



Northern Lincolnshire and Goole NHS Foundation Trust
2015/2016 Annual Report & Accounts

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Annual Report for the year ended March 31 2016

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About us

We aim to improve lives by providing quality care for our patients and their carers. We care for people across North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire from our three acute hospitals and community services. The Trust manages Scunthorpe General Hospital, Grimsby's Diana, Princess of Wales Hospital and Goole and District Hospital. We also provide a range of community health services in North Lincolnshire.

Our mission and vision and values

Our Mission

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

Together we care

We care about providing safe, compassionate and attentive services for patients

Together we respect

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

Together we deliver

We will deliver forward thinking services through listening to, learning from, and empowering those I work with.

If you are aged 16 and over, you can become a member of the Trust. This enables you to help shape how our services develop and to get regular updates from us.

For more information, go to our website at www.nlg.nhs.uk or ring our membership office on (01724) 387946 or email nlg-tr.foundationtrustoffice@nhs.net

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Chapter 1

Chairman's and chief executive's joint foreword

We are proud to introduce the Trust's annual report and accounts for the year 2015/16. It provides us with the opportunity to highlight some of the significant developments and improvements to services and patient care, as well as look to the future.

Patient care is at the forefront of what we do and we continue to work hard to improve our services for patients in northern Lincolnshire and the East Riding of Yorkshire.

This has been a year of mixed fortunes for the Trust, with continued progress in improving the quality of care we provide for our patients but, in common with the majority of other acute trusts across the UK, an increasing demand for our services, a national shortage of staff and an escalating financial challenge. While outside the period of this report we have recently received a disappointing inspection report from the Care Quality Commission which reflects these challenges and recognises the commitment of our staff in providing good care, but which also reinforces the need for continued improvements to our internal systems and processes.

Our overarching priority remains to ensure that our services are safe, caring and responsive and we are both adamant there can be no compromise on this. We share the ambition of all of our staff to strive to continually develop and enhance the services we provide, and to capture the views of our patients as their experience is vitally important to us.

Refreshed vision and values

In September 2012 we launched our vision and values *Together we care, we respect, we deliver*. We made a commitment that we would keep these under review and refresh them if necessary to ensure they continue to reflect the organisation's common goals and aspirations.

Our priority remains our patients, placing them first before everything else. Furthermore team work, safety and innovative quality improvements remain core values that we continue to hold close to our hearts.

We have therefore reviewed our vision and values and concluded that they should be even more explicit, that we should simplify the message and refresh our values to improve their impact to make sure that they leave no doubt as to what we stand for and strive to deliver. Our revised vision and values can be found on page 7.

Mortality

In 2013 our organisation was identified as a Keogh Trust because our mortality rates were higher than expected. We are delighted to be able to report that the latest national Summary Hospital-level Mortality Indicator (SHMI) published in March 2016 (for the period October 2014 and September 2015) show a continued improvement in both the SHMI and the Trust's ranking and, in particular, that we continue to be well within the 'as expected' range. The SHMI provides a useful 'smoke alarm' for the entire health community to make sure that patient pathways always operate in the best interests of patients whether inside or outside the hospitals. Even though our SHMI continues to improve, we are not complacent and have established a number of clinically-led specialty based improvement work streams to drive and embed further improvement. We are grateful to all the staff involved who continue to work incredibly hard to improve the quality of our care and thereby to reduce our SHMI.

Care Quality Commission rating

During October and November 2015 and January 2016, the Trust received announced and unannounced visits by the Care Quality Commission (CQC). The Trust responded to the initial feedback received in respect of the issues identified including review and follow-up of the backlog of outpatient follow-up patients, which the Trust was aware of and already dealing with prior to the CQC inspection, and in respect of the environment in A&E for the management of patients with a mental health problem, and has provided assurances to the CQC on the implementation and delivery of plans to address the issue. The final report of the inspection was published on April 15 2016. An action plan in response to the additional findings and recommendations was drafted and was submitted to the CQC by the deadline of May 6 2016. The Trust expects another inspection during 2016/17.

Financial position

Our hospitals, like most others in the country, have faced enormous financial challenges during 2015/16. The local NHS position mirrors the national NHS position with the whole system under stress as a result of increasing demand, meaning that the payments we receive no longer cover the costs of the services we provide.

During the year, the Trust, together with its commissioners and other local NHS providers, applied for additional funding from the Department of Health to support the local health economy. The aim of this loan was to assist us in closing our funding gap during this financial year and to help the healthcare community to begin to make the necessary changes to achieve financial and clinical sustainability for the longer term. There are two elements to our sustainability plan: firstly the savings and quality improvements that we need to make from within our own resources as an organisation and secondly collaboration with our commissioners, the local authorities and other local and regional providers on community wide changes to improve the quality and efficiency of health and care services across our patch.

The Trust's internal Sustainability Plan

Our staff have made excellent progress throughout the year on the internal Sustainability Plan. We delivered on the really challenging cost improvement target that we agreed at the start of the year with our regulator Monitor and we have done so while continuing to invest in quality and sustainability. We have already met with them to review our internal sustainability plan for the forthcoming financial year. They have asked us to achieve an equally challenging target for 2016/17. With the rest of the NHS we have accepted the need to seek continued efficiency savings but our main focus with all of this work will be to ensure that the quality and safety of patient care is at the forefront of any decisions made.

Healthy Lives, Healthy Futures

Healthy Lives Healthy Futures (HLHF) is the name of the joint programme across the whole health and care community to transform our local health and care systems. With the agreement of the community Karen Jackson took over the leadership of the HLHF programme board some 18 months ago. Considerable progress has been made over the year although there remains much to do. A number of initial projects led by the Trust and its staff, in active partnership with other local organisations, are now live and are already benefiting patients. These include:

- Launch of a new £2.48million cardiology day case unit at Grimsby hospital

- The expansion of the rapid assessment time limited service (RATL) which provides a community service for people in their homes, seven days a week, 24 hours a day, for mainly elderly or frail people who are in urgent need of care
- The creation of a £1.3million multi-disciplinary hospital team at Scunthorpe which focuses solely on frail elderly patients.

Key to the programme is for organisations and clinicians and other staff across the local health community to work together in the best interests of patients.

Changes to the Board of Directors

In response to the challenges faced by the Trust and its services, we have made a number of changes to strengthen the Board of Directors and the Executive Team. Firstly, to enable Karen Jackson to take on the leadership of the HLHF programme, we established a substantive deputy chief executive post. Dr Karen Dunderdale was appointed to this new role which also focuses on organisational development, ensuring we have robust training and development in place for our staff and embedding a culture of listening. We are very clear that to deal with the scale and complexity of challenges we face we need to act together as an organisation and listen to our staff to determine how we can drive forward high-quality sustainable services.

Secondly we recruited a new chief nurse. Tara Filby brings with her a wealth of experience of our local hospitals. She is determined that senior management are not only visible on the frontline, but that they also see for themselves the challenges our ward staff face on a daily basis. For example, Tara has launched a new 'step up to the plate' initiative in which senior management spend one lunchtime a month on a designated ward as one way of connecting management more closely to actual service delivery. They help alongside our hospital support assistants in serving meals, and spend time with staff and patients.

Thirdly we appointed Mr Lawrence Roberts to the post of medical director. As a senior and highly regarded clinician Lawrence also brings huge experience of the hospitals and their services and is already making great progress leading and supporting our doctors and in working with local commissioners and local GPs.

Improving quality of services

We know that our staff are our most valuable asset in all that we do: delivering frontline services, providing essential support services and ensuring our estates and facilities work on a daily basis, 365 days a year. To this end, we know that staff ideas in enhancing and developing services are key and we are always keen to hear from them about possible innovations. For example, two members of staff from the Trust successfully completed the NHS Improving Quality Train the Trainer programme for the Quality, Service Improvement and Redesign (QSIR) programme. The intention is to give staff the skills to successfully drive forward evidence-based change that will benefit their area, or department.

We are also keen to hear from our patients and value the feedback we receive from the Friends and Family Test, as well as national surveys. As a Board we listen to a patient story – good and bad - every month so we can learn lessons and recognise and share good practice. Several of the Board's sub-committees are now doing the same.

Challenges in recruiting staff

In the face of increased activity, and the need to maintain patient safety and improve quality, we have sought to increase staff numbers on the clinical frontline. However, the supply of doctors and nurses and other clinical staff within our recruitment market-place remains

insufficient to meet our needs. This is particularly the case for doctors in medical specialties, registered nurses and specific skill sets within the allied health professions.

This shortage of qualified staff has tended to drive up costs as we have necessarily used increasing numbers of agency staff to maintain services. During the year we took robust action to seek to reduce these costs with some success. For example, we have worked with our internal flexible workforce called a bank office to provide incentives in the form of enhancements to encourage members of this flexible workforce (bank staff) to do more shifts, or join the Trust substantive workforce.

We have also launched a new pilot to up-skill some of our healthcare assistants to assistant practitioners. The pilot shows promise and we will continue its development as part of our strategy to help local people to develop into the healthcare professionals of tomorrow.

An important factor in our ability to recruit doctors and nurses is the quality of the residential accommodation that we are able to offer. We have therefore launched twin projects to redevelop our staff accommodation at Grimsby and Scunthorpe. We expect that the development at Grimsby will be part of a very significant redevelopment of the site which we expect to launch during the coming year. At Scunthorpe we are working closely with the local authority to link our plans into the council's own economic regeneration agenda.

Service developments

We have endeavoured to enhance the experience of our patients, develop new services, invest in our hospitals and deliver clinical sustainability with services that are local where possible and central where necessary.

Some of the developments and service improvements over the last 12 months include:

- A £1.9million project to refurbish the operating theatres at Grimsby got underway in 2016, which is due for completion in the summer
- We launched our very own Care Camp as a way of enhancing the clinical skills of our nursing staff when they join the organisation either as newly qualified nurses or as a new nurse to our hospital
- A new £1.2million Assisted Living Centre opened its doors to patients and the public at Grimsby hospital
- A new ambulatory care service at Scunthorpe to help keep people out of hospital.

Health Tree Foundation

There has always been a strong local tradition of fundraising and charitable giving. However we felt that 2015/16 was the right time to relaunch our fundraising strategy. The Board therefore supported the establishment of the Health Tree Foundation whose vision is of a local "community in which everyone can benefit from the best healthcare in the UK" and whose mission is "to inspire, engage and channel the charitable intent of people, helping them to donate and make a real difference to the quality of people's health care where it really matters". The Health Tree Foundation (www.healthtreefoundation.org.uk) is part of the Trust's approach to strengthen the engagement between our staff and the local community and with the many independent organisations that raise huge amounts of money for the benefit of our patients.

During 2015/16, the charity has contributed £761,000 to the Trust which has been used to fund things such as a £51,663 new theatre table for Goole hospital and two new ENT scopes for Scunthorpe hospital. Further details about the Health Tree Foundation can be found within this report.

Our staff, governors and volunteers

We would like to take this opportunity to thank all of our staff, governors and volunteers for their hard work and dedication over the last 12 months. They have helped put our local hospitals on the regional and national map for the excellent work they do. Here are just some examples of the awards they have won or been nominated for:

- The Trust was shortlisted in the Digital NHS Trust of the Year category at the E-health Insider awards
- We were selected as a finalist in a national awards scheme about the way patient and staff feedback is used to improve healthcare services. The Friends and Family Test Awards 2016 recognised NHS providers who go the extra mile in their work to listen to patients and staff. There were five categories and NLaG made the shortlist for the best FFT initiative in any other NHS-funded service category
- Our Macmillan therapy team was recognised for its community care when they were selected as a finalist in the Quality in Care (QiC) Oncology 2016 Awards in the Patient Experience category
- A project which has improved the cleaning service at our hospitals has saved more than £90,000 and has been recognised at a national awards evening. The facilities team was 'highly commended' in the facilities improvement category at the Building Better Healthcare 2015 awards, which celebrate innovation
- Our former deputy medical director, who retired from the Trust earlier this year, was awarded an honorary doctorate. Dr Bryony Simpson MBE, a speech and language therapist, received the award from Leeds Beckett University during a graduation ceremony. It came a month after she travelled to Buckingham Palace to receive her MBE. Both achievements recognise her commitment to speech and language services
- The Royal Society for the Prevention of Accidents (RoSPA) awarded our hospitals a silver award for our occupational health and safety management systems
- The Trust was shortlisted for in the Value and Improvement in Information Technology category at the HSJ Value in Healthcare Awards 2015 for its installation of a new type of locking system for the storage of medicines on wards and departments
- Our laboratory staff celebrated after winning a national award for their round-the-clock service. They walked away with The Chief Scientific Officer's Award for Clinical Leadership at the Advancing Healthcare Awards 2015.

It has been a challenging year, with further challenges ahead of us. However, by placing patients at the heart of everything we do, by continuing to work with our NHS colleagues across the community and with the continued commitment and dedication of our staff, governors and volunteers we can face the future with confidence.

Signed: Dr Jim Whittingham, chairman



Signed: Karen Jackson, chief executive





Chapter 2

Performance report

Overview of performance

The annual report and accounts 2015/16 have been prepared under the direction issued by Monitor under the National Health Service Act 2006.

Trust profile and history

The Trust was established as a combined hospital Trust on April 1 2001, and achieved Foundation Status on May 1 2007. It was formed by the merger of North East Lincolnshire NHS Trust and Scunthorpe and Goole Hospitals NHS Trust and operates all NHS hospitals in Scunthorpe, Grimsby and Goole. In April 2011 the Trust became a combined hospital and community services Trust (for North Lincolnshire). As a result of this the name of the Trust, while illustrating the geographical spread of the organisation, was changed during 2013 to reflect that the Trust does not just operate hospitals in the region. The Trust is now known as Northern Lincolnshire and Goole NHS Foundation Trust. Foundation status gives us more control over how we spend our money and plan our services. We remain firmly part of the NHS and are subject to NHS standards, performance ratings and inspections.

The Trust has a Council of Governors (CoG) with local, elected public and staff governors and appointed stakeholder governors. The CoG is responsible for holding the Board of Directors to account through the non-executive directors and for the appointment of the chairman and non-executive directors. The Trust has a duty to consult and involve the governors in the strategic plans of the organisation. The governors act as a communications channel for our foundation trust members, ensuring their views are represented when important decisions are taken about our services and the future direction of the organisation.

The Trust is regulated and licensed by Monitor, the independent regulator of foundation trusts and is registered with the Care Quality Commission (CQC) for the services we provide.

Our core business includes:

- A full range of emergency secondary health care services, including intensive and high dependency care
- A comprehensive range of planned services, in an environment of patient choice and contestability
- Providing care closer to home through delivering a range of community and outreach services
- Providing a full range of diagnostic and clinical and non-clinical support services, available locally.

There have been no significant changes in the range of services provided during 2015/16, but many quality improvements have been made which are detailed in the Quality Report.

Our performance over 2015/16

We have worked hard to try and maintain performance against the key targets required by our regulators. These include 18 week referral to treatment incomplete waiting times, cancer

standards, A&E four hour waits, infection control and data completeness in the community, as well as access to healthcare for people with learning disabilities.

18 week wait

There has been a change in the monitoring method for 18 week waits with a focus on the incomplete target; previously the targets were for admitted and non-admitted patients. We achieved both the non-admitted and incomplete targets, however we found the admitted a challenge. Nationally it was decided that the focus should be on incomplete patient pathways being treated within the 18 week timeframe.

Despite challenges on capacity, we were able to achieve the 92 per cent performance required for all patients being treated within 18 weeks of referral for the first three quarters of the year. However, during quarter four these challenges resulted in the unprecedented position of us marginally falling short of the target.

The pressures primarily affect our surgical specialties and these include cancelled operations as a result of bed pressures as we see increased numbers of medical patients being cared for in surgical ward areas; the impact on capacity due to ongoing junior doctor strike action and continued challenges in our ability to recruit to vacant doctor posts.

These are national challenges and this has been further impacted by our Grimsby hospital theatre suite undergoing refurbishment work which has limited our ability to increase our capacity to meet demand. The surgical group developed a comprehensive plan to ensure theatre capacity was maintained as a result of the refurbishment which included fully utilising all available theatre capacity across our other theatre suites. However, we experienced a reluctance by patients to move their surgery to an alternative site or indeed opt for surgery outside of normal working hours ie evening theatre lists. We are working with local private providers to help increase available capacity in order to improve waiting time performance.

Within the medical group there are two key areas which we have had to focus on during 2015/16 and these are dermatology and cardiology. Service reviews have been undertaken by our strategy and planning team and work with our commissioning teams has supported the configuration of services to support improved performance.

We have also developed a plan, with overview by the Executive Team, which focuses at specialty level on improving the overall performance of all specialties to ensure we are compliant with the waiting times.

A&E performance

The four hour wait in A&E target has been a challenge for us in the past two quarters experiencing similar pressures to those being seen nationally and mirroring the performance of the Trust for the same period during 2014/15. The winter months proved most challenging to the organisation as quarter one and quarter two met the standard and quarter three and quarter four saw a deterioration of this position. March experienced the highest level of patient attendances which resulted in a five per cent increase in patient attendances in comparison to the previous year.

Performance for the four hour wait target is as follows:

Quarter one: 95.3 per cent

Quarter two: 95.2 per cent

Quarter three: 93.7 per cent

Quarter four: 88.5 per cent.

We have responded to these pressures by focusing on improved patient discharges by ensuring discharge assessment takes place early in the day and increasing the doctor provision to support improved discharge at the weekends. We have also developed a new model of care by acute care physicians and ambulatory care support to ensure improved and early discharge of patients in order to ensure the flow of patients through our beds is optimised.

