Strengthening radiotherapy services
- Same day robotic prostate surgery
- Maternity Review.

Wendy Lawtey highlighted that the Multi-Agency Discharge Events (MADE) had been taking place for three years and queried what would be different this time. Lyn Simpson noted that where the Humber Health Partnership (HHP) had directed focused attention, work had been delivered effectively. It was noted that staff required clear direction on best practice, with an emphasis on embedding changes incrementally to support the development and implementation of the new process.

Kev Allen raised a query regarding the appropriateness of discharge staff requesting volunteers to ensure that a patient used the taxi arranged for their journey home. Additionally, the patient was wearing hospital gowns. Lyn Simpson reported that it was difficult to comment on individual cases although generally it was not appropriate for a patient to go home in hospital gowns. As a matter of dignity they should leave in their own clothes. If a patient has been discharged, there is no reason for a clinical member of staff to be with them although it was unfair to ask a volunteer to take responsibility of the patient when they have their own duties to fulfil.

Murray Macdonald reminded Governors that if they have a specific concern to follow the agreed procedure and raise it through the Foundation Trust Office and not wait for the next CoG meeting. This is to ensure any issues are addressed in a timely manner.

Jackie Weavill drew attention to the relocation of the Discharge Lounge at Scunthorpe General Hospital (SGH), noting that its current location was less accessible for transport than the previous arrangement.

In response to a query from Mike Bateson about the timescale for improvements to radiology services and the concern that the proposed two-year plan appeared to be a lengthy period before meaningful benefits would be realised, Lyn Simpson outlined a link between each business case which created a service improvement. There was a programmed timeline which could be mission critical in terms of access times and quality of service to patients. The key roles would be addressed first and followed by the supporting roles in terms of recruiting the thirty additional colleagues into radiotherapy. Lyn Simpson confirmed that there were conversations still to be had regarding the vacancy freeze and the recruitment of the additional radiotherapy staff due to the difficult financial position, noting it was important to ensure skills were maintained in the correct areas.

Mike Bateson highlighted concerns regarding the potential impact of financial controls on service quality, noting that timely access to diagnostic services is critical to patient diagnosis and subsequent treatment pathways. Lyn Simpson confirmed this issue was taken very seriously by reviewing efficiency and productivity against financial stability. Murray Macdonald highlighted this as one of the most significant discussions currently being undertaken by the Board, as it would help identify priority areas for future investment. It was noted that workforce numbers had increased over the previous five years, while performance had declined, suggesting no clear correlation between increased staffing levels and improved performance.

Lyn Simpson provided an in depth update on the organisational structure and review of the operating model and Care Group arrangements as outlined in the report. The HHP has fourteen Care Groups under the current arrangements, and it was reported that other organisations of a similar size have less, which was contributing to the destabilisation. The reviews presented an opportunity to listen to staff, and the results of the reviews were expected in August.

Ian Reekie suggested that, from both an accountability and patient perspective, there would be merit in having a senior manager with overall responsibility for each hospital site. Lyn Simpson agreed, noting that this was a valid observation and one that had been raised on a number of occasions in relation to the current operating model.

Wendy Lawtey queried whether there was a risk that the three reviews currently being undertaken could result in conflicting recommendations or outcomes. Lyn Simpson considered this risk to be low, noting the widely held view that all three reviews should progress in parallel, with a coordinated approach to ensure alignment and avoid any significant divergence in outcomes.

Brent Huntington highlighted ongoing concerns that patients in Goole continued to be directed to services at other hospital sites, despite those services being available at Goole District Hospital (GDH) and sought assurance that this issue was recognised.

Cllr Anne Handley sought clarification regarding accountability for the Emergency Departments (EDs) and Urgent Treatment Centres (UTCs). Lyn Simpson confirmed that HHP was responsible for the EDs, while the UTC at Goole District Hospital (GDH) was operated by City Health Care Partnership. Cllr Anne Handley advised of an upcoming meeting with Jason Stamp, Chair of Humber and North Yorkshire ICB, to discuss concerns regarding the operation of the UTC, including reports that patients were being turned away early before the closing time. Lyn Simpson emphasised the importance of collaborative working between partner organisations, noting the different commissioning arrangements in place. It was acknowledged that, although accountability for the UTC sat with the ICB, it was appropriate for HHP to raise and discuss feedback received with City Health Care Partnership as NHS partners.

Murray Macdonald reiterated the importance of reporting specific concerns through the Foundation Trust Office, who would ensure that the feedback was escalated to the Group Chief Executive's Office as required.

Actions:

- To review the Volunteer role in relation to patient responsibilities (eg. ensuring a discharged patient accesses their arranged transport)
- Foundation Trust Office to share the CoG Operational Log issues with the Group Chief Executive's office

2.3 **Lead Governor's Update**

Ian Reekie presented the report and referred to work being undertaken by Gatenby Sanderson on the recruitment of a Non-Executive Director (NED) and two Associate NEDs, with an emphasis on attracting strong candidates from the NLaG area. Early indications suggested a positive level of interest.

The Council's attention was drawn to the review of the Governor Engagement Protocol following a governor-related incident referenced in the report. The actions taken by the governor concerned were formally commended.

It was also reported that discussions with Melanie Onn MP and Sir Nic Dakin MP had been well received and had focused on proposals set out in the Health Bill regarding the potential removal of the role of members and Councils of Governors within Foundation Trusts.

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

3.1 Audit, Risk and Governance (ARG) Committees-in-Common (CiC) Highlight Report

Jane Hawkard provided a summary of the report which included updates on the Annual Report and Accounts 2026/26 from the internal and external auditors, the Board Assurance Framework (BAF) and the Cyber Assessment Framework (CAF).

Mike Bateson commended the work of the Committee but noted concerns regarding the pace of improvement. It was also observed that greater clarity was required regarding the Group's digital infrastructure and Mike Bateson queried whether sufficient capacity existed to deliver the required programme of work. Murray Macdonald confirmed that a meeting had taken place on 15 July 2026 to discuss these issues. Jane Hawkard confirmed that there were no overdue actions and extended particular thanks to Hilda Gwilliams, Group Chief Patient Safety Officer for support with the actions. It had been agreed that the digital aspect of work would be transferred to the Performance, Estates and Finance (PEF) CiC with a view to returning to ARG CiC in due course. It was reported that the IT Health Product was being implemented to help document critical software. Jane Hawkard added that interviews were due to take place for the Group Chief Digital Officer in the coming week.

Dietmar Harteveld emphasised that digital transformation should form a core component of the Group's programme of work. Lyn Simpson agreed and confirmed that responsibility for this agenda sat with the Executive Team and Board, where it continued to receive oversight and focus.

Brent Huntington expressed concern regarding patients who were digitally excluded and emphasised the importance of ensuring their needs were fully considered as digital initiatives and service developments progressed.

Brent Huntington sought clarification regarding the limited number of external audit providers with the capacity and expertise to undertake audits for organisations of the scale and complexity of NLaG and HUTH. Jane Hawkard advised that informal market intelligence suggested conditions within the external audit market had improved. However, it remained unclear whether a single audit provider would have the capacity to undertake the audit of the Group as a whole, or whether separate auditors would continue to be required for each Trust.

3.2 **Performance, Estates and Finance (PEF) Committees-in-Common Highlight Report**

Murray Macdonald provided a brief summary of the report which included the new format of Alert, Advise and Assure.

Ian Reekie sought assurance regarding the actions being undertaken to address the 154,000 overdue outpatient appointments and whether appropriate mitigations had been implemented to manage the associated risks. Murray Macdonald reported a deep dive into planned care where Sam Peate, Group Chief Delivery Officer was restructuring and reorganising that entire workload. It was noted that providing assurance would be an overstatement, as the issue had been raised as an alert requiring ongoing monitoring and action. Lyn Simpson added there was a large focus on ensuring effective data quality, shared learning from neighbouring trusts and working with clinicians for follow up. Murray Macdonald explained from a personal experience that Patient Initiated Follow Up (PIFU) allowed patients to feel empowered and be seen in a timely manner. Jackie Weavill expressed concern that communication with patients was not always sufficiently effective in meeting patient needs.

Wendy Lawtey highlighted the lack of detailed timescales in the escalation reports. Murray Macdonald explained that a comprehensive action plan was already in place for the CiC and emphasised that the purpose of the escalation and highlight reports was not to duplicate the detail contained within that plan. Murray Macdonald agreed this could be discussed and considered for future reports.

Action: Timescales to be added to the CiC highlight and escalation reports where it is appropriate/essential. This is particularly in relation to long-standing items which demonstrate little progress

A break took place at 15:39 hours when Henry Anderson left and the meeting resumed at 15:51 hours.