Cancer waiting times

Our performance is measured against seven indicators of which five have been achieved consistently over the whole year. The other two have been more challenging with those patients who are identified through screening programmes not meeting the 90 per cent target for receiving treatment within 62 days. The numbers of patients measured against this target are very low and performance during quarter one and quarter two was achieved, with small numbers affecting compliance during quarter three and quarter four.

The cancer 62 day wait from GP referral to treatment (post breach reallocation) target has been the area of challenge for the Trust over the past financial year in contrast to 2014/15 where performance was maintained through the financial year. A trustwide action plan has been put in place which has chief executive overview. This plan has implemented daily monitoring of patient pathways; review of patient pathways to ensure the most efficient diagnosis and treatment of patients with suspected cancer. The focus is on early review, quick diagnostic testing and decision making and where patients are not treated within the 62 day timescale, a full root cause analysis takes place to determine what improvement could be made to the pathway and management for the future benefit of patients. Performance is measured at tumour site level and is reviewed by the Trust Board.

Infection control

We have continued to perform well against the infection control target for cases of clostridium difficile, where the Trust was not expected to exceed 21 instances where there was evidence of a lapse in care. We have reported a total of 10 for the year with two further cases awaiting review which is considerably lower than the target which had been set for the organisation. We want to improve on this position and are implementing an internal improvement trajectory for 2016/17 which will create greater challenge than the target set by our commissioners.

Mortality rates

The NHS Health and Social Care Information Centre published the summary hospital-level mortality indicator (SHMI) statistics in March 2016 for the period October 2014 to September 2015. It showed the SHMI for NLaG remains in the 'as expected' banding with a figure of 107.6.

The previous SHMI issued in January 2016 was 109.7 and therefore this latest SHMI showed a marked improvement, which also corresponds with a positive shift of six places for NLaG in the overall rankings of NHS trusts nationally.

The SHMI figures are published quarterly and always refer to a 12-month time period occurring 18 to six months before the publication date. It provides a useful 'smoke alarm' for the entire health community to make sure that patient pathways always operate in the best interests of patients whether inside or outside the hospitals.

Following the acquisition of the University Hospitals Birmingham's Healthcare Evaluation Data (HED) reporting product, the Trust is able report on more up to date SHMI data which

allows for a breakdown of the data to an in-hospital and out-of-hospital level. For the 12 months to October 2015, the in-hospital SHMI was 104 and the out-of-hospital SHMI was 115. ‘Out of hospital’ figures relate to patients treated in hospital who are discharged into the care of a community service but die within 30 days of that discharge.

Patient safety and good quality care is always at the top of our agenda, so it is reassuring once again to see the mortality rate as expected and is steadily improving. A high number of the in-hospital and out-of hospital deaths involve patients who are already approaching the end of their life when they are admitted to hospital. The question then is whether the hospital is the most appropriate place for them to die or if they or their families would prefer them to be at home, and this is one of the issues we are discussing with the clinical commissioning groups and with our healthcare partners in the community.

Purpose and activities of the Trust

We aim to provide the very best accessible healthcare to our local population. We aspire to do this through delivery of our vision, crafted by staff at all levels from within the organisation so that ‘Together we care, we respect, we deliver’. This vision forms the central part of our organisation’s commitment to be the best and deliver services in line with this vision.

Our visions and values directly relate to and are the basis for our aims and objectives:

Aim: To provide the very best accessible healthcare to our local population.

Objectives, these can be grouped into five specific areas:

1. Quality, patient experience and safety

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

2. Clinical service transformation

To continuously examine the services we offer to determine where best they can be provided whether they be in traditional hospital settings or in the community setting. To effectively work with commissioners and, where appropriate, other providers, to secure appropriate facilities and support services for delivery of the very best healthcare in an accessible way to our local population.

3. Effective and efficient use of resources

To provide a range of sustainable, high quality clinical services which enable us to deliver planned, emergency and community services to our local population.

4. Investment in staff, leadership, management, teaching and training.

To invest in our staff ensuring they are fully equipped to deliver now and in the future effective local healthcare. To invest in innovative ways of working with local teaching and training centres to identify the doctors, nurses and other professional leaders of the future locally.

5. Accountability and regulation

To continuously strive to demonstrate assurance that the Trust is compliant with key regulation frameworks from the Care Quality Commission, Monitor and other regulators through its internal governance arrangements. To continue to work with

other organisations in being accountable for provision of quality services and a quality learning environment for trainees/students.

We primarily serve the population of North Lincolnshire, North East Lincolnshire and the East Riding of Yorkshire. During 2015/16 we treated 109,907 inpatients. Of these 52,020 were day cases, 7,114 electives and 50,773 were non-electives (emergencies). We also provided 394,281 new and review outpatient appointments, delivered more than 4,500 babies and attended to 149,029 A&E patients, an increase of 4,034 from the previous financial year.

We operate three hospitals, as well as community services, as follows:

Grimsby hospital



It was built in 1983 and provides the full range of district general hospital services, including an emergency care centre (A&E), medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services.

The hospital, which is known as the Diana, Princess of Wales Hospital has 428 overnight beds of which 134 are for surgery and critical care patients, 195 are for medical patients, 84 are for women and children and 15 beds on the Home from Home unit.

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

Surgical specialties on site include trauma and orthopaedics, anaesthetics, critical care, general surgery, breast services, urology, ophthalmology, ENT and maxillo-facial and orthodontics. The surgical floor of the hospital has a 28 bedded surgical assessment unit and short stay ward dedicated to the assessment and care of acute surgical emergency patients. The theatre suite provides eight fully equipped theatres each with its own anaesthetic room, with two theatres dedicated to orthopaedic use (both with ultra clean air facilities). One theatre is dedicated to emergency work, staffed at all times. A separate session for acute trauma cases is reserved each day, including weekends.

Women and children services provide maternity services and paediatric services in a custom built building comprising of maternity wards, gynaecology wards, dedicated obstetric theatres, newborn intensive care unit, children's wards and the Child Development Centre. Care throughout the maternity pathway is provided through a pregnancy assessment centre for antenatal and postnatal care. Complementary to this is the community midwifery service we provide. Emergency/acute paediatric services are provided through the dedicated paediatric assessment and observation unit co-located in A&E. This is supported by a neonatal intensive care unit and the children's ward, caring for medical and surgical patients. Four designated beds are provided for babies requiring transitional care within the maternity unit. We also have a range of outpatient clinics, providing general paediatric clinics to specialist paediatric clinics. The pathway is continued through the delivery of community paediatrics, ensuring children are provided appropriate care at an appropriate setting.

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

Community and therapy services provide a wide range of support for inpatients, outpatients and throughout the community covering physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental. A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg.

The hospital, which is situated on a single site, has undergone considerable expansion since it was built. Projects completed in 2015 have included:

- A new £2.48million cardiology day case unit including a dedicated cardiac catheter laboratory
- An Assisted Living Centre and a Home from Home ward as an integrated service with the local mental health provider to care for patients with confusion any cause once medically fit
- A £1.9million project launched in January 2016 to refurbish the operating theatres at Grimsby hospital.

Scunthorpe hospital



It was first built in the 1920's and occupies a 'land-locked' site surrounded by residential properties. The site has expanded over time with expanded builds attached to original structures. Recent developments during 2015/16 include:

- Ambulatory Emergency Care Unit
- A new £1.3million frail elderly assessment support service
- Modification to the emergency care centre
- Newly replaced cardiac catheterisation laboratory.

Schemes currently under construction or in development include a new endoscopy unit and lower gastrointestinal unit, further modifications to the emergency care centre, a nursing Care Camp facility and clinical simulation unit for staff training.

The hospital provides the full range of district general hospital services, including emergency care centre (A&E), medicine, surgery and critical care, paediatrics, obstetrics and gynaecology, outpatients, diagnostics and therapy services.

It has 406 overnight beds of which 95 are for surgery and critical care patients, 231 are for medical patients and 80 are for women and children's patients. Medical specialties on site include diabetes and endocrinology, cardiology (with facilities for cardiac catheterisation and pacing), respiratory medicine, elderly care, dermatology, haematology and gastroenterology, stroke services, palliative medicine and rheumatology. Neurology, oncology, cardiothoracic surgery, plastic surgery and renal medicine are provided by visiting consultants from Hull.

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

Women and children services provide the entire maternity pathway using a more traditional service model comprising antenatal/postnatal clinics, a dedicated central delivery suite (with a dedicated operating theatre) and a dedicated obstetric ward. In addition gynaecology is provided through a range of outpatient clinics and an inpatient ward facility.

Acute/emergency paediatrics is provided by specialist nurses in A&E in conjunction with doctors. The children's ward works closely with A&E assessing and receiving medical and surgical patients ensuring the pathway is seamless. An inpatient paediatrics service is provided caring for children aged 0-16 years, supported by a community service. In addition a neonatal intensive care unit is based close to central delivery suite allowing easy access for mum to baby. There are also four transitional care beds managed by the neonatal team.

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

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

Community and therapy services provide a wide range of support for inpatients, outpatients and throughout the community for adults, children and young people covering nursing, physiotherapy, occupational therapy, speech and language therapy, nutrition and dietetics, wheelchair services, orthotics, podiatry, psychology and community dental. A satellite outpatient service in rehabilitation medicine is provided from premises in the nearby town of Brigg. The development of three care networks, which is being led by North Lincolnshire Clinical Commissioning Group, will result in further integration of primary, community and social care provision.

Goole hospital



This is a purpose built community-plus hospital which opened in 1988 and brought together services from a number of scattered sites in and around the town of Goole. Medical services include general medicine, elderly, cardiology, rheumatology, gastroenterology, dermatology including a new light treatment service, diabetes and endocrinology, haematology and immunology, oncology and a minor injuries unit.

Surgical services provided include general surgery, orthopaedics, ophthalmology, ENT and audiology, urology and pain services. There is also a surgical day case unit complete with a theatre. Two further main theatres are equipped for major orthopaedic work and other types of surgery. In addition, the site has a well-equipped ophthalmic suite and theatre, endoscopy unit and an outpatient department.

Internationally renowned specialist laser treatment is provided at Goole in collaboration with the Yorkshire Laser Centre.

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

Therapy services are provided for both inpatients and outpatients with physiotherapy, occupational therapy, nutrition and dietetics and psychology services. There are two x-ray

rooms together with mobile units, and an ultrasound room. The diagnostics department also provides a regular mobile MRI/CT service.

The hospital also accommodates a neurological rehabilitation centre which is run by the Brain Injury Rehabilitation Trust (BIRT) under a formal partnership with the Trust. The Trust continues to develop the hospital-based services through the Goole Healthy Lives Healthy Futures Programme in collaboration with the Goole community stakeholders and commissioners.

The environment we operate in

North Lincolnshire Clinical Commissioning Group, North East Lincolnshire Clinical Commissioning Group and East Riding of Yorkshire Clinical Commissioning Group were the Trust's main commissioners of services during 2015/16.

Key issues and risks in 2015/16 affecting the Trust in delivering its objectives

The NHS at its inception some 68 years ago was designed to meet three ambitious principles: that it meets the needs of everyone; that it is free at the point of delivery and that it is based on clinical need not the ability to pay.

While the principles remain, pressures in the system need to be managed: financial stability versus the NHS meeting the needs of its customers. Amid such pressures we continue to keep the needs of our patients at the forefront of our thoughts. By doing this we continue in our aspiration to focus on continuous quality improvement.

The Trust consists of five overall services separated by considerable distances. The footprint of Trust services provides both opportunities, given the larger population, and challenges in terms of service delivery across such a geographic spread while maintaining efficient services. Overall the Trust comprises of:

- Three hospitals, Diana, Princess of Wales Hospital in Grimsby, Scunthorpe General Hospital located in Scunthorpe and Goole District Hospital
- Community services in North Lincolnshire
- Therapy services across northern Lincolnshire.

Across northern Lincolnshire health and care services are facing:

- Growing patient expectations in terms of speed of access to care
- Inconsistent delivery of timely access across primary care practices
- The Trust has seen referrals from GP practices remain static over the last two years overall, with some specialty specific exceptions
- The Trust has continued to see growth in A&E attendances at both the Scunthorpe and Grimsby sites. This increase in attendance has not translated into an increase in admissions from A&E suggesting less complex health needs
- A 2.8 per cent (1,100 admissions) increase in non-elective inpatient admissions, the increase similar in size at each of the Trusts main sites
- Both North and North East Lincolnshire have significantly higher elderly populations than the national average, 2.1 per cent and 1.6 per cent respectively. This situation is expected to grow by 2019, with the elderly population forecast to reach 2.8 per cent and 1.9 per cent above national average
- Continued growth in diagnostic demand
- Greater volume of patients with multiple co-morbidities – older patients typically require more health and social care and are more likely to suffer from complex,

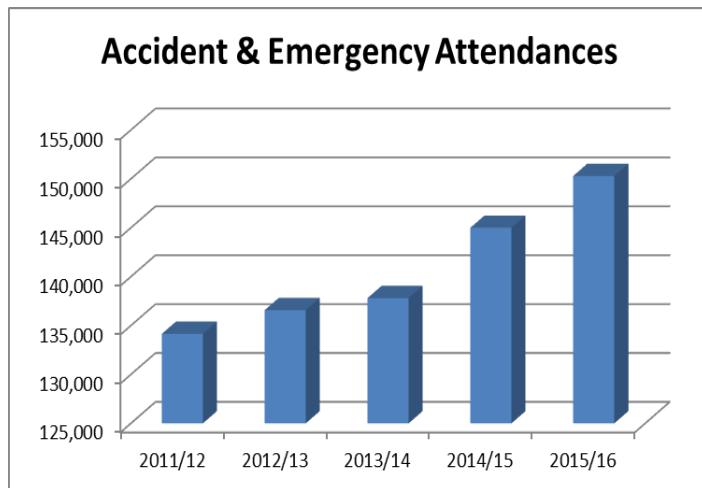
multiple co-morbidities which are typically more costly and require greater co-ordination across provider organisations.

Public Health England annually report Health Profiles. The latest publications demonstrate that the population served by Trust services continue to face challenges which are below the England average:

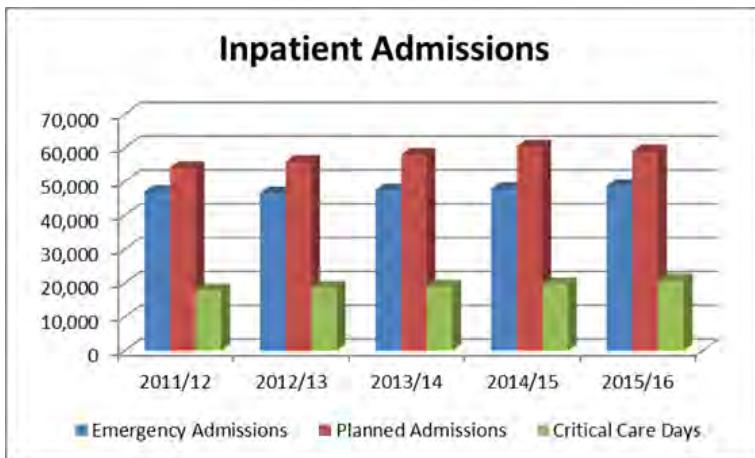
- The health of people in North East Lincolnshire is generally worse than the England average. Deprivation is higher than average and about 28.5 per cent (8,500) children live in poverty. Life expectancy for both men and women is lower than the England average. Estimated levels of adult smoking are worse than the England average. The rate of people killed and seriously injured on roads is worse than average
- The deprivation in North Lincolnshire is generally worse than the England average and about 19.8 per cent (6,000) children live in poverty. Life expectancy for both men and women is lower than the England average. Estimated levels of adult smoking are worse than the England average. The rate of people killed and seriously injured on roads is worse than average.

All of the above places significant strain on the unplanned care services in particular and therefore the Trust's ability to deliver consistent, timely access elective care. The health and care needs of the population across northern Lincolnshire have resulted in the following activity undertaken by the Trust over the last five years:

We have accident and emergency units at both Grimsby and Scunthorpe hospital sites. Goole hospital operates a doctor-led minor injuries unit. The chart below shows we have seen a continuous increase in the number of people needing/choosing A&E services since 2011/12. There is variation at each site however in total actual numbers in 2015/16 there were 44 more people per day attending than there were in 2011/12.



Across the Grimsby and Scunthorpe hospitals we have also seen an increase in emergency admissions over the last five years, equating to approximately five people per day. The needs of the population has also led to an increase in demand for planned care admissions, approximately 14 people per day have been seen. We are forecasting an increase in planned care activity in 2016/17 as a result of improving timely access to services.



Working in partnership with the wider community, we see outpatient services as an area where by working together we can further improve the care delivered for the patient. By working together to provide the care most clinically appropriate for patients, we aim to ensure they are cared for by the most appropriate health and care professional, reduce the number of cancellations and enable improved access and ultimately experience.

People who have needed to access our outpatient services have experienced longer waits and cancellations. With the Trust experiencing such a significant volume of activity through its outpatients services, the transformation programme is multi-faceted and will span across into both 2016/17 and 2017/18.

The above charts do not highlight the pressure faced in meeting the growing need for timely planned care services while ensuring all patients needing emergency care are treated. This pressure coupled with the growing recruitment challenge facing us and the wider NHS has led to increased waiting times for planned care services. This is not an acceptable position and in 2016/17 we plan to take the following steps to overcome this:

- Led by the clinical teams, commence a programme of clinical service redesign to enable the services capacity to be increased to meet the increasing demand
- Prioritise our investment programme to ensure clinical developments can be progressed within the financial envelope available
- Redesign our patient administration systems and processes
- Through the northern Lincolnshire wide Healthy Lives, Healthy Futures Programme, we are working with key partner organisations to support the development of out of hospital services. The aim being to provide services closer to the person as possible, seven days where appropriate, reducing the need for acute care through crisis/emergency intervention.

During 2015/16 we have not delivered the 95 per cent of people attending A&E to be seen within four hours target. Our performance is in within the top performers when compared to all hospitals, however we recognise that it needs to be continually improved, even in the context of growing demand and scarce workforce within this area and key transformational schemes in 2016/17 aim to deliver this improvement. Further information on this target can be found with the Annual Governance Statement.

We have also not delivered against the cancer 62 day wait target. This is not acceptable for our patients and actions have been taken to ensure that this is turned around. Further information on this target can be found with the Annual Governance Statement.

Compliance with action taken as a result of the National Early Warning Score (NEWS) has exceeded the quality target for a number of months. A new inclusion of another mortality

related indicator is in place, that of screening patients for sepsis and on identification the provision of timely antibiotics to prevent deterioration.

The identification and care of patients with dementia remains a priority for us. The first element of dementia screening for patients over the age of 75 has been achieved for the last few months. Other related indicators to do with onward referral have been achieved fully consistently for a number of months.

National Institute for Health and Care Excellence (NICE) guidance is another indicator that has not yet been met, despite good progress having been made. However, the specific nature of the target has been tweaked to ensure compliance with Technology Appraisal Guidance. These are issued by NICE and intended as statutory guidance for all trusts to comply with.

Our performance with response rates to the national Friends and Family Test (FFT) has not been within the top 50 per cent of reporting trusts. While focusing on the response rate is important to ensure the validity of the comments received, this target does not reflect on the content of the FFTs themselves, therefore not accurately representing how we listen to and act on this valuable feedback from our patients. The FFT indicator will be refocused to examine the feedback from patients instead of being aimed at quantitative response rate. This will enable greater focus on the findings from this.

Workforce issues continued to be a source of pressure during 2015/16, especially within nursing and medical recruitment. The Trust's ability to recruit and retain staff with the right skills and knowledge is critical to our service delivery and continued to be a focus throughout the financial year.

There were, and continue to be, national shortages of skilled clinical staff especially within the nurse, medics and allied health professions and trust's with such an isolated geographical area such as ours struggle more than large town and city hospitals. With vacancies covered by locum and agency staff, pressure on expenditure was increased however this started to reduce in the latter part of 2015/16 due to the continued focus on both recruitment and the Trust's internal bank systems.

This continues to remain a high risk for 2016/17 and the focus will remain on recruitment and retention of our skilled and dedicated workforce. The Trust knows that a workplace where the staff feel valued and supported increases retention rates and our attractiveness to potential new recruits.

Our aim continues to be one of creating and maintaining a working environment where people can reach their full potential within their jobs. The Trust's mentoring and coaching programme continues to support this work. Recognition of the hard work, dedication and staff innovation is also an important part and our 'Our Stars' awards in October 2015 attracted more than 250 people to celebrate their achievements with us.

The work of the recruitment team was also awarded within year when they received the Employer of Year 2015 from the Health Education Yorkshire and Humber.

Nurse recruitment

Challenges faced include a shortfall on estimations of candidate numbers expected for interview by our third party agencies. A number of candidates withdraw from the process or just fail to turn up on the day of interview without prior notification. In addition, a small number withdraw their interest following interview and offer of employment and fail to arrive to commence employment with the Trust. Using previous recruitment data collected we now work with an actual predicated number of starts based on the planned recruitment events for the financial year using a known conversion rate which is applied to our plans. We have also

experienced a high turnover of nurses in main due to a high number of retirements within this financial year.

To help with the recruitment agenda the Trust has invested in additional posts within the recruitment team which includes a dedicated non-medical recruitment manager, medical recruitment manager and an on-boarding manager and assistant. These roles have proved pivotal in their ability to continue to deliver and support new staff to the organisation. In addition during this financial year the recruitment team introduced a new electronic application management system called Trac. It has increased the productivity of the recruitment team and allows a full transparent process to be visible by the candidate, recruiting manager and team. Social media is a growing tool particularly as a recruitment tool and methodology. The recruitment team now uses social media platforms with plans to extend their capacity and reach.

The Trust has also introduced nurse incentive packages which are proving successful in attracting candidates to our organisation. A bespoke induction/training programme called Care Camp has been devised and implemented by the chief nurse directorate to ensure a comprehensive induction is completed by all new nursing staff joining the Trust.

The teams, with support from our clinical colleagues, have been busy recruiting in Madrid, Portugal, Romania, Philippines, as well as full local and UK wide recruitment incentives. This will continue for both local and EU recruitment in 2016/17 while acknowledging added delays which came into effect from January 2016 with EU nurses now being required to pass IELTS (Internal English Language Testing System).

UK university engagement and the 'employment promise'

The Trust is working closely with local universities in Hull and Lincoln and we have held several recruitment events at both during the year, with more planned for the future. It is hoped that earlier meaningful engagement and continued support with this group will increase the numbers of those applying to NLaG within our immediate region. This approach will also be adopted when engaging wider universities within the Yorkshire and Humber Region.

Medical recruitment

The recruitment team has focused their efforts for medical recruitment on an agreed priority list in partnership with the operational divisions. Recruitment tours have been undertaken in India and Romania for medical staffing during 2015. NHS jobs and the Trust website are utilised to advertise all medical staff vacancy adverts. Use of this media is free, and 38 per cent of new medical staff who have started during 2015/16 has applied to adverts posted on NHS jobs and the NLaG website. A project working group has been established which will review the Trust's attendance at career events and advertising for posts in 2016/17. The Trust has also used recruitment agencies to source candidates both from the UK and overseas, with 62 per cent of new medical staff sourced this way. We have also been developing links with a hospital in Holland, and it is hoped this may lead to an established scheme that provides candidates for training opportunities at NLaG in the future.

The key components of the Trust's Workforce Strategy as we enter 2016/17 are as follows:

- To ensure the right people with the right skills are in the right place at the right time
- To ensure that the workforce is working efficiently and effectively, minimising duplication of time
- To equip the workforce with the necessary skills and frameworks to deliver the services to meet the needs now and to design and deliver the required transformation

- To ensure that the necessary training and education is in place to support the workforce
- To identify and design potential new roles to support/enable transformational service delivery and continue to meet the continued growth in needs of the population
- To support the workforce to achieve their personal and organisational objectives and achieve health and wellbeing
- To recruit and retain the appropriately skilled and experienced workforce.

There are focused recruitment and retention plans in place that continue to be developed and strengthened to support the safer staffing national initiative in addition to a planned programme of establishment reviews and reconfiguration. All of which support the Trust to ensure staff with the right skills are in the right place at the right time.

Financial pressures

The 2015/16 financial plans across the health community confirmed that service obligations set out in the NHS Constitution couldn't be maintained without external financial support.

Combining the Trust's and key partners planned income and expenditure, capital requirements and a workable cash balance, the original plan forecast a potential support package of £25.98million within 2015/16. As a result of actions taken to integrate care and further improve service efficiencies through consistency across pathways, the actual financing support applied for totalled £19.74million. Appropriate liquidity support arrangements were approved and established for the Trust by regulators. Through planned slippage of the capital programme, and strong management of working capital, the Trust drew down only £15.0million in liquidity support.

The Trust delivered a significantly increased savings level in 2015/16, delivering a £13.8million cost improvement. For next year, the Trust has in place plans to deliver challenging efficiencies significantly in excess of the national expectation of two per cent of expenditure. At £13.8million for the Trust, the savings plan for next year is double the national target level, reflecting the extent of the local challenge to achieve financial sustainability. All efficiency programmes are assessed for any impact on quality of care during the planning phase and do not progress to delivery without the assurance from the medical director and chief nurse that frontline care will not be adversely impacted upon as a result.

While the Trust is developing further capacity to meet the growth in demand and quality needs, building on tight management of investments in 2015/16 to meet increased demand for services. We anticipate further growth in activity demand in 2016/17, in line with local historical trends, and the national picture. At the time of writing, the Trust has not agreed service contracts with local commissioners. Threats to funding levels remain the largest financial risk facing the Trust looking to 2016/17. The Trust will insist upon appropriate financing to support the level of demand for its services, and will not be prepared to compromise the safety effectiveness or quality of services to patients. Further information about the risks faced, and our system of internal risk in managing these risks, can be found within the Annual Governance Statement.

Going concern disclosure

These accounts have been prepared on a going concern basis, under the historical cost convention modified to account for the revaluation of land and buildings. Plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities have been reviewed to represent fair value as at March 31 2016.

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust's Annual Reporting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

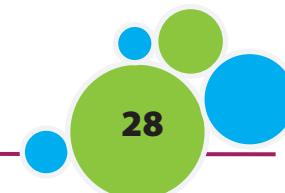
The Trust's performance in year showed a deficit of £26.035million inclusive of all non-cash balance sheet review adjustments. The Trust had year-end cash balances of £5.20million. However, to maintain this level of liquidity, the Trust utilised in full a £15.0million Interim Revenue Support Loan. The Trust is forecasting a further deficit of £11.82million in 2016/17 after Sustainability and Transformational Fund income of £11.5million. The projected 2016/17 deficit of £11.82million should be viewed in the light of a Control Total for 2016/17, set centrally by the regulator for the Trust, of a £12.27million deficit. The Trust to date agreed an Interim Revenue Support Loan for 2016/17 of £18.9million.

The Trust has the following material financial risks in 2016/17:

- There is a risk to contract income which at the point of writing is partially mitigated but not fully resolved, arising from affordability and allocation concerns for key CCG commissioners
- The Trust must deliver sufficient activity through the right sizing of its clinical capacity to deliver upon its service obligations, if it does not core contracting is under threat
- The Trust is reliant on up £11.5million of proposed sustainability and transformational income to deliver its plan. At the time of writing this still has to be fully confirmed by regulators and will be dependent upon acceptable financial and service delivery performance through the year
- The Trust has an ambitious savings target set at around twice the national expectation of 2.0 per cent. This creates significant management challenge and a degree of financial risk
- The Trust has yet to finalise with regulators full sign off of its 2016/17 financial plan and the liquidity support package linked to that plan. It should be noted that progress on this issue is tied to the national planning agenda.

Having considered the material uncertainties the directors have determined that it remains appropriate to prepare these accounts on a going concern basis.

The accounts do not include any adjustments that would result if Northern Lincolnshire and Goole NHS Foundation Trust was unable to continue as a going concern.



Performance analysis

How the Trust measures its performance

Every year the Board of Directors agrees objectives and how it will be measured to review the Trust performance. These measures are developed into key performance indicators and monitored monthly throughout the year. In setting these measures, the Board takes into account the governors, staff, regulators and the priorities of both commissioners and NHS England, and sets indicators that best fit these.

Detailed analysis and explanation of the development and performance of the Trust

During 2015/16 the Trust strengthened still further its performance management arrangements with the approval of a new Performance Management Framework by the Trust Board. The Trust measures performance against a number of measures including:

- Indicators prescribed by Monitor
- Indicators prescribed through the standard NHS Contract
- Indicators agreed locally with commissioners
- Indicators identified as a priority by the Trust.

These indicators are reported monthly to the Trust Board and relevant sub-committees.

Monitor compliance framework summary Performance against key thresholds for the period April 1 2016 to February 29 2016								
Performance metric	Weighting	Qtr 1	Qtr 2	Qtr 3	Jan 16	Feb 16	Qtr 4 actual to date	Qtr 4 Failure weighting
Infection control*								
Total hospital acquired C.difficile cases lapses in care (YTD)***	1.0	G	G	G	1	0	8	G
Referral to treatment waiting times								
Incomplete – maximum waiting time of 18 weeks	1.0	G	G	G	92.0 %	91.4 %	91.7 %	R
Cancer***								
31 day wait diagnosis to treatment	1.0	G	G	G	100 %	100 %	100%	G
32 day wait for subsequent treatments – surgery	1.0	G	G	G	100 %	100 %	100%	G
31 day wait for treatments – anti cancer drugs		G	G	G	100 %	100 %	100%	G
62 day wait GP referral to treatment POST allocation		R	R	R	79.9 %	80.3 %	77.8 %	R
62 day wait GP referral to treatment PRE allocation	1.0	G	G	G	82.5 %	82.8 %	82.6 %	R
62 day wait consultant screening service referrals allocation		G	G	R	100 %	77.8 %	88.2 %	R
2 week wait referral to consultations	1.0	G	G	G	97.9 %	98.7 %	93.3 %	G
2 week wait breast symptomatic referrals		G	G	G	95.3 %	96.9 %	96.2 %	G
A&E								
A&E 4 hour wait compliance	1.0	R	G	R	86.0 %	89.0 %	87.5 %	R
Data completeness community								

services**								
Referral to treatment information	1.0	G	G	G	100 %	99.9 %	99.9 %	G
Referral information		G	G	G	100 %	99.9 %	99.9 %	G
Treatment activity information		G	G	G	78.6 %	88.4 %	83.3 %	G
Access**								
Access to healthcare for people with learning disability	0.5	G	G	G	Y	Y	Y	G
*Quarterly cumulative figures					Total Monitor compliance score		4.0	
**Forecast position					Monitor compliance rating		Amber	
***Provisional data					Monitor over ride rating		Red	

Further information can be found within the Annual Governance Statement and the Quality Report.

Environmental matters, including the impact of the Trust's business on the environment

The Trust has in place a Sustainable Development Management Plan (SDMP) which sets out the following mission statement:

"The Trust is committed to long-term sustainability, it also recognises its corporate responsibility both as one of the largest employers in the local economy and as an emitter of carbon into the local environment. It seeks to use its position to engage, inform, persuade and influence staff, visitors, patients and contractors to reduce the emissions of carbon."

The Trust is committed to reducing its levels of carbon and has continued working on its energy performance contract with British Gas during 2015/16. This contract will deliver 14 per cent carbon reduction by lowering our emissions by 3,360 tonnes of CO₂. It also includes the installation of photovoltaic panels, a combined heat and power unit and the upgrade of all the internal and external light fittings across the Trust. Further information about our carbon reduction work can be found within the Sustainability Report and the Annual Governance Statement.

Focus in the financial year has also been on establishing a Trust Travel Plan as it is recognised that how people travel to and from health facilities is an environmental concern, with the Government estimating that five per cent of all UK transport is generated by the NHS (Source: Philip Insall, Director Active Travel).

The Trust's three hospitals are separated by considerable distances which pose a significant service delivery challenge, and it also provides a range of services delivered outside the hospital setting.

NLaG recognises its responsibilities to contribute to a greener environment and is committed to sustainable transport and aims to implement measures to help reduce the need for staff to bring their car to work and promote awareness of the benefits of alternative travel methods.

The Trust's Travel Plan 2015 – 2018 was approved by the Trust Board in December 2015. It is a package of actions to encourage safe, healthy and sustainable travel options. Some of the key aims identified in the plan are as follows:

- Reduce car usage and in particular single car occupancy journeys

- To increase the use of public transport, walking, cycling and car sharing by staff (including outpatients, visitors and Grimsby residential development) commuting to and from work and on business travel
- Contribute towards reducing carbon emissions
- Encourage more sustainable and healthier forms of travel among staff, outpatients and visitors
- Encourage good urban design principles that open up the permeability of the site to the more sustainable means of walking, cycling and public transport, reducing pressure on the highway network at peak times
- To raise awareness of sustainable travel options and benefits to employees, outpatients and visitors
- To reduce the number of single occupancy private car users while carrying out work duties
- To set an example of good practice to other organisations in the area.

Social, community and human rights issues

Human rights are central to our work, not just in terms of the legal requirements, but in terms of the fundamental principles of fairness, respect, equality, dignity and autonomy. The protection and promotion of people's human rights are not only good for individuals' health, it also makes for better services for everyone.

Putting human rights at the heart of our work helps improve the experience and outcomes for patients, service users and staff by approaching services and decisions in a person-centred way. Some examples of human rights issues in practice include avoiding unsanitary conditions or excessive force in restraint and ensuring privacy on wards and family visits.

Our human rights based approach:

- Puts human rights at the heart of policy and planning
- Ensures accountability
- Empowers staff and service users
- Enables participation and involvement
- Creates an environment where non-discrimination and attention to vulnerable groups are part of service delivery.

Important events since the end of the financial year

During October and November 2015 and January 2016, the Trust received announced and unannounced visits by the Care Quality Commission (CQC). The Trust responded to the initial feedback received in respect of the issues identified including review and follow-up of the backlog of outpatient follow-up patients, which the Trust was aware of and already dealing with prior to the CQC inspection, and in respect of the environment in A&E for the management of patients with a mental health problem, and has provided assurances to the CQC on the implementation and delivery of plans to address the issue. The final report of the inspection was published on April 15 2016. An action plan in response to the additional findings and recommendations is currently being drafted and will be submitted to the CQC by the deadline of May 6 2016.

As outlined within the Annual Governance Statement, as at March 31 2016, the Trust was not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust expects a further re-visit within six months.

Details of any overseas operations

The Foundation Trust has no branches or other activities outside the UK.

Signed:



Name: Karen Jackson

Job title: Chief executive

Dated: May 20 2016



Chapter 3

Accountability report

Directors' report

The directors leading Northern Lincolnshire and Goole NHS Foundation Trust (NLaG) in 2015/16 were as follows:

- Dr Jim Whittingham, chairman
- Karen Jackson, chief executive
- Dr Karen Dunderdale, chief nurse/deputy chief executive
- Wendy Booth, director of performance assurance and Trust secretary
- Pam Clipson, director of strategy and planning
- Tara Filby, chief nurse
- Karen Griffiths, chief operating officer
- Marcus Hassall, director of finance
- Jane Heaton, interim director of organisational development and workforce
- Dr Neil Pease, director of organisational development and workforce
- Jug Johal, director of estates and facilities
- Mr Lawrence Roberts, medical director
- Alan Bell, non-executive director
- Neil Gammon, non-executive director/deputy chairman/senior independent director
- Linda Jackson – non executive director
- Anne Shaw – non-executive director
- Stan Shreeve – non-executive director.