3.3 **Quality and Safety (Q&S) Committees-in-Common Highlight Report**

In the absence of David Sulch, an overview of the report was provided by Murray Macdonald, supported by Julie Beilby. It was noted that improvements had been observed in relation to Patient Experience, with digital exclusion remaining a key area of focus. Julie Beilby recognised and commended the contribution of Hilda Gwilliams, Group Chief Patient Safety Officer. The CiC also highlighted ongoing concerns regarding Infection, Prevention and Control (IPC), including instances where inappropriate cleaning products had been used in response to specific microbial outbreaks.

Ian Reekie queried whether, given the current financial constraints, it was necessary to commission external consultants to review what appeared to be a demand-related issue with regards to the backlog of Patient Advice and Liaison (PALS) and complaints. Lyn Simpson confirmed that the Value Circle review formed part of the support package provided by NHS England (NHSE) and therefore did not incur any additional cost to the Group.

In response to a query from Jackie Weavill about the timescale for addressing the PALS and complaints backlog, Murray Macdonald confirmed there was a timetable included in the Improvement Plan which would be circulated after the meeting.

Julie Beilby reported there was some short term investment for staffing resources to address the backlog.

Kev Allen reported three recent medical incidents at SGH on 10 July 2026, including an incident in which an 80-year-old man suffered a suspected heart attack at the main entrance. It was noted that nearby clinical staff commenced cardiopulmonary resuscitation (CPR), with a trolley on standby. It was reported that ED staff advised to call an ambulance which then took fifteen minutes to arrive. Kev Allen requested that the procedure for such incidents was reviewed and circulated to staff. Lyn Simpson had not been made aware of the incident and would review the procedure alongside Keith Haynes. Lyn Simpson suspected the procedure followed by the ED staff may have reflected indemnity considerations, with reference made to a similar incident experienced at another Trust. It was confirmed that the policy was written by NHSE and adapted for each organisation.

Actions:

- Foundation Trust Office to request and circulate the timetable within the Improvement Plan for the PALS and complaints backlog
- A review of the procedure for medical assistance required on hospital sites to be undertaken by Lyn Simpson and Keith Haynes.

Corrin Manaley left the meeting at 16:06 hours

3.4 **Workforce, Education and Culture (WEC) Committees-in-Common Highlight Report**

Julie Beilby provided a comprehensive summary of the report which was taken as read.

Brent Huntington sought clarification on whether a scoping report would be produced in relation to voluntary redundancy. Julie Beilby confirmed that a report was due to be considered by the Trust Boards-in-Common and noted that any voluntary redundancy scheme would require approval from NHSE. It was reported that options under consideration could include either a Mutually Agreed Resignation Scheme (MARS) or a voluntary redundancy scheme, with this expected to be an early priority for the substantive Group Chief People Officer once appointed.

Brent Huntington sought clarification on the potential for consultants to undertake industrial action. In response, it was noted that it was not currently known whether industrial action by consultants would proceed and, as such, it was not possible to provide a definitive assessment at that stage.

Cllr Anne Handley left the meeting at 16:28 hours

4. COG BUSINESS ITEMS

4.1 **Model Hospital Data and Financial Implications**

Alison Drury delivered the presentation and welcomed any questions.

Cllr Anne Handley queried whether expenditure on agency and bank staff was a key contributing factor to the financial issues being faced. In response, Alison Drury explained that NLaG operated two Emergency Departments compared to

HUTH's single site, resulting in cost differences associated with the duplication of estates, resources and diagnostic facilities, as well as challenges relating to staff recruitment and retention.

Murray Macdonald highlighted that Model Hospital data was one of a number of tools used to inform decision-making. While there was a perception that the Group was primarily finance-driven, assurance was provided that there remained a strong and ongoing focus on quality and safety.

Cllr Anne Handley left the meeting at 16:28 hours

Ian Reekie queried whether comparable benchmarking tools were available for out-of-hospital services, including community-based care. Alison Drury reported that the developed metrics were generally for acute services and there was not a standardised approach for community services. There was however progress with the development of Community Healthcare Resource Group (HRG).

Dietmar Harteveld queried whether the Model Hospital data took account of demographic factors and geographical differences. It was confirmed that the data presented compared HUTH and NLaG performance against regional benchmarks. It was suggested that future comparisons should also include organisations of a similar size and those serving populations across comparable geographical areas to provide greater context.

Alison Drury confirmed that it was the data covered out-of-area patients as it was based on full services provided, in response to a query from Jackie Weavill.

Brent Huntington noted that more effective utilisation of the UTC at GDH could help alleviate pressure on the Emergency Departments at both SGH and Hull Royal Infirmary (HRI).

Lyn Simpson concluded that Model Hospital data was a valuable tool that should be utilised more extensively across the Group. While the data provided significant insight to support service transformation and improvement, it was noted that it should be considered alongside other sources of information and was not a standalone solution to all challenges.

Julie Beilby reported there was appetite from a number of Care Groups to use the Model Hospital data. It was also highlighted that there was a UTC in Louth which was open 24 hours.

Murray Macdonald thanked Alison Drury for the valuable insight the presentation provided.

5. OTHER

5.1 Questions from Governors

Murray Macdonald welcomed any questions from Governors.

Mike Bateson referred to the provision of free visitor parking on Christmas Day in 2021 and requested that consideration be given to implementing a similar arrangement for Christmas Day 2026. Lyn Simpson agreed to reflect on the request and provide an answer at the next CoG meeting.

Dietmar Harteveld requested clarification on supplier payment terms and requested consideration for small suppliers which could be based within our community. Alison Drury advised that the Group adhered to the Better Payment Practice Code, which included a target of paying 95% of invoices within 30 days. It was noted that achieving this target remained challenging in the context of ongoing financial pressures and required a careful balance of priorities. Murray Macdonald agreed that the Group could be an anchor institution to the local community.

A discussion took place regarding progress within the CiCs, particularly the ARG CiC. Jane Hawkard confirmed that a meeting had been held with Murray Macdonald and Keith Haynes, during which it was agreed that the November ARG CiC meeting would be brought forward.

Action: Free visitor parking on Christmas Day 2026 be considered

5.2 **Items for Information / To Note**

Murray Macdonald drew the Council's attention to the items for information noted in Appendix A.

5.3 **Any other Urgent Business**

No items were raised.

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

No items were raised in respect of this matter.

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

Murray Macdonald welcomed any reflections on the meeting.

Murray Macdonald noted a general sense of impatience regarding the pace of change, with a strong focus on delivery and a desire to see tangible improvements and outcomes being achieved.

6. DATE AND TIME OF THE NEXT MEETING

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

The next Council of Governors meeting would be held on Thursday, 20 August 2026 at 16:00 to 17:30 hours virtually via Microsoft Teams

Muray Macdonald thanked those present for their attendance and contributions and the meeting closed at 16:45 hours.

Cumulative Record of Governor / Executive and NED Attendance 2026/2027 - Public

Governors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Ahmed Aftab	2	0	Wendy Lawtey	2	2
Kevin Allen	2	2	Corrin Manaley	2	1
Paula Ashcroft	2	0	Cllr Nigel Oliver	1	0
Mike Bateson	2	2	Emma Mundey	2	0
Marian Davison	2	1	Ian Reekie	2	2
Cheryl George	2	1	Caroline Ridgway	2	0
Cllr Anne Handley	2	2	Dr Sandeep Saxena	2	0
Dietmar Harteveld	2	2	Dr Gorajala Vijay	2	1
Brent Huntington	2	2	Jackie Weavill	2	2
David James	2	0	Clare Woodard	2	0

Executives					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Paul Bunyan	2	0	Emma Sayner	2	1
Keith Haynes	1	1	Mr Peter Sedman	2	1
Alison Hurley	2	2	David Sharif	2	1
Jo Ledger	2	1	Lyn Simpson	2	2
Sam Peate	2	1	Dr Kate Wood	2	0

Non-Executive Directors					
Name	**Possible**	**Actual**	**Name**	**Possible**	**Actual**
Julie Beilby	2	2	Murray Macdonald	2	2
Alan Downey	2	1	David Sulch	1	0
Jane Hawkard	1	1			

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Northern Lincolnshire and Goole
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COUNCIL OF GOVERNORS
ACTION TRACKER