Further details about the Trust Board can be found in section: Disclosures set out in the NHS Foundation Code of Governance.

Register of Interests

A register of director interests' and governor interests' is in place, is reviewed and updated annually and confirms there are no material conflicts of interest. No director or governor held any company directorships or had any significant interest which might conflict with his or her responsibilities. In accordance with the Trust Constitution, the Trust secretary maintains the register of interests to formally record declarations of interests of directors and governors. In particular the register includes details of all directorships and other relevant and material interests which have been declared by both executive, non-executive board directors and governors. The register is reviewed annually and is available to view on the Trust website at: www.nlq.nhs.uk

Cost allocation and charging requirements

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

Political and charitable donations

As an NHS foundation trust, we make no political or charitable donations. We launched our own charity – The Health Tree Foundation – and it continues to benefit from charitable

donations received and is grateful for the efforts of fundraising organisations and members of the public for their continued support.

Prompt payment for suppliers

In the absence of other contract terms we aim to pay suppliers within 30 days of receipt of goods or a valid invoice, which is the later. Our performance is summarised below:

	2015/16		2014/2015	
	Number	£000	Number	£000
Total non-NHS trade invoices paid in the year	73,095	127,997	71,693	123,889
Total non-NHS trade invoices paid within target	25,451	54,958	10,132	36,407
Percentage of non-NHS trade invoices paid within target	35%	43%	14%	29%
Total NHS trade invoices paid in the year	3,404	19,298	3,644	16,055
Total NHS trade invoices paid with target	1,084	12,198	1,706	8,435
Percentage of NHS trade invoices paid within target	32%	63%	47%	53%

The Better Payment Practice Code (BPPC) requires us to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

We aim to pay all our suppliers within the normal payment terms. During 2015/16 we actively managed our working capital balances to maximise cash. The payment of Non NHS trade invoices has improved during the financial year.

Enhanced quality governance reporting

The Annual Report includes the Annual Governance Statement, which reports in detail how we deliver quality governance. More specific detail about the identified quality priorities for 2015/16 and achievements for 2015/16 are included in the Quality Report. In delivering quality governance, we have used the Monitor Quality Governance Framework as an assessment tool. This identifies compliance and improvement actions required and enables the Board to make judgements in signing off its responsibilities for quality governance. The Annual Governance Statement sets out how we manage risk. This includes clinical risk, performance risk and the Trust Board Assurance Framework (BAF). It also includes information about our systems of internal control.

In addition to this the Trust has developed a Quality Development Plan. This is a report which brings together in one place, all of the Trust's quality actions. The Trust Board and relevant sub-committees receive a monthly report outlining progress against the actions and performance against associated key performance indicators which demonstrate the impact of the actions over time.

Statement as to disclosure to auditors

The directors consider that the annual report and the accounts taken as a whole are fair, balanced and understandable and provide the necessary information for patients, regulators and other stakeholders to assess NLaG's performance, business model and strategy. Each director confirms they have taken all requisite steps to make themselves aware of any relevant audit information and establish that the auditors are fully aware of that information

Income disclosures

The Foundation Trust has met the requirement that the income from the provision of goods and services for the purposes of the health service in England is greater than the income from the provision of goods and service for any other purposes.

Other declarations

- The Foundation Trust engages in research and development projects funded by external resources, usually for a fixed term. No research and development is undertaken without external funding
- So far as the directors are aware there have been no post-balance sheet events which require disclosure
- The accounts haven been prepared using the Annual Reporting Manual (ARM) guidance and a direction issued by Monitor
- Accounting policies for pensions and other retirement benefits are set out in the Remuneration Report section of the annual report. Details of director's remuneration can also be found in this section on page 55.

Patient care – how we have worked with other agencies to improve patient care

We are always looking for ways to develop our services and improve patient care and have worked together with other NHS and healthcare providers during 2015/16 to facilitate the delivery of improved healthcare.

We have undertaken a number of key work streams in North East Lincolnshire with the primary aim of alleviating the demand pressures faced by the hospital on its inpatient services.

We have worked together with NAViGO (mental health providers) to deliver the Home from Home service which comprises of both a 15 caseload community team, and a 15 individual room unit based at Grimsby hospital. This multi-disciplinary team cares for people with confusion of any cause in the location most appropriate to their clinically assessed needs.

We have also worked with the Care Plus Group (community providers) and FOCUS (social care providers) to form one discharge team with the aim of reducing excessive delayed transfers of care. Working together the team aims to assign onward care where an assessed need is identified to the most appropriate person regardless of organisation or health/social need.

During 2015 we opened the Assisted Living Centre which delivers multi-disciplinary services provided by NLaG, North East Lincolnshire Council and the Care Plus Group. The service operates across seven days ensuring no patient discharge is delayed because they are waiting for equipment. It also aims to ensure all equipment needs are met in the person's home where possible avoiding admissions over a weekend.

The full year effect of the above work streams are aimed at:

- Reducing delayed transfers of care
- No delayed transfers of care for people with confusion (any cause) or people awaiting equipment
- Reduction in admissions and length of stay for people with confusion any cause, equivalent of one acute ward.

In North Lincolnshire we have also worked with partners to create new services for people which in turn help to reduce inpatient admissions.

Through the Better Care Fund Initiative we have launched FEAST – frail elderly assessment support team – at Scunthorpe hospital working together with Rotherham Doncaster and South Humber NHS Foundation Trust RDASH (mental health providers) and North Lincolnshire Council social care.

We have also introduced the super 6 model of care within diabetes. This pathway aims to deliver care for this cohort of the population in the right place, in this case primary care, thus enabling us to focus on the more complex diabetic patients. This work stream has also acted as a catalyst to redesigning our outpatient care across a wider specialty basis.

The full year effect of the above work streams are planned to:

- Reduce admissions by at least three per day
- Reduce length of stay
- Reduce diabetic outpatient attendances by 1,000 per annum.

Patient care – new and significantly revised services

Patient care is at the heart of what we do. Our patient services are managed by the chief operating officer directorate. We have five clinical groups: medicine, surgery and critical care, women and children, clinical support services and community and therapies. They are clinically led by associate medical directors (AMDs) who combine their leadership roles with day-to-day clinical practice. The AMD works alongside the group associate chief operating officer, as well as associate chief nurse to provide a triumvirate arrangement of leadership and management.

There is also Path Links which provides pathology services not just to NLaG but across the whole of Lincolnshire including Boston, Grantham and Lincoln. It is a single managed clinical pathology network providing a wide range of diagnostic investigations and clinical services.

Our support services contribute to the care we provide to our patients. Our domestic staff work extremely hard to make sure that our three hospitals maintain a high level of cleanliness to reduce the risk of infection to our patients. Our portering staff are very important in making sure the right patient is in the right place at the right time. A £80,000 investment in new technology has seen them issued with a specially adapted mobile phone. They link with the Trust's WebV system, a bespoke computer system developed at the Trust primarily as a patient and bed management tool. It means instead of staff having to pick up a phone they can book a porter electronically. The system can see which porters are busy and which are free and sends a notification to the porter's phone of the job so they can access the information while on the move.

Our catering department, working with nursing staff and dieticians, ensure we provide good nutrition and hydration to our patients, as well as providing food for staff and visitors. Our catering teams across all three hospitals have been awarded five star ratings during 2015/16, the highest you can achieve, following visits from environmental health officer as part of routine checks.

We have invested £430,000 into the community nursing team in North Lincolnshire thanks to funding we received from a national £35million nursing technology fund. It has enabled us to equip more than 300 staff who work in the community visiting patients at home with small, lightweight laptops giving them access to patient notes and much more. It means they can order prescriptions and equipment for patients, update their notes, write up care plans and fill in risk assessments as well as make referrals to other services.

Our tissue viability nurses have had a busy year developing a series of tools for Trust frontline nursing staff to better identify and grade pressure ulcers. They have devised a pressure ulcer grading wheel which features photographs of real ulcers, showing how they worsen from grade one to four. On the other side are images showing what moisture lesions and deep tissue injuries look like, to prevent these being incorrectly identified as a pressure ulcer. The team also came up with the idea of nursing staff having a pocket mirror which they can use to check hard to see pressure sores. These have been rolled out across the Trust's three hospitals. And they have developed a children's activity book to help spread the message to youngsters and their families. All of these items have featured a pug dog, which has become the emblem for all things related to pressure ulcer prevention. The team were able to implement these measures thanks to the Trust's dragons den scheme where they pitched for funds to tackle pressure ulcers.

We have made a number of changes within our women and children group including introducing a new streamlined patient pathway for children needing an MRI under sedation at our Grimsby hospital. Historically, children were admitted as an inpatient onto the children's ward and then taken by a porter to the MRI department, where they would have their scan and be returned back to the ward. Children now attend the MRI department direct. A paediatric nurse is on hand working alongside the imaging staff providing a more seamless service, which has not only reduced anxiety for the child but frees up a bed on the children's ward.

New blood test clinics in the community have also been introduced in North East Lincolnshire for children. The aim is for families to access services closer to home and it also helps reduce the anxiety of children.

Another area of focus for us has been around palliative care and ensuring we have responsive, patient-focused services in place which meet people's needs at the end of their life. We were delighted to be able to attract two new palliative care consultants to North Lincolnshire providing inpatient care at Scunthorpe hospital, as well in the community and at the local hospice, where one of them is based. We also created a new 12-month post in 2015 which saw a clinical practice educator rolling out our new care pathway which we developed following the end of the Liverpool Care Pathway. This aims to ensure that patients who are likely to die in the next few hours or days are positively identified and given the best care possible.

There have been further developments for people with cancer with the launch of:

- A nurse-led breast cancer survivorship team at Scunthorpe and Grimsby hospitals
- A community-based physiotherapist has joined the Macmillan therapy team in North Lincolnshire
- Two new appointments have been made Trust-wide who will roll out the Macmillan recovery package project.

We have also been doing a lot of work behind the scenes in our outpatient departments to make it easier for people to book, change and cancel their appointments. Our Trust Board approved a new model following a clinical administration review and consultation process with our staff. The rationale for change was the number of patient complaints from call abandonment, high hospital appointment cancellation rates, backlog typing and high outpatient 'did not attend' rates. The new model has seen the creation of 15 specialty admin teams (SATs) across our three hospitals, the development of two internal typing pools, and for some teams a move to seven-day working.

In addition to this, we have also introduced a text message reminder service to help reduce wasted appointments in our outpatient departments. By reminding patients of their appointments we have not only prevented patients from missing them, but we've also been

able to offer slots to other patients because people have given us notice when they can't make it. The service sends patients two texts, one seven days before the appointment and one two days before. The text reminds them of the date and time of the appointment, the specialty it is with and the hospital site to attend. We have also created a cancellation portal area on our website where people can cancel or rebook their appointment.

Patient care - Service improvements following staff or patient surveys/ comments and Care Quality Commission reports

Feedback is essential to understand what our patients are saying. It provides us with the knowledge to share what we are doing well and the building blocks to make improvements where necessary. The fact that 'what matters to me' is fundamental to this process and ensures we are directing any service improvements in the way that makes the most difference to patients. Examples of service improvements following surveys and reports include:

- Patients attending zone one of our outpatients department at Grimsby hospital said they found the area to be quite stuffy. This was fed back to the department manager who then had some wall mounted fans installed
- Our MRI department at Grimsby hospital received a piece of feedback to say that a television would make the waiting area better, especially for children. This has now been purchased via the Health Tree Foundation and is now in place, improving the waiting experience
- Sometimes our feedback is about challenging aspects which we cannot control, such as waiting times in our accident and emergency departments. While we are constantly striving to ensure patients are seen in a timely manner there are times when the department is busy and patients have to wait. Our unit sister at Grimsby hospital is trying to improve the experience by going out into the waiting area and seeing patients, explaining why they are having to wait. Communication is fundamental to a good patient experience and this is a really simple improvement example
- The emergency centre at Scunthorpe hospital had recurring feedback that during the evening the floors were dirty. The unit charge nurse asked for increased cleaning to tackle this, and this was immediately implemented
- We had some feedback around women who had experienced previous miscarriages and felt this wasn't dealt with sensitively when they returned for appointments for a further pregnancy. One of the midwifery team leaders has taken this piece of work on to work with the doctors and raise awareness of its importance.

Patient stories are incredibly important to us as it allows us to learn how we can improve care and services, as well as share good practice across our three hospitals. Every month our Trust Board hears a patient story at their public meeting. We also feed them into our group quality and safety days, and at a selection of other meetings with teams and departments.

One of our patient stories, Mel's story focused on the unexpected loss of a newborn baby in our Scunthorpe hospital. Mel bravely shared her story to highlight how the environment she stayed in following this reminded her of well babies. She suggested a dedicated area would be far more appropriate. This has been embraced by the team and the Trust Board, and working alongside Mel and her family, a room is in the development stage. This change will benefit all who come in contact with the service in the future.

We are also improving how we share the patient feedback directly with teams and providing them with an easy mechanism to share how they are dealing with issues captured in feedback. Going forward it is hoped this new system will make it easier for staff to see the

feedback for their areas and equally share what actions they are doing to make improvements. This will enable us to share good practice more effectively and evidence the wealth of 'you said, we did' which we know exists.

Patient care - Improvements in patient/carer information

Ensuring good communication for patients and carers is a key element to providing excellent person centred care. We are constantly driving this agenda forward and have seen several examples of this over this last year, and some which are about to start in 2016/17.

In 2015 we launched a trial of extended visiting across the Trust. This has relied heavily on feedback from patients and carers throughout its course. Understanding what is important to both these groups is helping us shape the final version of what visiting will look like at our Trust. Gathering face-to-face feedback and anonymous feedback via a card system has shown us that for patients, carers and families a more flexible approach is required. This will be combined with feedback from clinical staff to determine the new times. One of the themes from feedback was that an extended visiting period offered better communication between patients, carers and clinical staff, which in turn improved the experience of care.

We will be building on this by looking to implement the nationally recognised 'John's Campaign' in 2016. This is about the recognition of carer input into care during hospital stays, and the difference this can make. We actively encourage carers to be involved but this will add additional status to those in caring roles, providing carer passes/badges, so everyone knows they are actively involved. Specialist carer packs will contain useful information and signposting for carers.

We are working alongside carer forums and partnerships to understand the areas which need focused improvements and continue to build those links. This also encompasses the work we have linked into with our clinical commissioning group colleagues in trying to share what we are doing to improve patient and carer experiences at the Trust. Getting the messages back out into our communities helps people understand that we are actively listening to them, and it gives them opportunities to talk to us directly.

Our two carer liaison officers Hannah Saleh and Bev Herron provide expert resources for carers as they have bases in both main hospitals. Working with operational teams and matrons, quality matrons and the experience team they are helping provide a supportive service for our carers.

We have been asking for carers to help us 'what matters most' to them when we have been carrying out engagement work. This will help us prioritise where our energies should be as we move forward to provide an excellent approach to our carers.

A team of carers is scheduled to talk at our chief nurses' annual best practice day in 2016 to raise the profile of carers and how we can best help them, this will reach many disciplines within our Trust.

Our patient information leaflets which are written are shared with our Patient Panel to ensure that we are getting the right information and at the right level out to our patients.

We have also in 2015/16 been updating our patient folders which are now ready to move to their next phase and will provide a bedside resource.

Social media has helped update patients and carers in many areas and is becoming an increasing method of providing live information in a responsive way. Our communication and marketing team deal with any questions promptly which contributes to the best possible

experience for those using this method of communication. Combine this with information for patients that is kept on our Trust website, we are trying to offer a range of information for people at any given time.

Concerns, complaints and compliments

We constantly focus on providing the best care but accept there are times when patients, their relatives and carers are unhappy with their visit or the services they have received. When the experience does not meet individual expectations we listen to and respond to concerns and complaints. We take our concerns and complaints handling seriously and investigate all of those raised and ensure that the patient's right to care, treatment or service is not compromised by any feedback or complaint.

Complaints, concerns, comments and compliments are valued as they provide an opportunity for us to examine and improve services. We are committed to listening to suggestions for improvement, to investigating and responding to complaints and concerns appropriately and to learn lessons.

We have a policy and procedure for the management of complaints, concerns, comments and compliments which is designed to ensure a timely, open and honest investigation and resolution of all complaints and concerns in accordance with the complainant's wishes.

In 2015/16 we received 446 new complaints. In line with the Trust policy 100 per cent of the new complaints received were acknowledged within three working days. We offer a tailored complaints service with communication between the Trust and complainants being offered in a number of different formats, including letters, emails, telephone calls and face-to-face meetings.

Each complainant is allocated a facilitator. Our team of facilitators are all accredited with a BTEC level 5 in complaint handling. Together they agree on an individual basis with each complainant how the Trust will address their complaint and agree a timescale.

In 2015/16 75 per cent of complaints were responded to within 65 working days which has reduced to 60 working days from February 2016. We recognise the importance of a timely resolution to complaints and we are therefore working towards reducing the timescales that we currently work to. Positive feedback has been received from the increased number of face-to-face meetings that have been held, including visiting patients or their families at home.

An important aspect of the complaints process is the opportunity to learn lessons from complaints raised and in 2015/16 173 action plans were prepared and implemented, with 97 per cent of the action identified completed within the 12-week target.

In 2015/16 we received 2,733 concerns, 65 per cent of which were addressed within five working days. We will continue to strive to improve this.