2026/27

ACTION TRACKER - CURRENT ACTIONS - 20 August 2026

COUNCIL OF GOVERNORS

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
COG(26)020	16/07/26	Questions from Governors	5.1	Request for consideration of free Christmas parking for visitors	Tom Myers	Nov-26	Response from Tom Myers: At this time with the financial challenges that we face and the large CIP gap we have in EF&D we are not in a position to be able to provide free parking over the Christmas period.	Complete	Emails
COG(26)019	16/07/26	Quality & Safety CiC Highlight Report	3.3	A review of the procedure for medical assistance required on hospital sites to be undertaken	Lyn Simpson & Keith Haynes / Di Hughes & Simon Treacher	Nov-26	Julie Dobbs, Voluntary Services Manager, advised that the Volunteer advice sheet was reviewed in March 2026 by Tracy Campbell, Site Nurse Director and remained appropriate.	Complete	Email
COG(26)018	16/07/26	Quality & Safety CiC Highlight Report	3.3	Request and provide timetable for addressing the PALS & Complaints backlog	Ben Smith	Jul-26	The PALS Plan on a Page (POP) emailed to Governors on 23 July 2026 along with updates to address the backlog.	Complete	Emails & POP
COG(26)017	16/07/26	Performance, Estates & Finance CiC Highlight Report	3.2	Request for timescales to be included on CiC Highlight Reports - Particularly on long standing items showing little progress	Rebecca Crashley	Jul-26	Rebecca Crashley emailed on 23 July and request noted on 27 July 2026.	Complete	Emails
COG(26)016	16/07/26	Group Chief Executive's Update	2.2	Share the CoG Operational Log issues with the Group Chief Executive's office, as required	Foundation Trust Office	Ongoing	Foundation Trust Office have noted this request and will escalate as required.	Complete	
COG(26)015	16/07/26	Group Chief Executive's Update	2.2	To review the Volunteer role in relation to patient responsibilities (eg. ensuring a discharged patient accesses their arranged transport)	Diane Hughes, Julie Dobbs & Simon Treacher	Nov-26	Julie Dobbs, Voluntary Services Manager, confirmed that part of the Volunteer Guides role is to support a patient who is waiting for transport home, where appropriate.	Complete	Email
COG(26)014	16/07/26	Action Tracker	1.5	Patient Transport - Consider a shuttle service between hospital sites similar to the service at DBTH FT NHS Trust	Tom Myers	Aug-26	Response from Tom Myers: We spent some time early in 2025 looking at various travel options between all Group sites and have discussed these both with the Local Authorities, Stagecoach and other providers. Unfortunately to make them viable for use and running regularly the costs were prohibitive and in the current financial environment are not able to be supported.	Complete	Emails
COG(26)013	16/07/26	Action Tracker	1.5	Provide feedback to Patient Experience regarding suitability of appointment time and distance/travel to appointment	Simon Treacher & Jackie France		Feedback provided via email on 22 July 2026.	Complete	Emails
COG(26)012	16/07/26	Action Tracker	1.5	Ensure contacts details for patient transport services are easily accessible	Comms	Jul-26	Patient transport - Northern Lincolnshire and Goole NHS Foundation Trust Comms advised that there is a page on the Trust website.	Complete	Email and website
COG(26)011	15/04/26	Putting Patients First - Ward Accreditation	4.3	Plan a future update of the programme once the pilot phase is complete	Foundation Trust Office / Michelle Drinkell	Aug-26	Pilot phase May - July 2026 - Michelle Drinkell suggested a further update July or August. On agenda for 20 August 2026 CoG meeting.		Emails
COG(26)010	15/04/26	The Group's Plan for Stabilisation	4.1	Arrange Governor briefing session for the Improvement Plan and Cost Improvement Plan	Foundation Trust Office	May/Jun	Governor briefing session delivered on 14 July 2026.	Complete	Emails & Presentations
COG(26)008	15/04/26	Interim Group Chief Executive's Update	2.2	Provide feedback on transport at the July CoG meeting	Lyn Simpson	Jul-26	Update provided by Lyn Simpson during the 16 July CoG meeting.	Complete	July CoG minutes
COG(26)002	08/01/26	Performance, Estates and Finance CiC Highlight Report	3.4	Consider briefing session to review comparative data for the model hospital	Lyn Simpson	Apr-26	Presented at the 16 July 2026 CoG.	Complete	CoG paper CoG(26)062

Key:

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

ACTION TRACKER - CLOSED ACTIONS

Council of Governors

NHS Hull University Teaching Hospitals NHS Trust

NHS Northern Lincolnshire and Goole NHS Foundation Trust

Minute Ref	Date / Month of Meeting	Subject	Action Ref (if different)	Action Point	Lead Officer	Target Date	Progress	Status	Evidence
COG(26)012	15/04/26	Questions from Governors	6.1	Provide an email response to the three Governor questions submitted on 14 April 2026	Foundation Trust Office	Apr-26	An email response was provided on 16 April and 20 April which covered all three questions.	Complete	Emails
COG(26)009	15/04/26	The Group's Plan for Stabilisation	4.1	Request and share the Improvement Plan presentation	Foundation Trust Office	Apr-26	The presentation was shared via email with Governors on 16 April 2026	Complete	Email
COG(26)007	25/02/26	CoG ARM - Summary	4.7	Arrange a Governor briefing session the the Accountability & Holding to Account role	Foundation Trust Office	May-26	Governor Briefing session held on 10 June 2026.	Complete	Emails
COG(26)006	25/02/26	CoG ARM - Conduct of Meetings	4.4	Arrange a Governor briefing with Jason Stamp, Integrated Care Board (ICB) Chair	Foundation Trust Office	May-26	Governor Briefing session held on 27 May 2026.	Complete	Emails
COG(26)003	08/01/26	Quality & Safety Committees-in-Common Highlight Report	3.5	Consider a flowchart to outline where and how clinical decisions are determined	Murray Macdonald	Apr-26	Addressed at the 15 April CoG meeting - agenda item 4.1	Complete	CoG paper: CoG(26)040
COG(26)005	25/02/26	CoG ARM - Accountability	4.3	Share the legal definition of private versus public topics and/or documents	Foundation Trust Office	Feb-26	Legal definition of of private versus public shared via email after the CoG ARM on 25 February 2026.	Complete	Emails
COG(26)004	25/02/26	CoG ARM - Engagement wih Members & Stakeholders	4.2	Plan & progress CoG Patient Administration and Patient Experience project	Foundation Trust Office		This action has been transferred to the Membership and Public Engagement & Assurance Group (MPEAG) for monitoring and management.	Complete	MPEAG Action Tracker & Emails
COG(26)001	08/01/26	Interim Group Chair's Update	2.1	Request an update for the link corridor at SGH which should have opened	Foundation Trust Office	Jan-26	Response provided by Senior Project Manager and shared via email to Governors/NEDs on 14 January 2026.	Complete	Emails

Key:

Grey	Completed - can be closed/archived following meeting

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)072

Name of the Meeting	**Council of Governors**
Date of the Meeting	20 August 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Alison Hurley, Group Deputy Director of Assurance
Title of the Report	**Governor Elections and Lead Governor Update**
Executive Summary	This report provides an update and overview of the Governor elections due in November 2026 and sets out the legal and governance context arising from the Health Bill introduced to Parliament on 14 May 2026. The current Lead Governor's term of office is also due to expire in November 2026, which means that the Lead Governor role will require appointment/election. **Recommendation** Members are asked to: • Note the elections update and overview especially the current legislative position and the uncertainty pending the passage of the Health Bill through Parliament • Agree to hold the November 2026 elections (whilst minimising costs where possible, including through proportionate publicity and use of existing communication routes) for the detailed reasons outlined in the report • Consider the option to include a "validity of acts" clause in the NLaG Constitution • Note the appointment/election of the Lead Governor will progress following the elections (as of November 2026).
Background Information and/or Supporting Document(s) (if applicable)	NLaG Trust Constitution and Model Rules for Election NHS Act 2006, Health Bill and associated Department of Health and Social Care (DHSC) fact sheets
Prior Approval Process	N/A
Financial implication(s)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	✓ Approval ✓ Information ☐ Discussion ☐ Review ✓ Assurance ☐ Other – please detail below:

Governor Elections update and overview 2026

1. Purpose

The purpose of this paper is to update the Council of Governors (CoG) on the annual Governor elections due in November 2026, the implications of the Health Bill, and the options available to maintain lawful and effective governance during the interim period before any legislative changes are enacted.

2. Background

The Health Bill was introduced to the House of Commons on 14 May 2026 and is progressing through Parliament. The Bill forms part of the Government's wider NHS modernisation agenda and includes provisions intended to reform the Foundation Trust (FT) model.

The Bill, if approved, would remove the requirement for FTs to have CoGs and members. The expected date for this would be as of 1 April 2027 dependent upon the Bill completing all Parliamentary stages and receiving Royal Assent by then. At present, the Bill had its second reading in the House of Commons on 1 June 2026 and is now at the Committee stage before the report stage and third hearing. It will then progress through the House of Lords and Royal Assent is expected to be received by the end of December 2026.

3. Annual Governor elections

As part of the annual Governor elections, plans are underway to review the seats up for election in November 2026 as per the Trust Constitution and Model Rules for Election.

Due to the uncertain future for CoGs and the potential for them to be abolished as of 31 March 2027, Trusts have been asked to continue business as usual but consider if elections are essential or whether quoracy could be maintained if they were to be postponed etc., with CoG approval. This advice has come from various sources including NHS England and NHS Alliance. Some Trusts have agreed to postpone their elections already, other Trusts have reduced and 'right sized' the composition of the CoG to cover the essential constituency seats whilst still ensuring quoracy, which in the case NLaG is nine Governors of which five must be public governors.

The composition of the Council of Governors is as set out below, with 11 seats due for election in November 2026 across three public constituencies and the staff constituency:

Electing/Appointing Body	Number of Governors	Vacancies as at November 2026
Public Constituency Governors		
North East Lincolnshire Constituency	5	2 seats (1 for re-election)
North Lincolnshire Constituency	5	3 seats
East and West Lindsey Constituency	3	3 seats (1 for re-election)
Goole and Howdenshire Constituency	3	0 seats
Staff Governors	4	3 seats
Partnership Organisations		
North East Lincolnshire Health and Care Partnership	1	
North Lincolnshire Health and Care Partnership	1	
Qualifying Local Authority Governors		
East Riding of Yorkshire	1	
Lincolnshire	1	
North East Lincolnshire	1	
North Lincolnshire	1	
Total Number of Governors and seats for election	**26**	**11 vacancies including eight for potential re-election**

If all current Governors whose terms of office are due to expire in November were to re-stand in the elections, then three seats would remain vacant: two in East & West Lindsey and one in North East Lincolnshire.

4. Consideration of the options

- **Postpone the elections**

  If approved by a majority of CoG members, a decision could be made to extend the current terms of office of Governors who are due for election as of November 2026 until 31 March 2027, where they are willing to continue. This would provide continuity and avoid the election and any associated costs. However, the primary legislation specifically provides for a maximum term of office of an elected governor as three years. Consequently, any non-elected governor is effectively co-opted on to the CoG and would not have any voting rights in the event of decisions having to be taken.

  In circumstances where governors are not re-elected but co-opted, consideration would need to be given to quoracy arrangements for CoG meetings and decision-making purposes. As stated, the quoracy currently is nine governors, five of whom must be public governors. If the elections do not proceed and taking into account governor vacancies this would result in there being eight public governors, one staff governor and one local authority governors, a total of 10 voting governors with a required quoracy of nine governors. However, there only be one of three legislated Staff Governors required for the composition of the CoG.

  It should be noted that whilst this approach has been used in the past, during Covid in 2020 and also to avoid bi-elections during the year in 2024 (allowing all elections to be

held in November each year), on these occasions this only related to one or a small number of Governors. On this occasion, it relates to 11 Governor seats up for election, including three of the four staff Governor seats.

Consideration has also been given to reducing quoracy and changing the composition of the CoG. Any change in quoracy and/or composition based on the remaining number of elected governors would impact on the number of governors who were able to participate in CoG business, and at a time when the CoG may to consider important strategic matters.

Operating outside the usual legislative and constitutional provisions would also be usefully supported through the inclusion in the NLaG Constitution of a "validity of acts" clause. This is a protective clause which provides that the acts, decisions or proceedings of the Trust remain valid despite a vacancy among governors or directors, or a defect in the appointment or election of a governor or director. In practical terms, it helps reduce the risk that otherwise lawful decisions could be challenged solely because of a technical vacancy or appointment issue. It would not remove the need to comply with the Trust Constitution and relevant statutory requirements, but it would provide additional assurance in the event of unavoidable vacancies or interim governance arrangements. Currently there is no such clause in the NLaG Constitution and it would be sensible to make provision for this going forward. This could be addressed by the inclusion of the following in the Constitution:

> 10.4 The validity of any act of the Trust is not affected by any vacancy among the Council of Governors or by any defect in the appointment or election of any Governor.
>
> 24.5 The validity of any act of the Trust is not affected by any vacancy among the Board of Directors or by any defect in the appointment of any director.

For the reasons outlined above, particularly in order to avoid an impact on quoracy and to avoid the CoG potentially operating with such reduced governor numbers, it is recommended that the elections scheduled for November should not be postponed.

- **Proceed with Annual Elections**

Accordingly, it is recommended that the elections scheduled for November 2026 be held. This provides the most conventional route under existing arrangements but may result in governors serving only a short period if legislation takes effect on 1 April 2027. Efforts will be made to ensure that the costs of running the election are minimised where possible. This will include utilising a proportionate approach to election publicity by using the Trust website and direct member communications where required and avoiding unnecessary print or postal activity where this is not required. The position will also be kept under review with the election provider so that any additional expenditure is only incurred where necessary, for example if a contested election requires further promotion to support participation. If the elections are held and are uncontested, the costs are estimated to be under £1,500 in total.

5. Lead Governor term of office

The current Lead Governor's term of office is due to expire in November 2026. As the current Lead Governor has been in this role for the maximum term of six years, this role will require appointment/election for the next three year term and consideration of the timelines required. Further details are captured in the Criteria & Process for the Appointment of a Lead Governor document at Appendix 1.

6. Conclusion

The Health Bill creates a significant and time-limited uncertainty for FT governance. The CoG will remain a statutory and constitutional body until legislation changes the current position and the most proportionate approach is therefore to maintain continuity and lawful governance while avoiding unnecessary election costs where legally permissible.

For the reasons outlined above, at present the most effective approach for the current CoG composition and quoracy and to address the 11 Governor seats due for re-election in November, is to proceed with the planned elections, whilst keeping costs to a minimum where possible through proportionate publicity, use of existing communication channels and close oversight of election administration costs.

7. Recommendation

Members are asked to:

- Note the elections update and overview especially the current legislative position and the uncertainty pending the passage of the Health Bill through Parliament;
- Agree to hold the November 2026 elections (whilst minimising costs where possible, including through proportionate publicity and use of existing communication routes) for the reasons outlined above;
- Consider the option to include a "validity of acts" clause in the NLaG Constitution;
- Note the appointment/election of the Lead Governor will progress following the elections (as of November 2026).

Humber Health Partnership

Criteria and Process for the Appointment of a Lead Governor

Document control use only	
Reference	DCM116
Directorate / Care Group	Corporate Assurance
Version	1.7
Result of last review	Minor changes
Issue date	28/07/25

Author / Owner Use Only	
Group or Trust specific document	NLaG
Date approved by owner (for minor changes only outside committee)	24/06/25
Date approved	16/04/19
Approving body	Council of Governors
Next full review date	June, 2028
Lead Director	David Sharif, Group Director of Assurance
Document type	Miscellaneous
Author / Contact	Alison Hurley, Deputy Director of Assurance
Key words	Criteria and Process for the Appointment of a Lead Governor

Printed copies valid only if separately controlled

Contents

Section Page

1. Introduction

1.1 The proposal to introduce Lead Governors, who would have a role in specific circumstances, was first suggested by Monitor in their consultation 'Guide for NHS Foundation Trust Governors: Meeting Your Statutory Responsibilities', which closed in July 2009.

1.2 Examples provided by Monitor* of the specific circumstances where the lead Governor would have a role include:

- Leading the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another one of the Non-Executive Directors to lead. [Monitor suggests that these occasions are likely to be in-frequent but one example cited by Monitor is a meeting to discuss the appointment of the Chair]
- Where the Council of Governors decides that they wish to communicate directly with Monitor, but for whatever reason it is decided by the Governors that the usual channel (through the Chair) is not warranted. Likewise, where there is direct communication by Monitor with Governors, and in circumstances where for whatever reason this may not be appropriately channelled through the Chair (the normal route). Monitor plans to communicate through the Lead Governor. [Monitor have clarified that routine communication from Monitor to Governors will, as a matter of course, be disseminated via board secretaries. Further, that the existence of a Lead Governor does not, in itself, prevent any Governor from making contact directly with Monitor if they feel it is necessary.]

  *Monitor became part of NHS England as of 1 July 2022, and will be noted as NHSE for the remainder of the document.

1.3 The process and criteria for the appointment of a Lead Governor within Northern Lincolnshire & Goole NHS Foundation Trust (NLAG) is as outlined in the following sections.

Note: See annex 6 (Standing Orders for the Practice and Procedure of the Council of Governors).

2. Criteria

2.1 The Council of Governors shall select a public governor to undertake the role of Lead Governor of the NLAG. This will ensure greater independence, that adequate time is committed to this role (which may potentially be an issue for both Staff and Stakeholder Governors) and also avoid potential conflicts of interest which may arise for Staff Governors. An outline of the responsibilities of the Lead Governor is provided at **Appendix A**, although these are subject to change should further guidance be received from NHSE.