Our staff work extremely hard and this is recognised by our patients in various ways. In 2015/16 309 compliments and thank you letters were sent to the chairman and chief executive. Many more letters and cards are sent directly to our wards and departments thanking staff for the care they have received. These are not formally recorded but are shared with staff to recognise the excellent care they provide every day.

NHS Choices provides another valuable way for patients to provide online feedback to us about their care. The site allows for patients to rate their experience at a hospital, out of five

stars. People also provide feedback via social media on our Twitter and Facebook accounts, which the communications and marketing team responds to.

Stakeholder relations

We work with many partners across all aspects of health and social care. In particular we are grateful for the supportive relationships we have with all of our local authorities. North Lincolnshire, North East Lincolnshire and East Riding of Yorkshire councils provide many adult and children's services alongside our own as well as being the main provider of public health expertise. We have strong links with the three council's Health and Wellbeing Boards and members of our executive team deliver regular updates to them.

We also work closely with a number of partners across the NHS including our commissioners, neighbouring acute hospitals, East Midlands Ambulance Service, Yorkshire Ambulance Service, Rotherham Doncaster and South Humber NHS Foundation Trust, Care Plus and NAViGO. We work closely with our main 'tertiary' hospitals and have many staff liaise with them to ensure our patients access expert specialist care when needed.

Our chief executive has led the Healthy Lives, Healthy Futures (HLHF) sustainability programme during 2015/16 across the local health community in North and North East Lincolnshire in conjunction with our partners across commissioning, NHS provision and local authorities. It is essential that we continue to work with our partners and stakeholders across the local health community to improve and provide sustainability services for the future. Across our services we have various initiatives which have been developed with our partners in 2015/16.

The Rapid Assessment Time Limited Service (RATL) is a round-the-clock hospital avoidance scheme which has been helping vulnerable people stay well and out of hospital. It was launched in September 2015 and is run by the unscheduled care team at NLaG helping mainly elderly or frail people in North Lincolnshire who are in urgent need of care. The project is part of the HLHF programme and means patients assessed by RATL will either be treated there and then and discharged from the service, referred to the relevant community team, referred back to their GP or if necessary admitted to hospital.

Working with the North Lincolnshire Clinical Commissioning Group (CCG) as part of HLHF we have also developed a £148,000 new ambulatory care service at Scunthorpe hospital which assess, treats and discharges patients on the same day. People referred to the unit are seen by a senior clinician so decisions about their care can be made quickly, preventing where possible the need to admit them to an inpatient bed.

Further partnership working with North Lincolnshire CCG, as well as North Lincolnshire adult social care team and Rotherham Doncaster and South Humber NHS Foundation Trust (RDASH) saw us launch a new £1.3million service which again focuses on caring for frail elderly patients at Scunthorpe hospital. FEAST – frail elderly assessment support team – has seen the creation of a multi-disciplinary, dedicated service for elderly patients. Based on wards 16 and 17 at the hospital it operates a chair-based unit where patients receive a full comprehensive geriatric assessment. The medical reason for their admission is dealt with and plans to expedite their discharge that same day are put in place. There is also a short-term frailty assessment unit for those patients who need a short stay in hospital, typically between 48 to 72 hours, as well as inpatient beds for people needing to stay longer. The benefits include reducing duplication, rapid access to a consultant and a dedicated team specialised in looking after the frail and elderly. Patients are referred by the hospital's emergency care centre, East Midlands Ambulance Service, GPs or community matrons/emergency care practitioners only if they meet the Bournemouth criteria.

Working with Humberside Police, the Crown Prosecution Service for Yorkshire and Humberside and NHS Protect, the Trust developed and a new joint working agreement aimed at strengthening partnership arrangements in tackling violence and antisocial behaviour against NHS staff. The agreement is to ensure we are all adopting a consistent and integrated approach to reduce the risk of violence and anti-social behaviour against our staff.



Remuneration report

Introduction

The terms and conditions of employment for most of NLaG's employees are linked to the agreed national frameworks, for example Agenda for Change. The exceptions to this are the executive and non-executive directors whose terms and conditions of employment and remuneration are determined by remuneration committees. The details of this are set out in this chapter of the Annual Report.

Under Company law a senior manager is defined as "those persons in senior positions having authority or responsibility for direction or controlling the major activities of a foundation trust".

The NHS Foundation Trust Annual Reporting Manual indicates this means those who influence the decisions of the Trust as a whole, rather than the decisions of individual directorates or services. For the purpose of this remuneration report the description of "senior manager" will refer to the executive directors and the non-executive directors holding positions on the Trust Board of Directors.

The remuneration report contains details of senior managers' remuneration and pensions. It also sets out further information about the appointment of those senior managers (where these have occurred during 2015/16) as required by Monitor's Code of Governance. The narrative and figures in this report relate to those individuals who have held office as a senior manager of the Trust during the periods 2015/16 and 2014/15.

The information in this section is not subject to audit by our external auditors, but they will read the narrative to ensure it is consistent with their own knowledge of the Trust. The auditable section is on page 55.

Annual statement on remuneration

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

The key decisions made on senior managers' remuneration in 2015/16 were as follows:

- The Remuneration Committee made its decisions concerning the chief executive and executive directors and there were no substantial changes made to the policy or approach
- There were some structural changes in the portfolios of two key posts during the course of the year and the affected posts were subjected to further job evaluation, benchmarking and assessment with external advice
- Of the ten executive directors:
 - Three were awarded a small increase, one of which declined this increase
 - One had a previously awarded retention premium consolidated into their substantive salary, which gave no increase to their overall salary
 - Four received no increase
 - One was a new appointment
 - One was a vacancy
- There were no retention premiums implemented in 2015/16. These premiums are only used if there is concern that the post will be very difficult to recruit to and current

benchmarking is unclear for a post with a significant level of particular skills. They are intended to be temporary while clarification is achieved using the resources at the Trust's disposal.

A new medical director was appointed during the year at the same salary as the predecessor. With new requirements from the Secretary of State in respect of salaries higher than that of the national salary of the Prime Minister, the salary for this post had to be sanctioned by his office, which it was.

In making the above decisions the Remuneration Committee looked at a number of remuneration comparisons which included 22 exemplar trusts of similar size and complexity identified and recommended by an external consultancy group. It was concluded from this that the remuneration levels set by the committee for the Trust were appropriate and none of the changes made during 2015/16 were deemed major or substantial.

It was also agreed that the Trust chief executive would keep her current salary while undertaking Healthy Lives, Healthy Future work.

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

The Remuneration Committee has not agreed to any board member leaving their employment by the Trust except in accordance with the terms of the contract of employment.

Remuneration Committee – executive directors' remuneration

For executive directors the overarching policy of the Remuneration Committee is to follow the guidance given by the Department of Health in determining their pay and terms of service.

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

Council of Governor's Appointments and Remuneration Committee for non-executive directors

In accordance with the Trust Constitution the appointment and remuneration of the chairman, deputy chairman and non-executive directors are the prerogative of the Council of Governors (CoG). The ARC has delegated authority to consider this on behalf of the CoG, and provide advice and recommendations to the full council in respect of these matters. The ARC reviews the remuneration and terms of office of the chairman, the non-executive directors and can consider and recommend the appointment, re-appointment or removal of the chairman and the non-executive directors to the full CoG.

The ARC also considers and makes recommendations to the CoG for the re-appointment of the lead governor. The ARC utilises an approved process for review which includes specific criteria on qualifications, skills and experience eligibility and also takes into account the views of the Trust Board as to the particular skills required.

The Monitor Code of Governance echoes the general principles concerning probity and transparency which apply to executive directors, and also sets out some additional principles. These are:

- Levels of remuneration should reflect the time commitment and responsibilities of their roles (D1.2)
- The Council of Governors should consult external professional advisors to market test remuneration levels for the chair and other non-executive directors every three years and when they intend to make a material change to their remuneration (D2.3).

The work of the ARC is in line with the requirements of paragraph 18(2) of Schedule 7 of the Health and Social Care Act 2006.

The ARC is made up of seven governors elected by the CoG, of whom no more than one is a staff governor. It is chaired by the lead governor of the CoG and can call on the expertise of external specialist advisors, as well as other persons to attend their meetings to provide advice as required. People called to attend during 2015/16 included the chairman, director of performance assurance and Trust secretary, deputy director of performance assurance and deputy Trust secretary and interim director organisational development and workforce.

The table below shows the number of Appointments and Remuneration Committee meetings in 2015/16 that were attended by each member of the committee.

Name	15.7.15	16.12.15	31.3.16	Total
Paul Grinell Leads governor (chair)	Y	Y	Y	3/3
Ian Davey, public governor	-			0/1
Harold Edwards, public governor	Y	Y		2/2
John Frost, public governor	-	-	Y	1/3
Liz Stones, public governor	-	-	Y	1/3
Max Withrington, public governor	Y	Y	Y	3/3
Louise Salt, staff governor	-	Y	-	1/3
Jim Whittingham, Trust chairman	Y	Y	Y	3/3
Kathryn Helle, deputy director of performance assurance and assistant Trust secretary	Y	Y	-	2/3
Jane Heaton, interim director of organisational development and workforce		-		0/1
Wendy Booth, director of performance assurance and Trust secretary	-	Y	Y	2/3

The ARC periodically reviews the process to be followed for the appointment of the chairman, deputy chairman, senior independent director and non-executive directors, including the means by which views will be obtained from the Trust Board on the qualifications, skills and experience required for each position when considering potential candidates. These processes summarised below:

Process for the appointment of the chairman

The appointment process for a forthcoming vacancy will commence approximately six months prior to the vacancy arising. The Trust Board's advice will be obtained via the senior independent director for the ARC, and opinion on the skills, knowledge and expertise required by the Board to fulfill the role in the form of a job description and person specification for the appointment.

Unless it has been reviewed within the preceding 12 months, prior to advert the ARC will confirm the proposed remuneration of the chairman with reference to remuneration levels in comparable organisations and advice from external agencies. Should the ARC conclude that a level of remuneration other than that previously approved for the existing chairman should be offered, this will require approval of the CoG prior to appointment.

The vacancy will be advertised in the newsprint media covering the catchment area of eligibility for Trust membership, plus at least one major national newspaper. In addition, an external agency (selected by the director of human resources, and approved by the ARC) should be employed to undertake the work to identify suitable candidates.

A nominations sub-committee of the ARC will be established comprising a maximum of three governors, at least two of whom should be public governors, the senior Independent director and chief executive to work with the external agency to both shortlist and interview suitable candidates. The nominations sub-committee will be chaired by the senior independent director, and will take account of the requirements for eligibility and independence set out in the Trust Constitution. At interview the nominations sub-committee may be supplemented by an independent assessor, typically an experienced chairman from another foundation trust.

The nominations sub-committee will make a recommendation to a general meeting of the CoG setting out the preferred candidate for appointment).

Process for the appointment of non-executive directors

The appointment process for a forthcoming vacancy will commence approximately three months prior to the vacancy arising, and the appointment and remuneration of the non-executive directors are the prerogative of the Council of Governors (as per the see Trust Constitution).

The ARC, via the chairman, obtains the Trust Board's advice and opinion on the structure, size and composition of the Board of Directors and on the skills, knowledge and expertise required by the Board to fulfil the role in the form of a job description and person specification for the appointment(s).

Prior to advert, the ARC will confirm the proposed remuneration of the non-executive directors with reference to remuneration levels in comparable organisations (unless it has been reviewed in the preceding 12 months). Should the ARC conclude that a level of remuneration other than that previously approved for the existing non-executive directors should be offered, this will require approval of the CoG prior to appointment.

The vacancy will be advertised in the newsprint media covering the catchment area of eligibility for Trust membership, plus at least one major national newspaper.

A nominations sub-committee of the ARC will follow the same process for appointing the non-executive directors as with the chairman, but will also provide a 'meet and greet' session for the other governors on the ARC to have exposure to the candidates in addition to the three governors on the nominations sub-committee.

Once a suitable candidate has been identified, the nominations sub-committee will make a recommendation to a general meeting of the CoG, who will be asked to ratify the appointment. The nominations sub-committee, through the chairman, also consult the Trust Board (particularly the other non-executive directors) before the final decision is made by the CoG.

Where an existing non-executive director seeks re-appointment, the appointment process will be by external competition. In exceptional circumstances, the nominations sub-committee may wish to consider re-appointment without external competition, and will make a recommendation to a general meeting of the CoG who will be asked to ratify the appointment. In such instances and prior to a recommendation being made, an assessment will be undertaken of the candidate's ongoing suitability for the role against the current job

description and person specification, any changes to the time commitment for the role and the need for progressive refreshing of the Trust Board.

Senior managers' Remuneration Policy

Futures policy tables

This section describes the policy narrative relating to the components of the remuneration packages for senior managers (executive and non-executive directors). Each of the components detailed in these supports the Trust in terms of its long-term strategic objectives.

No new components were added within the remuneration packages during 2015/16 and they are consistent with the previous financial year.

Element	Policy
Base pay	Base pay is determined through job evaluation, market benchmarking and internal relativities and is used to attract and reward the right calibre of leadership to deliver the Trust's short, medium and long term objectives.
Pension	Executive directors are able to join the standard NHS pension scheme that is available to all staff.
Temporary retention premium	A retention premium is paid to reflect the nature of the individual contribution of the post holder and encourage retention in the face of a difficult recruitment market. None were paid in 2015/16.
Additional incentive payment	This was previously paid to the deputy chief executive role when it was added to the chief nurse role, but it ceased once this became a substantive role.
Bonuses	Bonuses are not given to staff, including senior managers.
On call payment	In relation to executive pay no board members receive on call payment.
Benefits	The Trust operates a number of salary sacrifice schemes including cycle scheme, child care vouchers, a car lease scheme and a computer scheme. These are open to all permanent members of staff. The individual forgoes an element of their basic pay in return for a defined benefit.
Travel expenses	Appropriate travel expenses are paid for business miles.

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

Remuneration of the chairman and non-executive directors

Name	Salary 2015/16	Salary 2014/15
Jim Whittingham	£40,000	£40,000
Alan Bell	£12,500	£12,500
Anne Shaw	£12,500	£12,500
Linda Jackson	£12,500	£12,500
Neil Gammon	£12,500	£12,500
Stan Shreeve	£12,500 £2,926	£12,500 £2,926 for chair of the Audit Committee

Components of the remuneration of the executive team and the Trust's Remuneration Strategy

The Trust's reward strategy, agreed during 2013/14, is designed to take the following issues into account:

- The importance of addressing historical anomalies
- Internal relativities and equitable pay between members of the executive team
- Internal relativities in relation to staff on Agenda for Change bands reporting into the executive team members
- The positioning of individuals on or below the pay ranges for the posts
- Consideration of the appropriate external market benchmarking information
- The applications of the principles framework in practice
- The ability to, and mechanism for, progressing through a scale
- The transparency of decision making and communication processes.

This was considered to meet the Trust's strategic objectives through a range of means as set out in the principles framework:

- The Trust's competitive position in attracting, appointing and retaining candidates of the highest calibre from the national market
- The reputation of the Board and the Trust in terms of internal equity within the public sector
- The proposals made by the committee are affordable
- The executive's performance/objectives are clearly being achieved and worked through.

Due to historical anomalies in relation to pay and some lack of clarity as to how pay was determined for the executive directors, a key priority was to ensure a methodology was created which was clear and transparent. The Remuneration Committee was advised on a range of approaches and methods with different strategic impacts and the system established was based on the following elements:

- Job evaluation to establish job size, enable a consideration of internal relativities and provide assurance – as far as possible – concerning equal pay and equal value
- Benchmarking against relevant NHS trusts, and other sectors where appropriate, to assess the market worth of posts, taken from several sources: the Hay Group database; an independent NHS boardroom survey; the Foundation Trust network executive pay survey and the confidential exchange of data with neighbouring trusts.

- There was a pre-existing contractual agreement for a lease car which was considered necessary to the due to the geographical location of the Trust's sites as well as being a retention measure
- A consideration of internal relativities between senior members and also between them and their direct reports on Agenda for Change terms and conditions
- Salaries are spot within a range and there is no performance related pay
- There is a slightly different approach in alternate years. In year one a fuller review of the job descriptions and wider benchmarking. In year two, an annual market review of salaries against relevant NHS benchmarking only.

Affected staff have in previous years had the opportunity to comment on strategy. During 2015/16 there have been no policy changes.

Performance and appraisals

Performance of members of the Board is not linked to remuneration, as they are paid a base salary. Directors have a monthly one-to-one meeting with the chief executive, with an annual appraisal in April which agrees their objectives. There is then an objective review for all of the directors in October.

Service contract obligations

The Trust acknowledges that on occasions it may be necessary for staff to relocate to take up employment. As such relocation packages can be provided to newly appointed staff that need to relocate in order to take up a substantive post with the Trust. Relocation fees will only be paid in respect of one individual as part of family relocation. Claims relating to the same relocation by another family member working at the Trust are not permitted and would be classed as fraudulent

The Trust will reimburse Trust directors up to a maximum of £10,000. This can be used for the following agreed purposes: estate agent fees; legal fees; removal fees; survey fees; search fees and land registration; rent allowance; travel costs; bridging loan; purchase of domestic goods. Taxation rules apply to relocation packages.

Claims will only be paid upon submission of all supporting original receipts, quotes etc and must be made within one year of commencement with the Trust. Employees who accept the relocation incentive package signs an undertaking to refund all costs reimbursed if they leave the Trust within the first 36 months of NLaG employment.

Where someone leaves the Trust before the 36 month period is ended and are required to pay the costs paid out they agree to repay the amount to the Trust from their final salary payment.

Policy on payment for loss of office

There is currently no provision with the Remuneration Policy for payment for loss of office on senior managers' contract and no payments have been made during 2015/16. There is a clause for the senior managers' contract which enables the Trust to reclaim relocation monies if the individual leaves within an agreed period of their appointment. None have been claimed during 2015/16.