2.2 Governors wishing to undertake the role of Lead Governor must be:

- Able to commit time to this role
- Prepared to acquire a detailed knowledge and understanding of Foundation Trust governance arrangements/requirements and their role and responsibilities within those arrangements
- Prepared to acquire a detailed knowledge and understanding of current issues within the Trust and the wider Integrated Care System (ICS)
- Able to act as a point of contact for NHSE should the regulator wish to contact the Council of Governors on an issue for which the normal channels of communication are not appropriate
- The conduit for raising any Governor concerns with NHSE that the Foundation Trust is at risk of significantly breaching the terms of its authorisation, having made every attempt to resolve any such concerns locally

2.3 Desirable personal qualities for a Lead Governor include:

- Excellent interpersonal and communication skills
- The ability to deal with potential conflicts
- A willingness to challenge constructively
- The ability to influence and negotiate
- The ability to command the respect, confidence and support of their governor colleagues
- The ability to represent the views of governor colleagues and present a well-reasoned argument as required
- Be committed to the success of the Foundation Trust

3. Process

3.1 The Lead Governor shall be chosen by the Council of Governors, who will also approve the process for the appointment.

3.2 The process for the selection and appointment of the Lead Governor shall be as follows below.

3.2.1 The Lead Governor shall be elected by their peers at the last general meeting of the Council of Governors prior to the expiry of the incumbent Lead Governor's term of office or via e-mail if required due to timescales. Where there is to be a change of incumbent, the newly elected Governor shall hold office as shadow Lead Governor whilst the incumbent Lead Governor completes their term in office. Where a ballot is required, all Governors present shall be entitled to vote. The Group Chair (or Trust Vice Chair if presiding as Chair of the Council of Governors) shall not participate in the ballot but shall have a casting vote in the event of a tie.

3.2.2 At least one calendar month before the date of the meeting of the Council of Governors the Group Director of Assurance shall contact e-mail all Governors inviting nominations together with a short election statement.

3.2.3 Where more than one nomination is received, ballot papers showing the names of all the nominated candidates shall be distributed with the papers for the meeting and a secret ballot shall be conducted at the meeting. The Group Director of Assurance, or their nominee, shall act as returning officer and shall announce the results of the election before the close of the meeting when completed ballot papers will be made available for scrutiny by Governors as required. Where there is only one nomination, the Council of Governors shall be asked to ratify the appointment.

3.2.4 Once elected in accordance with paragraph 3.2.2 above, the shadow Lead Governor's term as Lead Governor shall commence upon the expiry of the incumbent Lead Governor's term of office.

3.2.5 The appointment as Lead Governor shall be for a period of three years or:

- Until the end of that Governor's current term of office whichever is the sooner; or
- Until they resign the position of Lead Governor by giving notice to the Group Chair in writing; or
- Until they are removed from the position of Lead Governor by a resolution passed by a two thirds majority of the remaining governors at a general meeting of the Council of Governors; or
- In the event of the term of office of the Lead Governor ending as a consequence of expiry of his/her term of office as a Governor, the retiring Lead Governor may stand for re-election if re-elected as a Governor.

3.2.6 The Group Director of Assurance shall be responsible for notifying NHSE of a change of Lead Governor.

4. References

Trust Constitution: Annex 6 (Standing Orders for the Practice and Procedure of the Council of Governors).

5. Equality Act (2010)

5.1 NHS Humber Health Partnership (the Hull University Teaching Hospitals NHS Trust and the Northern Lincolnshire and Goole NHS Foundation Trust) is committed to promoting a pro-active and inclusive approach to equality which supports and encourages an inclusive culture which values diversity.

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

5.3 The Partnership 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.

5.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably for any reason, including the "protected characteristics" as defined in the Equality Act 2010 (such as by reason of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual Orientation). These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

NB. It is the responsibility of the document author / contact to carry out an Equality Impact Assessment (EIA) and if there is no impact identified, it is recommended to include the following statement: 'As part of its development this document and its impact on equality has been analysed and no detriment identified'.

6. Freedom to Speak Up

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this document, please speak in the first instance to your line manager (if appropriate). The different ways to speak up and guidance on raising concerns are available in the Freedom to Speak Up in the NHS and Raising Concerns at Work policies. Staff can also contact either the NLaG or HUTH Freedom to Speak Up Guardians in confidence. Further details about how to raise concerns and the contact details of the Guardians are available on the Group intranet, Bridget: Freedom to Speak Up Guardians - Bridget.

Appendix A

Responsibilities of the Lead Governor

An indicative outline of the responsibilities of the Lead Governor is detailed below. The Trust and the Lead Governor shall have reference to Appendix B of Monitor's publication "The Foundation Trust Code of Governance" March 2010 (as amended and/or reissued or revised from time to time) in respect of the responsibilities of the Lead Governor and the discharge of them:

- To lead the Council of Governors in circumstances where it may not be considered appropriate for the Chair or another one of the Non-Executive Directors to lead (e.g. chairing a meeting to discuss the appointment of a new chair) and to act as the point of contact with NHSE where it is decided by the Governors or NHSE that the usual channel (through the Chair) is not appropriate
- To chair the Membership and Public Engagement & Assurance Group MPEAG) and Appointments and Remuneration Committee
- On behalf of the Council of Governors, to attend the monthly meetings with the Group Chair and the Group Director of Assurance
- On behalf of the Council of Governors, to raise issues for discussion at the Trust Boards-in-Common
- To assist the Group Chair in facilitating the flow of information between the Trust Boards-in-Common and the Council of Governors
- Work with the Group Chair to draft the Council's commentary for inclusion in the Quality Report

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)073

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	20 August 2026
Director Lead	Hilda Gwilliams, Group Chief Patient Safety Officer
Contact Officer/Author	Michelle Drinkell – Lead Nurse Accreditation
Title of the Report	**Putting Patient First – Accreditation Progress Report**
Executive Summary	**Pilot Progress** The Putting Patients First Accreditation Programme launched on 1st of May 2026 across 22 inpatient wards spanning 5 hospital sites. Development of bespoke accreditation frameworks is underway for Critical Care, Paediatrics, Theatres and Emergency Departments, ensuring standards are tailored to specialist services. Specialist service rollout begins in August and September 2026, with Critical Care and Paediatrics launching first, followed by Emergency Departments and Theatres. Pilot wards are nearing completion of Stage 1 Self-Assessment, with baseline compliance data expected from 28th of August 2026. 10 areas have completed self-assessment and are awaiting Stage 2 review meetings, 9 areas remain on track to complete by 28th of August and 4 areas require additional support and may need extended timelines. Stage 2 – Improvement Journey focuses on supporting teams to develop and deliver improvement plans following self-assessment findings, with access to leadership, safety and improvement support through the Learning, Improvement and Safety Academy (LISA) programme. Teams will have up to six months to implement improvements identified through accreditation action plans. **Gap Analysis** A short gap analysis has informed revisions to the accreditation standards, incorporating quality priorities, new workstreams and broader patient safety metrics. Training and support have been strengthened through enhanced guidance, one-to-one spreadsheet navigation sessions and practical resources. Strong Care Group leadership engagement has been identified as a key factor influencing successful progress and programme sustainability therefore, action on embedding accreditation through existing governance is ongoing to ensure ward and department accreditation progress is discussed in care group governance agendas.

	Next Steps Cohort 2 is proceeding as planned, with only minor adjustments due to ward relocations. Monthly compliance reporting will commence from September 2026, using ward scorecards and Care Group dashboards to monitor progress toward the target of 90% compliance and readiness for formal accreditation visits. **Overall Position** The programme remains on track to deliver its objectives of improving safety, quality and patient experience, with strong engagement across pilot areas and the first compliance data due later this month.
Background Information and/or Supporting Document(s) (if applicable)	The NHS Humber Health Partnership's *Putting Patients First* (PPF) Accreditation Programme is a cornerstone of the Group's work on patient safety and quality standards. The purpose of the programme is to continuously improve and provide the highest standards of care. The framework comprises of key quality standards set out across the Care Quality Commission (CQC) 5 Key Lines of Enquiry (KLOE). Data is collected from a variety of sources and metrics to form part of a self-assessment spreadsheet, Improvement plan and accreditation application. This is then followed by a formal accreditation visit and recognition rating based on compliance across key quality standards and metrics.
Prior Approval Process	NA
Financial implication(s) (if applicable)	NA
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	These standards are designed to deliver gold-standard care to all patients, taking account of patients' individual care needs and working on a patient-centered basis.
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Putting Patients First
Accreditation Programme

NHS
Humber Health Partnership

Putting Patients First – Accreditation Progress Report

1. Accreditation Programme

On the 1st of May 2026 the NHS Humber Health Partnership's *Putting Patients First* Accreditation Programme was launched on 22 inpatient wards spanning across 5 hospital sites within the group.

Ward areas included:

HRI	CHH	DPOW	SGH	GDH
• Ward H7 • Ward H8 • H60 • H100 • H120 • FAB • AMU	• Ward C1 • Ward C14 • Ward C16 • Ward C30 • Ward C32	• Amethyst • Ward C3 • Ward B2 • Ward C5 • Ward B6	• Ward 23 • Ward 25 • Ward28 • Stroke	• Ward 3

Work also began on developing bespoke self-assessment spreadsheets for Critical Care, Paediatrics, Theatres and Emergency Care Departments. It is important that each of the accreditation assessments measured standards specific to each specialist area, therefore stakeholder groups were held to ensure involvement of the Care Group Senior Leadership Teams.

The programme roll out for Theatres will take a considered approach due to the volume of areas; a schedule will be developed to ensure all Theatres have a planned start date following a review of the pilot area progress through stage 1 (self-assessment).

Specialist areas due to launch in August and September 2026 include:

Cohort 1 August/September	Cohort 2 – September/October

• **Critical Care**
  • CICU2
  • ICU (SGH)
• **Paediatrics**
  • Woodlands
  • Acorn
  • Rainforest
  • Disney
	• **Emergency Department**
	  • DPOW
	  • SGH
	• **Theatres** (Groupwide staggered approach)
	  • GDH Main Theatre
	  • Urology & Gynae Th 9 & 10
	• **Critical Care**
	  • CICU1
	  • ITU &HDU DPOW

Further work is being planned to review bespoke methodologies for support services, outpatients' services - including day case areas, community services and maternity services.

There have been challenges with the roll out to specialist areas and other patient and support services due to the complexity of the spreadsheet, limited resources and capacity to develop the spreadsheets whilst training and supporting those areas currently on or due to join the programme.

2. Pilot Progress

2.1 Stage 1 – Self-Assessment

Stage 1 of the framework is a self-assessment to be completed with 3 Months comprising of key quality standards individually marked to provide a score for Safe, Effective, Responsive, Caring and Well-led – this then populates an overall score for the area. The programme covers 34 sets of standards in total, which include as an example, Medications Management, Infection, Prevention and Control, Shared Direction and Culture, Kindness Compassion and Dignity and Supporting People to Live Healthier Lives.

The pilot areas are coming to the end of stage 1 and baseline compliance scores will be available for reporting from the 28th of August. Each area will have an accreditation scorecard with compliance scored across each standard, domain and overall percentage.

Example scorecard:

KEY SUMMARY

OUTCOME KEY: ● = 90 – 100% ● = below 90%

[redacted]EMPLATE 2026-7 Ver.2.0

SAFE		EFFECTIVE		CARING		RESPONSIVE		WELL-LED		OVERALL
●		●		●		●		●		●
Overall Score for Domain	81%	Overall Score for Domain	90%	Overall Score for Domain	86%	Overall Score for Domain	84%	Overall Score for Domain	82%	84%
SAFE	%	EFFECTIVE	%	CARING	%	RESPONSIVE	%	WELL LED	%	
Infection Prevention and Control	91%	Assessing needs	73%	Independence, choice and control	78%	Care provision, integration and continuity	100%	Capable, compassionate and inclusive leaders	88%	
Involving People to manage risk	79%	Consent to care and treatment	100%	Kindness, compassion and dignity	100%	Equity in access	50%	Environmental sustainability - sustainable development	100%	
Learning Culture	83%	Delivering evidence-based care and treatment	80%	Responding to people's immediate needs	67%	Equity in experiences and outcomes	100%	Freedom to speak up	100%	
Medicines Management	78%	How staff, teams and services work together	89%	Treating people as individuals	100%	Listening to and involving people	75%	Governance, management and sustainability	50%	
Safe and Effective Staffing	100%	Monitoring and improving outcomes	100%	Workforce, wellbeing and enablement	83%	Person-centred care	60%	Learning, improvement and innovations	50%	
Safe Environments	50%	Supporting people to live healthier lives	100%			Planning for the future	100%	Partnership and communities	67%	
Safe Systems Pathways and Transitions	69%					Providing information	100%	Shared direction and culture	100%	
Safeguarding	100%							Workforce, equality, diversity and inclusion	100%	

2.2 Stage 2 – Improvement Journey

Once the teams in cohort 1 have completed their Self-Assessment, they will meet with the Core Accreditation Team to review the information and ensure all elements are completed. The spreadsheet will then be filtered to provide an accreditation action plan with information provided on how to update the plan and signposting to teams that can support with improvements. The Learning, Improvement and Safety Academy (LISA) have developed a Clinical Accreditation Support Programme of leadership development, team effectiveness, safety training and improvement support. This will bring together clinical education, medical education and organisational development, where teams can access the skills, tools and support needed to deliver safe, high-quality, reliable care.

It is expected that the Nurse Directors, Deputy Nurse Directors and Matrons will keep an oversight of progress with actions and updating of action plans during the improvement journey and ensure issues are flagged up to medical, AHP and operational colleagues as appropriate. This should become part of 'business as usual' with the monitoring and progress regularly discussed at governance meetings within the care group. Teams will have 6 months to put in place any necessary improvements.

2.3 Progress updates

Of the 22 areas included in the pilot we have 10 that have completed their self-assessment and awaiting stage 2 progress meetings, 9 on track for completion of self-assessment by the 28th of August and 4 areas requiring additional support and may need extended timelines.

Awaiting Stage 2 Meeting	Working Towards Target	Support Needed
• Ward B6	• Ward C3	• Amethyst
• Ward B2	• Ward C30	• Ward C14
• C1 Complex Rehab	• Ward 28	• Ward H100
• Ward C16	• Stroke (SGH)	• Ward H120
• Ward C30	• H7	
• Ward 25	• H60	
• Ward 23	• Ward 3	
• Ward H8	• Ward C5	
• FAB		
• AMU		

3. Gap Analysis

A short Gap analysis based on feedback and challenges raised throughout the pilot has been completed alongside the pilot phase. Following discussion at the Accreditation Steering Group this analysis has informed revisions to the accreditation standards incorporating quality priorities, new workstreams, and a broader review of available data and patient safety metrics.

Suggested improvements to initial training, made by the pilot areas, has been considered with 1:1 navigation of the self-assessment spreadsheet now provided,

and training resources with how-to guides developed to support areas to remain on track at each stage.

Strong Care Group leadership engagement has been identified as a key factor influencing successful progress and programme sustainability therefore, further action on embedding accreditation through existing governance is ongoing to ensure ward and department accreditation progress is discussed in care group governance agendas.

4. Cohort 2

Cohort 2 is being launched as per schedule with some minor changes to the proposed areas at HRI and SGH due to ward moves planned for maintenance within the environment.

Cohort 2 areas include:

HRI	CHH	DPOW	SGH
• Ward H6 • Ward H4 • Ward H10 • Ward H9 • Ward H40 • Ward H80 • Ward H130E • Ward H12	• Ward C7 • Ward C9 • Ward C10 • Ward C20 • Ward C26 • Ward C33	• Ward C6 • Ward B3 • Ward A1 • Stroke Ward	• Ward 5 • Ward 22 • Ward 29 • Ward 27

5. Compliance and Improvement

From September 2026 the first cohort of compliance data will be available for reporting. Care Group dashboards have been discussed and agreed at Nursing, Midwifery and Allied Health Professional Board and The Accreditation Steering Group for recording purposes. Data will be pulled from the individual ward areas scorecards and added to the relevant care group dashboards each month. Improvements in compliance should be evident as areas work through their action plans towards a 90% compliance and readiness for a formal accreditation visit by the multi-disciplinary team.