Statement on consideration of employments conditions elsewhere in the Trust

There has been no formal consultation regarding senior managers' Remuneration Policy but this is something the committee may consider in the next financial year.

Policy on notice periods

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

Signed:



Name: Alan Bell

Title: Chairman of the Remuneration Committee

Dated: May 20 2016

Annual report on remuneration

This section includes a brief description of the work of the committees that are involved in the appointments of both the executive and non-executive directors, and in determining their respective salaries and remuneration. These are:

- The Remuneration Committee
- The Appointments and Remuneration Committee

Directors' contracts

All executive directors have a permanent contract and their appointments are not time limited and the period for servicing notice is three months. The remuneration for executive directors does not include any performance related bonuses and none of the executives receive personal pension contributions other than their entitlement under the NHS pension scheme.

Details of the contract start date for the chief executive and other members of the executive team who are served during 2015/16 are set out in the table below:

Post	Contract
Chief executive Karen Jackson	Appointed: September 2010 End date: indefinite term Notice period: three months
Deputy chief executive Dr Karen Dunderdale	Appointed: June 29 2015 End date: indefinite term Notice period: three months
Chief operating officer Karen Griffiths	Appointed: April 2014 End date: indefinite term Notice period: three months
Director of organisational development and workforce Dr Neil Pease	Appointed: October 2011 End date: May 31 2015 Notice period: three months
Chief nurse Tara Filby	Appointed: acting chief nurse June 29 2015 Appointed: chief nurse October 9 2015 Notice period: three months
Medical director Mr Lawrence Roberts	Appointed: July 7 2015 End date: indefinite term

	Notice period: three months
Acting medical director Mr Lawrence Roberts	Appointed: March 2015 End date: July 2015 Notice period: three months
Director of performance and assurance Wendy Booth	Appointed: August 2012 End date: indefinite term Notice period: three months
Director of finance Marcus Hassall	Appointed: August 2014 End date: indefinite term Notice period: three months
Director of strategy and planning Pam Clipson	Appointed: June 2014 End date: indefinite term Notice period: three months
Director of facilities and estate Jug Johal	Appointed: August 2014 End date: indefinite term Notice period: three months
Interim director of organisational development and workforce Jane Heaton	Appointed: May 1 2015 End date: February 15 2016 Notice period: N/A

Details of the non-executive directors who have served during the course of 2015/16 are shown in the table below along with details of their current terms of appointments.

The tenure (length) of employment for non-executive directors is set out in the Trust's Constitution and is three years for the chair and non-executive directors, and then subject to reappointment. Any terms beyond six years is subject to rigorous review by the Council of Governors (CoG) and non-executive directors serving beyond this are subject to an annual reappointment.

Name	Appointment date	Start of current term	End of current term
Jim Whittingham	19.7.2010	18.7.2013	18.7.2016
Alan Bell	1.8.2010	31.7.2016	31.12.2016
Anne Shaw	12.8.2013	11.8.2015	12.8.2018
Linda Jackson	30.9.2014	30.9.2014	29.9.2016
Neil Gammon	1.8.2010	31.7.2013	31.7.2017
Stan Shreeve	7.6.2012	7.6.2015	7.6.2018

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

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

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

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

this purpose will include the first layer of management below board level (see Monitor Code of Governance D2.2).

The committee is comprised of three non-executive directors. Other directors attend meetings or parts of meetings by invitation as required for specialist advice including the chairman, chief executive, director of organisational development and workforce and the Trust secretary. In accordance with Monitor's Code of Governance no director is involved in deciding his/her remuneration (Para D2a).

The Remuneration Committee is independent of the executive arm of the Board of Directors. However, during 2015/16 the committee has taken advice from the following officers of the Trust: Director of organisational development and workforce, the Interim director of organisational development and workforce and the Trust chairman.

Between April 1 2015 and March 31 2016, the Remuneration Committee met five times. The table below illustrates the attendees and their attendance.

Name	Title	Date of attendance
Alan Bell	Non-executive director Chairman of the committee	13.5.15 22.7.15 12.8.15 11.11.15 10.2.16
Stan Shreeve	Non-executive director	13.5.15 22.7.15 12.8.15 11.11.15 10.2.16
Nail Gammon	Non-executive director	13.5.15 22.7.15 11.11.15 10.2.16
Jim Whittingham	Trust chairman	22.7.15 10.2.16
Wendy Jones	Secretarial support	22.7.15 12.8.15 11.11.15 10.2.16
Heidi Forster	Secretarial support	13.5.15
Sue Miller	External advisor	13.5.15
Jane Heaton	Interim director OD and workforce	10.2.16
Neil Pease	Director of OD and workforce	13.5.15

Advice to the committee

External advice to the Remuneration Committee was provided by The Hay Group. They provided job evaluation and remuneration benchmarking from their NHS executive pay database. They were contracted by the Remuneration Committee to assist in the job evaluation of the deputy chief executive, medical director and director of human resources posts during 2015/16 as these posts required formal and independent evaluation of the job roles and remuneration.

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

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

During 2015/16 the Hay Group was paid £1,135 for their services which included carrying out the job evaluations and writing reports on their findings, together with the benchmarking information.

DACBeechcroft was also asked to provide job evaluation advice and received a total of £450 for their services which included analysis of information and attendance at the Remuneration Committee.

The chairman of the Remuneration Committee appointed The Hay Group and DACBeechcroft to provide advice during 2015/16 which was objective and independent in helping it make its decisions around executive remuneration.

Off-payroll arrangements

There were no off-payroll arrangements during 2015/16. This would be discretionary as there is no contractual obligation to pay this.

Directors' and governors expenses

Expenses have been paid to both directors and governors during the year. See the tables below:

Directors and governors expenses 2015/16

2015/16	Total in office	Total receiving expenses	Total expenses
Directors	17	11	£18,123
Governors	26	12	£3,450

Directors and governors expenses 204/15

204/15	Total in office	Total receiving expenses	Total expenses
Directors	18	14	£15,879
Governors	26	11	£3,596

Note: The number includes all directors, non-executive directors or governors who served for any part of the financial year.

Remuneration of all other staff

Agenda for Change (AfC), the nationally introduced pay reform for the NHS which was introduced in October 2004, covers all directly employed staff, except very senior managers and those covered by the Doctors Dentists Pay Review Body. For all local pay arrangements not determined by AfC, pay increases were consisted with AfC increases. A robust system of appraisal and personal development planning has been adopted for all staff.

A different approach is adopted in relation to the Trust Executive because all other staff are on national terms and conditions and the executive team members' remuneration is determined locally. AfC staff have clear incremental progression, which is performance related, and medical and dental staff are on a separate contractual agreement which also allows for incremental progression and the award of substantial additional payments for

clinical excellence. They are also able to benefit from an annual cost of living award, if this is agreed nationally. It was not felt appropriate for executive team members to be on an incremental scale unless this involved performance related assessments. The priority was to provide a simple, clear and transparent model in which senior posts are operating. Salaries are inclusive and there is no additional cost of living award. Strategically, this strategy is designed to enable the Trust to recruit and retain the level of skills and expertise we cannot effectively function without.

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



Audited director's remuneration 2015/16

Name and title	2015/16				2014/2015			
	Salary (bands of £5,000) £000's	Pension Related benefit (bands of £2,500) £000's	Benefits In kind (bands £00's	Total (bands of £5,000) £000's	Salary (bands of £5,000) £000's	Pension Related benefit (bands of £2,500) £000's	Benefits In kind (bands £00's	Total (bands of £5,000) £000's
Dr J Whittingham Chairman	£35 - £40	-	-	£35 - £40	£35 - £40	-	-	£35 - £40
Mrs K Jackson Chief executive 1	£180 - £185	£25.0 - £27.5	61	£210 - £215	£180 - £185	£20.0 - £22.5	20	£205 - £210
Dr K Dunderdale Deputy CEO (appointed 29.6.15, previously chief nurse) 1	£135 - £140	£5.0 - £7.5	79	£145 - £150	£130 - £135	£185.0 - £187.5	5	£315 - £320
Mrs T Filby Chief nurse (interim from 29.6.15, appointed 9.10.15) 1	£75 - £80	£147.5 - £150.0	29	£225 - £230	-	-	-	-
Mrs K Griffiths Chief operating officer (resigned 10.6.16) 1	£115 - £120	£10.0 - £12.5	33	£130 - £135	£115 - £120	£207.5 - £210.0	27	£330 - £335
Mr L Roberts Medical director 1	£180 - £185	£147.5 - £150.0	32	£345 - £350	£5 - £10	£2.5 - £5.0	2	£15 - £20
Dr M Withers Medical director (resigned 28.2.2015) 1, 4	-	-	-	-	£145 - £150	£210.0 - £212.5	63	£355 - £360
Dr E Scott Medical director (resigned 31.7.2013) 5	-	-	-	-	-	-	-	-
Mrs W Booth Director of performance assurance & Trust secretary 1,2,3	£105 - £110	£25.0 - £27.5	32	£135 - £140	£105 - £110	£227.5 - £230.0	25	£340 - £345
Mr M Hassall Director of finance 1	£105 - £110	£45.0 - £47.5	41	£155 - £160	£70 - £75	£65.0 - £67.5	18	£135 - £140
Mrs P Clipson Director of strategy and planning 2	£100 - £105	(£117.5 - £120.0)	-	(£20 - £25)	£80 - £85	£240.0 - £242.4	7	£320 - £325
Mr M Rocke Director of finance and business support (resigned 31.7.14) 1	-	-	-	-	£40 - £45	£25.0 - £27.5	3	£70 - £75

Mr J Johal Director of estates and facilities 1	£85 - £90	(£60.0 - £62.5)	90	£30 - £35	£55 - £60	£92.5 - £95.0	48	£150 - £155
Ms J Heaton Interim director of organisational development and workforce (appointed 1.5.15, resigned 15.2.16) 1	£45 - £50	£57.5 - £60.0	4	£105 - £110	-	-	-	-
Dr N Pease Director of organisational development and workforce (resigned 31.5.15) 1	£20 - £25	(£0.0 - £2.5)	7	£20 - £25	£120 - £125	£22.5 - £25.0	40	£145 - £150
Mr A Bell Non-executive director	£10 - £15	-	-	£10 - £15	£10 - £15	-	-	£10 - £15
Mr N Gammon Non-executive director	£10 - £15	-	-	£10 - £15	£10 - £15	-	-	£10 - £15
Mrs L Jackson Non-executive director	£10 - £15	-	-	£10 - £15	£5 - £10	-	-	£5 - £10
Mr P Jackson Non-executive director (resigned 30.9.14)	-	-	-	-	£5 - £10	-	-	£5 - £10
Mrs A Shaw Non-executive director	£10 - £15	-	-	£10 - £15	£10 - £15	-	-	£10 - £15
Mr S Shreeve Non-executive director	£10 - £15	-	-	£10 - £15	£10 - £15	-	-	£10 - £15
	£000		£00		£000		£00	
Gross remuneration including National Insurance and pension contributions	1,576		408		1,456		258	

Band of highest paid director's total remuneration (£'000)	£180 - £185		
Median remuneration (£'000)	22	6	6
Ratio	8.2	7	7

- 1 – Benefit in kind relates to lease car
 2 – Benefit in kind relates to computers
 3 - Benefit in kind relates to cycles
 4 – Dr M Withers on secondment to another Trust until 31.12.15
 5 – Dr E Scott on secondment Public Health England until 30.9.15
 6 – The median remuneration is the middle item salary when the annualised salaries of all members of staff including agency and seconded staff (excluding bank staff and the high paid director) are arranged in descending order
 7 – The ratio is obtained by dividing the highest paid directors salary by the median salary.

Audited pension benefits 2015/16

Name	Title	Real increase/(decrease) in pension at age 60 (bands of £2,500)	Real increase in lump sum at aged 60 related to real increase on pension (bands of £2,500)	Total accrued pension at age 60 at March 31 2016 (bands of £5,000)	Lump sum at age 60 related to accrued pension at march 31 2016 (bands of £5,000)	Cash equivalent transfer value at March 31 2016	Cash equivalent transfer value at March 31 2015	Real increase/(decrease) in cash equivalent transfer value
		£'000	£'000	£'000	£'000	£'000	£'000	£'000
Mrs K Jackson	Chief executive	2.5 – 5.0	(0.0 – 2.5)	45 – 50	130 – 135	807	766	32
Dr K Dunderdale	Chief nurse & deputy chief executive	0.0 – 2.5	2.5 – 5.0	45 – 50	135 – 140	729	698	22
Mrs T Filby	Chief nurse (part year)	5.0 – 7.5	20.0 – 22.5	30 – 35	95 – 100	502	346	116
Mrs K Griffiths	Chief operating officer	0.0 – 2.5	2.5 – 5.0	45 – 50	135 – 140	867	826	31
Mr L Roberts	Medical director	7.5 – 10.0	22.5 – 25.0	40 – 45	125 – 130	908	261	644
Mrs W Booth	Director of performance assurance and Trust secretary	0.0 – 2.5	0.0 – 2.5	40 – 45	120 – 125	722	685	29
Mr M Hassall	Director of finance	2.5 – 5.0	2.5 – 5.0	30 – 35	90 – 95	508	467	35
Mr J Johal	Director of estates and facilities	(0.0 – 2.5)	(10.0 – 12.5)	10 – 15	25 – 30	131	163	(34)
Ms Jane Heaton	Interim director of organis. Develop and workforce (part year)	2.5 – 5.0	5.0 – 7.5	25 – 30	75 – 80	455	360	49
Dr N Pease	Director of organis. Develop and workforce (part year)	0.0 – 2.5	(0.0 – 2.5)	15 – 20	45 – 50	265	267	(1)
Mrs P Clipson	Director of strategy and planning	(2.5 – 5.0)	(17.5 – 20.0)	20 – 25	65 – 70	280	335	(59)

The chairman and non-executive directors do not receive pensionable remuneration, therefore there are no entries in respect of pensions for them.

On March 16 2016, the Chancellor of the Exchequer announced a change in the Superannuation Contributions Adjusted for Past Experience (SCAPE) discount rate from 3.0 per cent to 2.8 per cent. This rate affects the calculation of CETV figures in this report.

Due to the lead time required to perform calculations and prepare annual reports, the CETV figures quoted in this report for members of the NHS Pension scheme are based on the previous discount rate and have not been recalculated.

Cash Equivalent Transfer Values

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

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

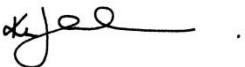
The basis of CETV calculations are based in the Department of Work and Pensions regulations which came into force on October 13 2008.

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

Real increase in CETV

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

Signed:



Name: Karen Jackson
Job title: Chief executive
Dated: May 20 2016

Staff report

Workforce issues continued to be a source of pressure during 2015/16, especially within nursing and medical recruitment.

Our ability to recruit and retain staff with the right skills and knowledge is critical to our service delivery and continues to be a focus of the organisation.

There were, and continue to be, national shortages of skilled clinical staff and trusts with such an isolated geographical area such as ours struggle more than large town and city hospitals.

The Trust knows that a workplace where the staff feel valued and supported increases retention rates and our attractiveness to potential new recruits. Our aim continues to be one of creating and maintaining a working environment where people can reach their full potential within their jobs. The Trust's mentoring and coaching programme continues to support this work.

Analysis of average staff numbers

Breakdown of male and female employees

	Director	Other senior managers	Employees	Total
Male	6	73	1,185	1,264
Female	5	129	5,086	5,220
Total	11	202	6,271	6,484

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

Average number of employees (whole time equivalent basis)

Group			2015/16	2014/15
	Permanent number	Other number	Total number	Total number
Medical and dental	515	12	527	533
Ambulance staff	-	-	-	-
Administration and estates	1,199	-	1,199	1,171
Healthcare assistants and other support staff	1,073	-	1,073	1,068
Nursing, midwifery and health visiting staff	1,520	-	1,520	1,561
Nursing, midwifery and health visiting learners	-	-	-	-
Scientific, therapeutic and technical staff	1,009	-	1,009	994
Healthcare science staff	-	-	-	-
Social care staff	-	-	-	-
Agency and contract staff	-	178	178	171
Bank staff	-	147	147	116
Other	-	-	-	-
Total average numbers	5,316	337	5,653	5,614

Sickness absence data

Staff sickness absence Number	2015/16 Number	2014/15 Number
Total days lost	50,750	48,279
Total staff years	5,309	5,106
Average working days lost (per WTE)	10	9

Trust policies around employing people with disabilities

We have revised our Recruitment and Selection Policy and best practice guide during 2015/16 which specifically sets out a framework to ensure that full and fair consideration is given to applicants for employment who may have a disability.

It also sets out good employment practice so that all applicants regardless of their disability have recruitment and promotion opportunities that are managed in a consistent and appropriate manner.

We have been awarded the 'two ticks' positive symbol by Job Centre Plus which is given to employers who have made a commitment to employ, keep and develop the abilities of disabled staff.

In being awarded the disability symbol, we have has made five commitments regarding recruitment, training, retention, consultation and disability awareness. The five commitments are:

1. To interview all disabled applicants who meet the criteria for a job vacancy and to consider them on their abilities
2. To discuss with disabled employees, at any time but at least once a year, what both parties can do to make sure disabled employees can develop and use their abilities
3. To make every effort when employees become disabled to make sure they stay in employment
4. To take action to ensure that all employees develop the appropriate level of disability awareness needed to make these commitments work
5. To review these commitments each year and assess what has been achieved, plan ways to improve on them and let employees and Job Centre Plus know about progress and future plans.

We also ensure that disabled employees have equitable access to training, career development and promotion. The current policy for the management of sickness specifically sets out provision for those individuals who have a disability.

A key objective is to promote an environment where individuals feel able to disclose any disability or condition which may have a longterm and substantial effect on their ability to carry out their duties in order that reasonable adjustments can be considered and wherever practical made.

Training on the application of this policy is run regularly throughout the year for those with line management responsibilities. In addition to this, as part of every employee mandatory training, an equality programme is undertaken which encompasses disability.

Any employee who becomes disabled, or who has suffered an injury where they were struggling to complete their duties at work, would be referred to the Trust's occupational health department which would provide recommendations for any suitable support on an individual basis.

Communication and involvement

Ensuring that we listen to our staff and take on board their views is pivotal in delivering better outcomes for patients and their care. It is also recognised that where individuals feel valued and respected, this supports the retention of skilled staff and increases our attractiveness to potential recruits. Significant efforts were made over the year to improve the quality and effectiveness of employee communications.

During 2015/16 the chief executive launched her 'Together we Blog' which she publishes on the Trust's internal intranet system called the Hub. In the blog she shares her personal thoughts on the NHS, our hospitals and community services, our achievements, our challenges and sometimes just life in general. She invites staff to comment and feedback their thoughts and views on what she blogs about.

Our chief executive also holds a monthly 'open office session' where any member of staff, or group, can pop along to see her to raise specific questions, talk about issues important to them or raise concerns. Staff do not have to book and can simply turn up to speak to her. For those staff working on a different site to the CEO, they can use the video teleconferencing system, or speak to her by phone.

The chief executive also invites staff to request an informal visit from her to their place of work where they can sit and have a chat over a cuppa to discuss any concerns or issues. Or alternatively she is happy to attend team meetings where she will provide an update or answer any general questions.

There is also a schedule of announced and unannounced director visits to wards and departments, providing frontline staff with an opportunity to meet members of the executive team and showcase their area, or raise any concerns and issues they may have.

The Trust also has a quarterly programme of director forums where a director and two non-executive directors invite staff to drop in to discuss any issues they would like to raise. They are held on each hospital site and in the community, with staff able to just turn up.

The chief nurse directorate senior nursing team don a uniform on the last Friday of every month and go out and work on the wards with frontline staff. It gives them an opportunity to speak and care for patients directly, as well as the chance to chat with frontline staff providing care on a daily basis.

There is also a monthly chief executive cascade in which managers or their representatives are invited to attend. Key corporate messages, issues and concerns are highlighted and discussed and fed back by attendees to their teams. A summary of the key discussions are also included in the staff weekly bulletin which is emailed out every Wednesday by the communications and marketing team.

Executive directors and the communications and marketing team also utilise all user emails to ensure employees are kept fully abreast of developments within the Trust.

As well as a weekly bulletin, the communications and marketing team also produces a bi-monthly staff and member magazine which is emailed out to all staff, as well as hard copies sent to wards, departments and key people. This contains a round-up of key developments, appointments, and general news, as well as a governor section 'Together we Speak' in which they feedback on their work, experiences and latest news and views.

2015/16 saw a lot of work around notice boards as it is acknowledged this can be a useful and simple way of disseminating information of interest and relevance to the workforce. A week-long notice board clean-up was undertaken to identify positioning of boards to ensure

they were appropriate, as well as clearing out of any inappropriate, old, and tatty posters which were removed. A Poster Policy was written and approved, which clearly defines what type of information can be displayed, by who and where.

Staff can also feedback to the Trust via its quarterly ‘morale barometer’ which staff can complete online, or by printing a questionnaire off. Its aim is to gauge how happy people are at work. It asks whether staff would recommend our hospitals as a place of treatment for family and friends, or as a place to work. It also asks how valued staff feel, and provides an opportunity for people to comment.

We have continued to enjoy a healthy and productive relationship with Trade Union representatives, and open and transparent communication has been instrumental in achieving this. It is clearly recognised that the Trust management and Trade Unions share a common objective in ensuring the continuing efficiency and quality of the services provided to patients and their relatives, and our staff.

The Joint Negotiating Consultative Committee (JNCC) and the Local Negotiating Committee (LNC) bring together union and trust representatives, and continued to be well established in discussing issues of concerns and organisational activity.

The organisation also strives to seek the views of its employees when making decisions which are likely to affect their interests. The JNCC and LNC continue to provide valuable insight into staff experiences and help to shape the approach to the development of relevant workforce strategies.

Key achievements in the last year have included the establishment of a policy sub-committee comprising a range of staffside representatives together with appropriate management leads. Together they have developed in partnership a number of workforce policies.

We recognise that the involvement and engagement of staff is key to organisational success and the patient experience, and we aim to be an employer that people want to work for, allowing employees to make contributions and achieve their full potential. In this respect a piece of work was commissioned in November 2015 to support the development of more effective staff engagement and partnership working. It is anticipated this will encourage new and innovative ways of engaging with staff and increasing partnership working in order to deliver sustainable change to improve quality and experience for both patients and staff.

The organisation also publishes consultations around service developments and changes on its internal intranet the HUB and encourages staff to provide feedback.

Our staff governors also provide a valuable link between the workforce and our executive team via the Council of Governors meetings and briefings. They play an important role in representing as wide a range of staff views as possible when contributing to discussions on a variety of agendas, including the Trust's performance.

The human resources team also undertook a partnership working forum with staffside representatives during 2015/16 which focused on how best staff and their representatives can be involved and communicated with regarding the wider Healthy Lives, Healthy Futures programme which is looking at sustainability across the whole of the local health community.

Health and safety performance

The SHE Assure electronic risk assessment system continues to develop with the Trust directorate structure mapped onto the system with just over 2,100 live activity risk assessments recorded. In addition nearly 300 COSHH assessments and more than 160 other specialist assessments are also live on the system.

There has been more than 750 actions generated and progress monitored during 2015/16 and only five are currently uncompleted (not yet overdue).

More than 300 assessments were reviewed during the year and this number will rise as automatic review dates are included (the assessor is notified that a review is due 30 days before the due date). This ensures that the assessments are kept up to date and archived if no longer required.

The system is being further developed to allow online assessments for staff, currently they use a paper based system. We are moving towards a DSE User Workstation Checklist which is expected to go live in the early part of 2016/17. These online assessments can be completed via the portal (this is an open view portal) which is now up and running. This portal is also being used for trialling a hazard spotting module to allow staff to report safety concerns directly with the health and safety team before an incident occurs. Currently this is being tested prior to roll out.

During the year the Health and Safety Executive (HSE) investigated an incident reported to them under the Reporting of Injuries Diseases and Dangerous Occurrences Regulations (RIDDOR). As part of that investigation a number of Improvement Notices were served in relation to water safety management issues. Work was carried out and all of the notices were signed off by the HSE by January 2016. Ongoing work to improve water safety is continuing throughout the 2016/17 period.

The year also saw the first part of the replacement of electric profiling beds for the intensive care units. These specialist beds will enable patients to be weighed and x-rayed without the need to transfer them off the bed. The completion of this project will be in the first half of the new financial year and in the meantime a review of bariatric profiling bed requirements is being conducted.

Fire safety management continues to progress with ongoing training for staff and additional fire wardens continue to be trained with the objective of all areas having access to a trained fire warden to assist with any response in the event of a fire.

The Trust has also worked with the Fire Authority to address a number of areas where compliance with fire regulations can be further improved and also address some other areas identified from audits and review of fire risk assessments. An ongoing action plan of all fire safety work is being used to allocate funding received on a priority basis and level of risk.

Occupational health performance

Our occupational team has experienced a busy 12 months with the implementation of a new health software system and a restructure.,

The first change was the implementation of new software Cohort, which is an established software package proven within the NHS and installed in more than 250 NHS hospitals. It has been designed to offer a simple interface for the management of employee's medical information, appointments, immunisations, specific health surveillance and other occupational health related data.

The biggest benefit is the streamlining, timeliness and communication of appointments, moving towards a paperless system, and providing management information and reports to inform the wider Trust agenda, particularly on workforce planning.

The system also ensures the Trust is compliant with key performance indicators. In addition, this system is web-based which provides easy access for the occupational health staff at all sites.

The team also underwent a restructure during 2015/16 with a consultation that ran between April 27 and May 27. The outcome was that the department now offers a five-day service across Scunthorpe and Grimsby hospitals, with a satellite nurse and physiotherapy clinic provided at Goole hospital. This new system provides adequate support to the occupational health physician, and planned time for working towards the occupational health accreditation (Safe Effective Quality Occupational Health Service - SEQOHS) and continuing professional development for the team.

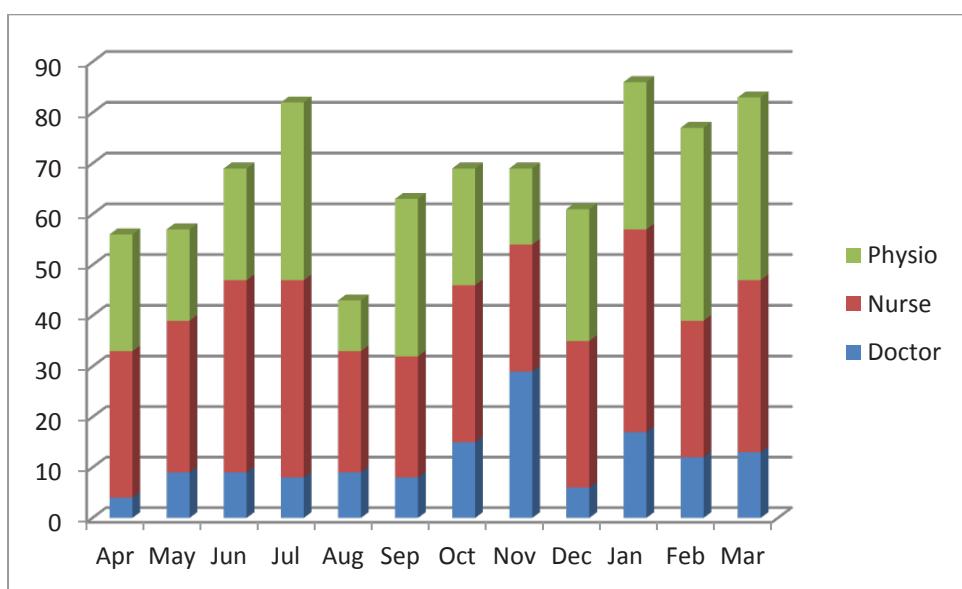
The administration team has been centralised onto the Scunthorpe site, and it has been agreed there will be 1.20 whole time equivalent senior occupational health nurses permanently based at each main site. This has currently been delayed until we can successfully recruit.

The daily hours for some of part time staff has also been increased to 7.5 hours, although the total hours worked per week has not been affected. This has helped to provide adequate cover for the departments.

One of the nurses has taken on the role of coordinating and progressing the health and wellbeing agenda one day per week with an administrator for support, minute-taking and planning associated with the Health and Wellbeing Steering Group meetings.

Operational activity

The team provides a full range of occupational health checks including pre-employment, vaccinations and referrals for staff. The team has received the following volume of referrals between April 1 2015 and March 31 2016:



October saw the annual flu campaign launched and the team was delighted with a total increase in uptake from 65.5 per cent in 2014/2015 to 70.7 per cent in 2015/16.

In November staff who attended the service for an appointment were asked to complete an anonymous survey, with 133 returned during the month. They showed:

- Of those who attended 87 per cent rated the overall experience as excellent, 10 per cent as very good and three per cent as good
- 98 per cent stated they felt they were treated with respect and dignity and that OH staff were polite and helpful, (two per cent did not answer the question)
- 95 per cent were happy with the current opening times and found it very easy to make an appointment
- There were some comments regarding better signposting to the departments. As a result we will be requesting additional signage where appropriate, and sending out maps to those who are not familiar with the whereabouts of the department
- There was a lot of positive feedback about the excellent, helpful, and friendly staff and excellent service.

How the Trust counters fraud and corruption

Fraud costs the NHS millions of pounds a year that could have been spent on patient care, so every member of staff has a duty to help prevent it. NHS fraud may be committed by staff, patients and suppliers of goods/services to the NHS. The Trust is committed to deterring and detecting all instances of fraud, bribery and corruption as far as possible within the Trust and ensuring that losses are reduced to an absolute minimum, therefore ensuring that valuable public resources are used for their intended purpose.

The Trust has a well-publicised system in place for staff to raise concerns if they identify or suspect fraud. They can do this via our local counter fraud specialist (LCFS), the director of finance, the Trust's electronic anonymous reporting system 'Bad Apple' or via the NHS fraud and corruption reporting line. Patients and visitors can also refer suspicions of NHS fraud to the Trust via the same channels with the exception of the 'Bad Apple' reporting system which is an internal staff system.

NHS Protect provide the national framework through which NHS trusts seek to minimise losses through fraud. The director of finance is nominated to lead counter fraud work and is supported by the LCFS. The Trust follows the guidance contained in the NHS Provider Standards and ensures our contractual obligations with our local clinical commissioning groups are adhered to. The Trust has a robust Local Counter Fraud, Bribery and Corruption Policy and Response Plan which provides a framework for responding to suspicions of fraud and provides advice and information on various aspects of fraud investigations. The Trust also has a Standards of Business Conduct Policy which contains a statement from the Trust's chief executive in relation to ensuring that our organisation is free from bribery and corruption. There are references to counter fraud measures and reporting processes in various other Trust policies and procedures.

We have an in-house collaborative counter fraud arrangement with two other local acute NHS trusts, which allows us to have a LCFS permanently on site, supported by a small team of counter fraud specialists dedicated to combatting fraud within a secondary care setting. An annual work plan, approved by the director of finance with oversight from the Trust's Audit Committee, has been in place over the last year. The key aims are to seek to proactively create an anti-fraud culture, implement appropriate deterrents and preventative controls and ensure that allegations of fraud are appropriately and professionally investigated to a criminal standard. Progress reports on all aspects of counter fraud work and details of investigations are received at each meeting of the Trust's Audit Committee.



Staff survey

In late 2015 the Trust approved a new people and organisational strategy, heralding the beginning of a new focus on organisational development and specifically staff engagement. This programme is being driven by the deputy chief executive's department, which is devising and implementing a new staff engagement strategy during 2016. The overarching objective is to develop an engaged workforce which feels committed to the organisation and highly involved in their roles, and in doing so ultimately deliver higher quality healthcare.

A refreshed set of vision and values are being launched so that all staff can share in the Trust's strategic direction. This involves every employee making a clear, personal pledge to support one of the organisational values – together we care, together we respect, together we deliver.

In 2015 the Trust continued to engage with staff through its internal morale barometer survey (incorporating the staff Friends and Family Test), nurse dashboard and other local surveys with appropriate actions being taken accordingly thereafter. In addition to this the Trust provided a range of 'open door' opportunities for staff to meet collectively and individually with members of the Trust Board and the senior management team.

Staff Survey 2015 response rates

The Trust, as in previous years, undertook a sample survey offering 1,250 of its c.7,000 staff. Despite a national deterioration in the number of staff overall participating in the staff survey, the Trust experienced a 4.1 per cent increase in its return rate.

	2015/16		2014/15		Trust improvement/deterioration
Response rate	Trust	National average	Trust	National average	
	33.7%	38.0%	29.6%	44.0%	4.1% improvement

Staff Survey 2015 findings

The staff survey report provides 32 key findings.

Top four ranking scores:

	2015/16		2014/15		Trust improvement/deterioration
Top four ranking scores	Trust	National average	Trust	National average	
Percentage of staff reporting errors, near misses or incidents witnessed in the last month	92%	90%	87%	90%	+5%
Percentage of staff working extra hours	69%	72%	69%	71%	No change
Quality of non-mandatory training, learning or development	4.05	4.03	Not available	Not available	Not available
Percentage of staff experiencing discrimination at work in last 12 months	10%	10%	10%	11%	No change

Bottom four ranking scores:

	2015/16		2014/15		Trust improvement/deterioration
Bottom four ranking scores	Trust	National Average	Trust	National Average	
Percentage of staff agreeing that their role makes a difference to patients / service	86%	90%	93%	91%	-3%
Staff recommendation of the organisation as a place to work or receive treatment	3.51	3.76	3.49	3.67	+0.02
Effective use of patient / service user feedback	3.52	3.70	3.54	Not available	-0.2
Percentage of staff satisfied with the opportunities for flexible working patterns	44%	49%	Not available	Not available	Not available

Where data is listed above as 'not available' this is due to changes made to the 2014/15 staff survey questionnaire meaning there is no comparable data.

Reviewing the survey highlights that improvements have been made in staff perception that:

- They can contribute towards service improvements at work
- There are improved communications between staff and managers, and
- Importantly staff feel motivated at work.

The survey also shows that the number of staff reporting the most recent experience of harassment, bullying or abuse has reduced. This is an area that needs addressing.

Future priorities and targets

There is significant read across between the Staff Survey 2015 and the Trust's own morale barometer surveys in quarter three and quarter four 2015/16. As such a single action plan is to be constructed. This action plan will form a key work stream during 2016/17 and will focus primarily on:

- Staff voice, engagement and communication
- Staff sense of value, recognition and reward
- Management: staff relationships
- Resilience and change management
- Retention and career development
- Utilisation of patient and service user feedback
- Staff behavioural standards linked to the Trust's vision and values
- Addressing any concerns relating to harassment, violence and aggression shown against NHS staff.

The above action plan will be linked and consolidated with the aforementioned People and Organisational Development Strategy deliverables to provide a prioritised and achievable delivery plan. The delivery of this plan will be monitored and measured by both the Quality and Patient Experience Group and ultimately the Trust Board. The aim of the action plan will be for the Trust to:

- Maintain or improve this position in areas the Trust is above the national average for acute trusts
- Improve this position in areas the Trust is below or equal the national average for acute Trusts.