The Accreditation Programme currently remains on track for delivery of key aims and objectives to improved safety, quality, and patient experience through improved clinical, safety and well-led standards.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)074

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	20 August 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Alison Hurley, Group Deputy Director of Assurance
Title of the Report	**Council of Governors and Trust Board Engagement Policy (DCP231)**
Executive Summary	The Engagement Policy outlines the mechanisms by which Governors and the Trust Board will interact and communicate with each other. This will support ongoing interaction and engagement, and takes into account the statutory role of Governors and their duty to hold Non-Executive Directors individually and collectively to account for the performance of the Board of Directors. The policy has been reviewed and updated as per the usual Document Control cycle. The Council of Governors is asked to note the updated document for information.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	Minor updates approved by the author.
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

COUNCIL OF GOVERNORS & TRUST BOARD ENGAGEMENT POLICY

Document control use only	
Reference	DCP231
Directorate / Care Group	Directorate of Corporate Assurance
Version	2.2
Result of last review	Minor changes
Issue date	

Author / Owner Use Only	
Group or Trust specific document	NLaG
Date approved by owner (for minor changes only outside committee)	23 April 2026
Date approved	29 July 2026
Approving body	Council of Governors / Trust Board
Next full review date	29 July 2029
Lead Director	David Sharif, Group Director of Assurance
Document type	Policy
Author / Contact	Alison Hurley, Group Deputy Director of Assurance
Key words	Council of Governors, Trust Board, engagement policy

Contents

1.0 PURPOSE

This policy:

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

2.0 AREA

2.1 Holding to Account definition

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

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

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

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

2.2 Raising Concerns/Resolution of Disputes

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

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

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

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

3.0 DUTIES IN RELATION TO COMMUNICATION AND ENGAGEMENT

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

3.2 Trust Chair/Vice Chair

The Trust Chair/Vice Chair:

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

3.3 Chief Executive

The Trust Chief Executive:

- ensures the provision of information and support to the Trust Board and Council of Governors and ensures that Trust Board's decisions are implemented.
- facilitates and supports effective joint working between the Trust Board and Council of Governors.
- supports the Trust Chair in their task of facilitating effective contributions and sustaining constructive relations between Executive and Non-Executive members of the Trust Board, elected and appointed members of the Council of Governors and between the Trust Board and Council of Governors.
- with the Trust Chair, ensures that the Council of Governors and Trust Board receive accurate, timely and clear information that is appropriate for their respective duties.
- with the Trust Chair, constructs the agendas for both the Trust Board and Council of Governors (with the input of others as appropriate).

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

3.4 Senior Independent Director

The Senior Independent Director:

- can act as an alternative source of advice to Governors from the Trust Chair.

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

3.5 Governors

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

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

3.6 Director of Assurance

As Trust Secretary for the Trust, the Director of Assurance shall:

- be a further point of contact for any Governor or group of Governors who wish to raise a concern covered by this policy, and where possible, resolve the matter informally and/or advise as to whether it is appropriate to the take the concerns to the Chair; and

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

4.0 ACTIONS

4.1 Holding to Account

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

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

- Governors are responsible for appointing the Chair and other Non-Executive Directors and may also remove them in the event of unsatisfactory performance.
- Governors have the right to receive the annual report and accounts of the Trust and can use these as the basis for their questioning of Non-Executive Directors.
- Governors have the power to appoint or remove the external auditor.
- Directors must take account of Governors' views when setting the operational and financial plan for the Trust, giving Governors the opportunity to feed in the views of Trust members and the public and to question the Non-Executive Directors if these views do not appear to be reflected in the strategy. Where Directors put a proposal in the forward plan for an activity outside of the principal purpose of the Trust, the Governors must decide whether carrying on the activity, to any significant extent, interferes with the Trust's principal purpose, and must notify the Directors of its determination. However, Governors should understand there may be valid reasons why member views cannot always be acted upon. Governors and Non-Executive Directors should have enough time to discuss these matters so Governors can be satisfied with the reasons behind the Board decisions.
- Governors have the power of approval on any proposal by the Trust Board to increase non-NHS income by 5% a year or more. They therefore need to be satisfied with the reasons behind any such proposals.

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

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

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

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

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

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

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

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

- the attendance of the Non-Executive Directors at the annual review of performance of the Council of Governors.

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

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

- involvement of Governors in the Trust's strategy and planning process through the holding of an annual planning / briefing session for Governors led by the Group Chief Financial Officer.

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

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

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

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

- the holding of Governor briefing and training opportunities, not least in order to ensure that Governors are equipped with the skills and knowledge they require in order to fulfil their role.

- the attendance of the Chair of the Membership and Public Engagement & Assurance Groupat meetings to set the agenda for the Council of Governors.

- each Council of Governors meeting to include a briefing(s) for Governors from the Trust Chair, Chief Executive or appropriate Executive Director or senior officer.

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

- the provision of an annual report to the Council of Governors from each Trust Board committee Chair to include the outcome of the annual review of performance and in turn a report to the full Council of Governors.

- Governors have elected a Lead Governor (and a Deputy Led Governor to deputise when the Lead Governor is unavailable). This role has specific responsibilities in terms of Governor and Board engagement built into the role description for this position. Joint meetings regularly take place between the Chair, Lead Governor, Deputy Lead Governor and the Group Director of Assurance. Feedback from these meetings is provided to the Council of Governors.

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

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

4.2 Raising Concerns

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

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

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

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

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

- the performance of the Trust Board.

- compliance with the Trust's Provider Licence; or

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

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

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

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

- the Governor/s are satisfied that their concerns were unjustified and withdraw them unreservedly. In this case no further action is required.
- the Governor/s are satisfied that their concerns have been resolved during the course of the investigation. The Trust Chair shall write a report on the concerns and the actions taken and present this the Council of Governors.
- the matter is not resolved to the satisfaction of the Governor/s. The Trust Chair shall call a closed extraordinary meeting of the Council of Governors as soon as possible in accordance with the terms of the Trust Constitution to consider the matter further. That meeting may choose either to take no further action or, if two thirds of the Governors present agree, to invoke the escalation process described from section 4.3.1 onwards.

4.3 Escalating Concerns

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

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

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

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

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

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

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

  A Governor may only refer a question for legal review if more than half of the members of the Council of Governors voting approve the referral. Individual Governors may not bring a question for legal without the approval of the Council as a whole. It is noted that once a legal response is provided, the Trust will not necessarily be required to adhere to the legal advice provided.

5.0 MONITORING COMPLIANCE AND EFFECTIVENESS

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

6.0 ASSOCIATED DOCUMENTS AND REFERENCES

6.1 NHS Code of Governance for Provider Trusts 2023

6.2 Trust Constitution

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

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

6.5 National Health Service (NHS) Act 2006

6.6 Health & Social Care Act 2012

6.7 Health and Care Act 2022 (the Act)

7.0 DEFINITIONS

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

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

Constitution means the Constitution of the Trust.

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

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

Director of Assurance is the Company/Trust Secretary of the Trust.

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

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

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

NHS England is the independent regulator of NHS Foundation Trusts and Trusts (and superseded Monitor).

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

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

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

Trust means the Northern Lincolnshire and Goole NHS Foundation Trust.

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

8.0 DISSEMINATION

8.1 This policy will be made available to Trust staff as a controlled document on the intranet/hub.

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

9.0 CONSULTATION

9.1 Council of Governors.

9.2 Trust Board.

10.0 EQUALITY ACT (2010)

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

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

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

10.4 We therefore strive to ensure that in both employment and service provision no individual is discriminated against or treated less favourably for any reason, including the “protected characteristics” as defined in the Equality Act 2010 (such as by reason of age, disability, gender reassignment, marriage or civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual Orientation). These principles will be expected to be upheld by all who act on behalf of the Trust, with respect to all aspects of Equality.

NB. It is the responsibility of the document author / contact to carry out an Equality Impact Assessment (EIA) and if there is no impact identified, it is recommended to include the following statement: ‘As part of its development

this document and its impact on equality has been analysed and no detriment identified'.

11.0 FREEDOM TO SPEAK UP

Where a member of staff has a safety or other concern about any arrangements or practices undertaken in accordance with this document, please speak in the first instance to your line manager (if appropriate). The different ways to speak up and guidance on raising concerns are available in the Freedom to Speak Up in the NHS and Raising Concerns at Work policies. Staff can also contact the NLaG Freedom to Speak Up Guardian in confidence. Further details about how to raise concerns and the contact details of the Guardian is available on the intranet/Bridget: Freedom to Speak Up Guardians - Bridget.

The electronic master copy of this document is held by Document Control, Directorate of Corporate Assurance, NL&G NHS Foundation Trust.

Northern Lincolnshire and Goole NHS Foundation Trust

Council of Governors Business Meeting

Agenda Item No: CoG(26)075

Name of the Meeting	**Council of Governors Business Meeting**
Date of the Meeting	20 August 2026
Director Lead	Keith Haynes, Interim Board Secretary
Contact Officer/Author	Alison Hurley, Deputy Director of Assurance
Title of the Report	**Acronyms and Glossary of Terms**
Executive Summary	A reference guide for any words, phrases or acronyms used during the meeting – updated March 2026. Document for information only.
Background Information and/or Supporting Document(s) (if applicable)	N/A
Prior Approval Process	N/A
Financial implication(s) (if applicable)	N/A
Implications for equality, diversity and inclusion, including health inequalities (if applicable)	N/A
Recommended action(s) required	☐ Approval ✓ Information ☐ Discussion ☐ Review ☐ Assurance ☐ Other – please detail below:

Northern Lincolnshire and Goole NHS Foundation Trust

ACRONYMS & GLOSSARY OF TERMS

Mar 2026 – v9.2

2WW - Two week wait

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

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

ACE – A Commitment to Excellence – Accreditation scheme previously known as 15 Step Reviews. Replaced by Putting Patients First in March 2026

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

AAU – Acute Assessment Unit

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

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

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

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

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

AGC – Audit & Governance Committee

AGM – Annual General Meeting

AHP – Allied Health Professional

ALoS – Average Length of Stay

AMM – Annual Members' Meeting

AO – Accounting Officer

AoMRC – Association of Medical Royal Colleges

AOP – Annual Operating Plan

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

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

ARM – Annual Review Meeting for CoG

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

ARGC – Audit Risk & Governance Committees-in-Committee

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

BAF - Board Assurance Framework

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

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

BLS – Basic Life Support

BMA – British Medical Association

Boards-in-Common – The meeting of the Boards of Directors for both NLaG and HUTH

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

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

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

CAP – Collaborative Acute Providers

CPE - Carbapenemase-Producing Enterobacterales

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

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

CDC – Community Diagnostic Centre

CFC – Charitable Funds Committee

CFO – Chief Financial Officer

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

CE/CEO – Chief Executive Officer

CF – Cash Flow

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

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

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

CMO – Chief Medical Officer

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

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

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

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

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

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

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

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

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

CoP – Code of Practice

CPA – Care Programme Approach

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

CPIS - Child Protection Information Sharing

CPN – Community Psychiatric Nurse

CPO – Chief People Officer

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

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

CSPO – Chief Strategy and Partnerships Officer

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

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

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

DD – Due Diligence

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

DGH – District General Hospitals

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

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

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

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

DNR - Do not resuscitate

DoF – Director of Finance

DOI - Declarations of Interest

DOLS - Deprivation of Liberty Safeguards

DOSA – Day of Surgery Admission

DPA - Data Protection Act

DPH - Director of Public Health

DPoW - Diana, Princess of Wales Hospital, Grimsby

DTOCs – Delayed Transfers of Care

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

ECC - Emergency Care Centre

ED – Executive Directors or Emergency Department

EDI – Equality, Diversity and Inclusion

EHR – Electronic Health Record

EIA - Equality Impact Assessment

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

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

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

EoL – End of Life

EPR - Electronic Patient Record

ERF – Elective Recovery Fund

ERoY – East Riding of Yorkshire

ESR - Electronic Staff Record

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

FD – Finance Director

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

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

FRC – Financial Risk Rating

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

FTE – Full Time Equivalent

FTGA – Foundation Trust Governors' Association

FTN – Foundation Trust Network

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

FY – Financial Year

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

GDH – Goole & District Hospital

GDP – Gross Domestic Product

GDPR – General Data Protection Regulations

GIRFT – Getting It Right First Time

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

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

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

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

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

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

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

H1 - First Half (financial or calendar year)

H2 - Second Half (financial or calendar year)

HAS - Humber Acute Services

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

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

HCCP - Humber Clinical Collaboration Programme

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

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

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

HEE – Health Education England

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

HOBS - High Observations Beds

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

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

HR – Human Resources

HSCA – Health & Social Care Act 2012

HSMR - Hospital Standardised Mortality Ratio

HTF - Health Tree Foundation (Trust charity)

HTFTC - Health Tree Foundation Trustees' Committee

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

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

HW – Healthwatch

HWB/HWBB – Health & Wellbeing Board

HWNL - Healthwatch North Lincolnshire

HWNEL - Healthwatch North East Lincolnshire

HWER - Healthwatch East Riding

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

HUTH – Hull University Teaching Hospitals NHS Trust

IAAU – Integrated Acute Assessment Unit

IAPT – Improved Access to Psychological Therapies

IBP – Integrated Business Plan

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

ICB – Integrated Care Board

ICP – Integrated Care Partnership

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

ICU – Intensive Care Unit

IG – Information Governance

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

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

IP – Inpatient

IPC - Infection Prevention & Control

IPR – Integrated Performance Report

IT – Information Technology

ITU – Intensive Therapy Unit

JAG – Joint Advisory Group accreditation

JHOSH - Joint Health Overview and Scrutiny Committee

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

JSNA – Joint Strategic Needs Assessment

KLOE – Key Line of Enquiry

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

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

LA – NHS Leadership Academy

LATs – Local Area Teams

LD – Learning Difficulties

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

LETB – Local Education and Training Board

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

LHE – Local Health Economy

LHW – Local Healthwatch

LiA – Listening into Action

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

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

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

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

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

LTC - Long Term Condition

M&A – Mergers & Acquisitions

MCA - Mental Capacity Act

MDT - Multi-disciplinary Team

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

MHA – Mental Health Act

MI – Major Incident

MIU – Major Incident Unit

MLU - Midwifery led unit

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

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

MRI – Magnetic Resonance Imaging

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

MSA – Mixed Sex Accommodation

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

NCTR – No Criteria to Reside

NED – Non-Executive Director

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

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

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

Neurology - Study and treatment of nerve systems.

NEWS - National Early Warning Score

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

NEL - North East Lincolnshire

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

NHS - National Health Service

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

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

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

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

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

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

NHSP - NHS Professionals

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

NHSTDA – NHS Trust Development Authority

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

NL - North Lincolnshire

NLaG - Northern Lincolnshire & Goole Hospitals NHS Foundation Trust

NMC - Nursing & Midwifery Council

NOF – National Oversight Framework

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

NPIP – National Provider Improvement Programme

NQB - National Quality Board

NSFs – National Service Frameworks

OBC - Outline Business Case

OFT – Office of Fair Trading

OLU - Obstetric led unit

OOH - Out of Hours

OP – Outpatients

OPA – Outpatient Appointment

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

OSCs – Overview and Scrutiny Committees

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

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

PAU – Paediatric assessment unit

PbR - Payment by Results

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

practice nurse, clinical pharmacist or other clinical profession working in general practice.

PCT – Primary Care Trust

PDC – Public Dividend Capital

PEWS - Paediatric Early Warning Score

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

PFI – Private Finance Initiative

PIDMAS – Patient Initiated Digital Mutual Aid System

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

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

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

PMO – Programme Management Office

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

PPE - Personal Protective Equipment

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

PPI – Patient and Public Involvement

PRIM - Performance Review Improvement Meeting

PROMS – Patient Recorded Outcome Measures

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

PSF - Provider Sustainability Fund

PST – Patient Suitability for Transfer

PTL – Patient Transfer List

PTS – Patient Transport Services

Putting Patients First – New ward accreditation programme rolled out on 23 March 2026. Previously known as A Commitment to Excellence (ACE) and 15 Step Reviews.

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

QGAF – Quality governance assurance framework

QI – Quality Improvement

QIA – Quality Impact Assessment

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

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

QRP – Quality & Risk Profile

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

QSIR – Quality & Service Improvement Report

R&D – Research & Development

RAG – Red, Amber, Green classifications

RCA – Root Cause Analysis

RCGP – Royal College of General Practitioners

RCN – Royal College of Nursing

RCP – Royal College of Physicians

RCPSYCH – Royal College of Psychiatrists

RCS – Royal College of Surgeons

RGN – Registered General Nurse

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

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

RoI – Register of Interests

RoI – Return on Investment

RTT – Referrals to Treatment

SaLT - Speech and Language Therapy

SDEC – Same day emergency care

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

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

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

SGH – Scunthorpe General Hospital

SHCA – Senior Health Care Assistant

SHMI - Summary Hospital-level Mortality Indicator

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

SIB - System Improvement Board

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

SJR - Structured Judgement Review

SLA – Service Level Agreement

SLM/R – Service Line Management/Reporting

SNCT - Safer Nursing Care Tool

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

SPA – Single Point of Access

SoS – Secretary of State

SSA – Same Sex Accommodation

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

Statutory Requirement - A requirement prescribed by legislation

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

T&C – Terms and Conditions

TCI – To Come In

Terms of Authorisation - Previously, when an NHS Foundation Trust was authorised, Monitor set out a number of terms with which the trust had to comply. The terms of authorisation have now been replaced by the NHS provider licence, and NHS Foundation Trusts must comply with the conditions of the licence

TMB - Trust Management Board

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

ToR – Terms of Reference

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

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

TTO – To Take Out

ULHT – United Lincolnshire Hospital NHS Trust

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

UTC - Urgent Treatment Centre

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

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

VTE – Venous Thromboembolism

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

WRES - Workforce Race Equality Standards

WDES - Workforce Disability Equality Standards

WTE - Whole time equivalent

YTD - Year to date