Expenditure on consultancy

The Trust during 2015/16 has spent £1,593k on consultancy fees compared to £1,654k in the previous financial year.

£496k of the 2015/16 spend relates to the Trust's hosting arrangement for the health community's strategic redesign project Healthy Lives Healthy Futures. Underlying spend on consultancy linked to Trust activities has therefore reduced year on year.

Exit packages 2015/16

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	1	-	1
£10,001 - £25,000	1	-	1
£25,001 - £50,000	-	-	-
£50,001 - £100,000	-	-	-
£100,001 - £150,000	-	-	-
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	2	-	2
Total resource cost (£)	£28,000	£0	£28,000

Exit packages 2014/15

	Number of compulsory redundancies	Number of other departures agreed	Total number of exit packages
Exit package cost band (including any special payment element)			
<£10,000	2	-	2
£10,001 - £25,000	3	-	3
£25,001 - £50,000	1	-	1
£50,001 - £100,000	3	-	3
£100,001 - £150,000	3	-	3
£150,001 - £200,000	-	-	-
>£200,000	-	-	-
Total number of exit packages by type	12	-	12
Total resource cost (£)	£614,000	£0	£614,000

Exit packages: other (non-compulsory) departure payments

	2015/16		2014/15	
	Payments agreed	Total value of agreements £000	Payments agreed	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	-	-	-	-
Mutually agreed resignations (MARS) contractual costs	-	-	-	-
Early retirement in the efficiency of the service contractual costs	-	-	-	-
Contractual payments in lieu of notice	-	-	-	-
Exit payments following Employment Tribunals or court orders	-	-	-	-
Non-contractual payments requiring HMT approval	-	-	-	-
Total	-	-	-	-
Of which: Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	-	-	-	-

Reporting of high paid off-payroll arrangements

The Foundation Trust did not have any high paid-off payroll arrangements in place during 2015/16.



Disclosures set out in NHS Foundation Trust Code of Governance

Northern Lincolnshire and Goole NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

The Board of Directors reviews its compliance with the Code of Governance provisions annually and where it does not comply it considers the risks associated with non-compliance and mitigates those risks as far as possible.

The Board of Directors

This section explains how we make decisions and manage the services we provide to our local communities. The Trust is run by the Board of Directors, which is collectively responsible for the quality of healthcare delivery and financial performance. The board is held to account for stewardship of public money and delivery of services, by the independent regulator of foundation trusts, Monitor, and locally by the Council of Governors. The Board of Directors is held to account for the quality of services by the Care Quality Commission.

The Board sets the strategic direction of the Trust ensuring that the necessary financial and human resources are in place to meet its priorities and objectives. It operates within a framework of processes, procedures and controls which allows performance and progress to be monitored and its risks carefully assessed and managed.

The Board is responsible for ensuring compliance with the Licence granted by Monitor, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations.

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

Its responsibilities include:

- Setting the strategic direction of the organisation (having taken into consideration the views of the Council of Governors)
- Ensuring that adequate systems and processes are maintained to deliver the Trust's Annual Plan
- Ensuring its services provide safe care for patients
- Ensuring robust governance arrangements are in place supported by an effective assurance framework that supports sound systems of internal control
- Ensuring rigorous performance management which ensures the Trust continues to achieve its local and national targets
- Seeking continuous improvement and innovation
- Measures and monitors the Trust's effectiveness and efficiency
- Ensuring the Trust, at all times, is compliant with its Licence, as issued by the sector regulator Monitor
- Exercising the powers of the Trust established under statute, as described within the Trust's Constitution which is available on the Trust website at: www.nlq.nhs.uk

The people who have served on the Board of Directors during the year are listed below, together with a brief biography and membership of Trust committees.



Dr Jim Whittingham, chairman

Appointed as chairman in July 2010, Jim was born and brought up in Scunthorpe. He has a PhD in soil microbiology and has an Honorary Doctorate from the University of Lincoln. He worked in IT before joining the University of Humberside in Hull where he undertook a wide range of management roles. His term of office comes to an end on July 18 2016.

Membership of committees: Mortality Performance Committee (chair) and Charitable Funds Committee (chair).



Karen Jackson, chief executive

Karen was appointed as chief executive in September 2010, after working at the Trust in the role as director of finance for two years. She started her career in the NHS at Leeds Teaching Hospital as chief financial accountant then assistant director and went onto work as deputy director of finance at Sheffield Teaching Hospitals. Karen has a degree in genetics and is a qualified chartered accountant. In her spare time she is involved in a number of NHS charities. As chief executive, Karen is the Accountable Officer for the Trust and carries full responsibility for its performance, forward planning and leadership of the Executive Team. Membership of committees: Resources Committee.



Wendy Booth, director of performance assurance and Trust secretary

Wendy specialises in governance and risk management and is the lead for our complaints, legal, risks and quality assurance teams, as well as our membership office. She was appointed to her role in August 2012, having previously held the posts of head of governance, assistant director of risk management and Trust risk manager. Prior to this she worked in a variety of administration/general management roles. Membership of committees: Audit Committee, Resources Committee, Trust Governance and Assurance Committee, Quality and Patient Experience Committee, Infection Prevention and Control Committee and Mortality Performance Committee.



Pam Clipson, director of strategy and planning

Pam has worked for the Trust since starting out as an apprentice straight from school in 1995. She has held a number of roles in the finance directorate focusing on planning, contracting and information functions. She was appointed as a director in June 2014. Membership of committees: Resources Committee.



Dr Karen Dunderdale, deputy chief executive

Karen was born and brought up in Scunthorpe. She qualified as a nurse in 1991 and worked at Scunthorpe hospital on a general ward before moving to coronary care. She became a cardiac nurse specialist developing cardiac rehabilitation and heart failure services. She has a PhD from York University and has contributed substantially to the development of cardiac nursing within the region. She was appointed as chief nurse in 2011 and took on the additional role of deputy chief executive from March 2014, before being appointed as a substantive deputy chief executive.

Membership of committees: Trust Governance and Assurance Committee, Quality and Patient Experience Committee, Mortality Performance Committee, Resources Committee and Infection Prevention and Control Committee.



Tara Filby, chief nurse

Tara was born in North Lincolnshire and qualified locally as a registered nurse in 1990. She has worked in medicine and surgery within the Trust, moving from staff nurse to sister, matron, head of nursing and deputy chief nurse roles before being successfully appointed to the chief nurse position. She has a degree in nursing and has recently completed the Nye Bevan Executive Health Care Leadership programme at the NHS Leadership Academy. She was appointed as interim chief nurse on June 29 2015 and appointed in the substantive post on October 9 2015. Membership of committees: Trust Governance and Assurance Committee, Quality and Patient Experience Committee, Mortality Performance Committee and Infection Prevention and Control Committee.



Karen Griffiths, chief operating officer

Karen has 35 years' experience of working in the NHS, beginning her career as a student nurse at Scunthorpe hospital in 1981. She went onto train as a midwife and has held a number of clinical and managerial posts across the Trust. She was appointed to her role in April 2014. Membership of committees: Mortality Performance Committee, Infection Prevention and Control Committee and Quality and Patient Experience Committee.



Marcus Hassall, director of finance

Marcus was previously deputy director of finance at the Trust for three years, and has been at the Trust in a variety of finance roles since joining the previous Grimsby Health NHS Trust back in 1995. Marcus has spent his working career in NHS finance, having started as a finance trainee in Bradford. He was appointed as director of finance in August 2014. Membership of committees: Audit Committee and Resources Committee.



Jane Heaton, interim director of organisational development and workforce

Jane has worked for the Trust in various roles. She started her career as a medical secretary in ophthalmology and then worked for a brief spell in the private sector as a personal assistant in personnel. She returned to the Trust in 1992 working as a medical staffing officer in human resources. She worked through the ranks as a human resources advisor, manager, assistant director and then as deputy director of human resources. During her time within human resources Jane has gained numerous management qualifications including her master's degree in business administration and becoming a qualified para-legal in employment law. She was appointed as interim of director of organisational development and workforce on May 1 2015 and remained in the post until February 15 2016. Membership of committees: Resources Committee, Quality and Patient Experience Committee, Infection Prevention and Control Committee and Mortality Performance Committee.



Jug Johal, director of estates and facilities

Jug joined the NHS in 2006 after working his way up from transport administrator to group operation manager in a private logistics firm. He has worked in a number of roles at the Trust including transport manager and general manager for hotel services before being appointed to director of estates and facilities in August 2014. He is also a Board member of the National Skills Academy for Health. Membership of committees: Resources Committee and Infection Prevention and Control Committee.



Mr Lawrence Roberts, medical director

Lawrence graduated from Charing Cross Medical School and was commissioned into the Royal Navy as a medical student on a short service commission. He then trained as a GP during his time in the Royal Navy before transferring to the Army where he trained in obstetrics and gynaecology at a military hospital in Aldershot. He went on to take up the post of Command Consultant in Obstetrics and Gynaecology (British Army of the Rhine) and was promoted to lieutenant-colonel before being made redundant in 1996. He then joined Scunthorpe hospital as a consultant, and has held various posts including clinical lead, clinical director, associate medical director, deputy medical director and more recently acting medical director as of March 2 2015. He was appointed medical director on July 7 2015. Membership of committees: Trust Governance and Assurance Committee, Quality and Patient Experience Committee, Resources Committee, Infection Prevention and Control Committee and Mortality Performance Committee.

Dr Neil Pease, director of organisational development and workforce

Neil resigned from the Trust on May 31 2015 after joining the organisation in October 2011. Membership of committees: Resources Committee, Quality and Patient Experience Committee and Mortality Performance Committee.



Alan Bell, non-executive director

Alan is a graduate of Durham University with electrical engineering qualifications acquired while working for BICC Plc. (now Balfour Beatty) after university. His business achievements include his time as marketing director and then managing director of Hepworth Industrial Plastics where he pioneered the development of uPvc windows in the UK. He is also responsible for the introduction of external gas and electricity meter boxes in British houses, made out of GRP. Another milestone was when he took a significant personal shareholding in a Scottish chipboard and MDF business whose fortunes he transformed in three years to the extent that it is now a world leader in particleboard and fibre board technology. Alan was appointed to the Board in August 2010 and his term of office ends on December 31 2016. Membership of committees: Resources Committee, Remuneration Committee (chair), Quality and Patient Experience Committee (chair), Infection Prevention and Control Committee and Charitable Funds Committee.



Neil Gammon, non-executive director/deputy chairman/senior independent director

During a 37-year career in the engineer branch of the Royal Air Force, Neil served in a dozen UK locations and in Germany and Saudi Arabia. His final post saw him commanding Royal Air Force Cosford and the Defence College of Aeronautical Engineering, where he was responsible for training aeronautical engineers for the three armed services. He left the Royal Air Force in 2009 and settled in Ashby cum Fenby. Neil has an Honorary Doctorate of Business Administration from the University of Lincoln, and he was appointed an independent member of Humberside Police Authority in May 2010. Neil joined the Board in August 2010 and his term of office ends on July 31 2017. Membership of committees: Resources Committee (chair), Remuneration Committee and Charitable Funds Committee.



Linda Jackson – non executive director

Linda is from Cleethorpes and studied hotel, catering and institutional management at Grimsby College before graduating with a Diploma in Management from the University of Reading. Her career in facilities management began in London where she secured a position of trainee manager for ISS Facility Services who provide facilities services across the NHS. Linda quickly worked her way up the ranks to hold positions including regional director providing facilities services across NHS organisations in the capital and became board director at the age of 38. In her last 10 years in the private sector she undertook a transformational change role responsible for implementing the company's new business and initiatives nationally within the NHS. She was appointed to the Board on September 30 2014 and her term of office ends on September 29 2016. Membership of committees: Audit Committee, Charitable Funds Committee and Mortality Performance Committee.



Anne Shaw – non-executive director

Anne is from the East Riding of Yorkshire but began her professional career as a staff nurse working in the accident and emergency department at John Radcliffe Hospital, Oxford. It wasn't long before she decided to move closer to home working as a staff nurse and ward sister in Hull. Her career took a different route when she moved to teaching nurses which opened new doors for her as she joined The Open University, teaching within the health and social care department for about a decade. Over the years Anne has also been a secondary school governor, a public sector director for the Doncaster Learning and Skills Partnership and Director of Aim Higher Humber. Anne also brings previous experience as a non-executive director having worked with Hull and East Yorkshire Community Mental Health and Learning Disability NHS Trust for seven years. Anne joined the Board on August 12 2013 and her term of office is until August 12 2018. Membership of committees: Charitable Funds Committee, Trust Governance and Assurance Committee (chair) and Quality and Patient Experience Committee.



Stan Shreeve – non-executive director

A semi-retired businessman and qualified accountant with experience at board level as chief executive, chief finance officer and non-executive director in both the public and private sectors. He has experience of evaluating, funding, integrating and reorganising businesses, often in a turnaround situation. He has worked with venture capitalists and financial situations raising more than £200million in structured finances. He has a wealth of experience of financial controls and the generation of cash from working capital. He also has experience of pan-European management and reorganisation within a culturally diverse business. Stan joined the Board 2012 and his term of office ends on June 7 2018. Membership of committees: Audit Committee (chair), Remuneration Committee, Charitable Funds Committee, Trust Governance and Assurance Committee and Infection Prevention and Control Committee.

The Board of Directors considered its composition, skills, balance and completeness and was satisfied that its composition was appropriate for the leadership of the Trust during 2015/16. Arrangements are in place to enable appropriate review of the Board's balance, completeness and appropriateness to the requirements of the Trust.

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

Attendance at Board meetings

Meeting attendance for NLaG Trust Board for the period April 1 2015 to March 31 2016:

Title and name	Atten	28.4 .15	26.5 .15	30.6 .15	28.7 .15	25.8 .15	29.9 .15	27.10 .15	24.11 .15	22.12 .15	26.1 .16	29.3 .16
Dr Jim Whittingham	11 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Karen Jackson	11 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Wendy Booth	10 of 11	Y	Y	Y	—	Y	Y	Y	Y	Y	Y	Y
*Dr Karen Dunderdale	10 of 11	Y	Y	Y	Y	—	Y	Y	Y	Y	Y	Y
Pam Clipson	9 of 11	Y	Y	Y	Y	—	Y	—	Y	Y	Y	Y
**Tara Filby, chief nurse	5 of 9	N/a	N/a	Y	Y	—	Y	—	—	Y	Y	—
Karen Griffiths	10 of 11	—	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Marcus Hassall	11 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Jug Johal	10 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	—
***Dr Neil Pease	1 of 2	Y	—	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a	N/a
****Jane Heaton, interim director of OD and workforce	6 of 8	N/a	N/a	—	—	Y	Y	Y	Y	Y	Y	N/a
*****Mr Lawrence Roberts, medical director	9 of 11	Y	Y	Y	Y	Y	—	Y	Y	Y	Y	—
Alan Bell, non-executive director	9 of 11	Y	Y	—	Y	Y	Y	Y	Y	—	Y	Y
Neil Gammon, non-executive director	10 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	—	Y
Linda Jackson, non-executive director	8 of 11	Y	Y	—	Y	Y	—	Y	Y	Y	—	Y
Stan Shreeve, non-executive director	10 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	—
Anne Shaw, non-executive director	11 of 11	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

*Dr Karen Dunderdale was appointed deputy chief executive on June 29 2015, prior to that she held the position of chief nurse.

** Tara Filby was appointed as acting chief nurse on June 29 2015. She was appointed as chief nurse on October 9 2015.

*** Dr Neil Pease resigned from the Trust on May 31 2015.

****Jane Heaton was interim director between May 1 2015 and February 15 2016.

***** Mr Lawrence Roberts was appointed as medical director on July 7 2015

The Board of Directors undertakes an annual review of the independence of its non-executive directors. The Board determines whether each director is independent in character and judgement and whether there are relationships or circumstances which are likely to affect, or could appear to affect, the person's judgement. The following non-executive directors are considered to be independent: Dr Jim Whittingham, Alan Bell, Neil Gammon, Linda Jackson, Anne Shaw and Stan Shreeve.

None of our directors or governors hold similar positions at any other NHS foundation Trust. No executive directors were appointed as a non-executive director in another organisation during the year, and no Board director is a governor or director of another Foundation Trust.

The chairman is responsible for leadership of both the Board of Directors and the Council of Governors. As chairman of the Board of Directors he is responsible for ensuring the Board's effectiveness and setting its agenda. As chairman of the Council of Governors he provides a pivotal link between governors and directors, especially the non-executive directors. Listening to the governors is one of the ways the chairman can hear the views of the local community, local people and local stakeholders. He regularly provides feedback to the Board of Directors on the views of governors and the local community.

Where directors have concerns that cannot be resolved about the running of the NHS foundation trust or a proposed action, any concerns are recorded within the Trust Board minutes. Minutes of the Trust Board are comprehensive and are published in the public domain.

In accordance with the Trust Constitution the composition of the board of the trust comprises of a chairman, five non-executive directors, and nine executive directors including: the chief executive, deputy chief executive, chief nurse, chief operating officer, medical director, director of performance assurance, director of finance, director of strategy and planning, director of estates and facilities. However, only five executive directors have voting rights, they are: chief executive, medical director, chief nurse, finance director and the chief operating officer. There are also five non-executive directors, with the chairman having the casting vote.

Changes were made to the Board during 2015/16 which saw a substantive full-time deputy chief executive post created with effect from June 29 2015. The post was created to ensure the Trust continues to have sufficient leadership capacity as the chief executive is leading the Healthy Lives, Healthy Futures programme on a part-time basis. The deputy chief executive role has previously been undertaken by an existing director on a two-year rotation as an additional responsibility to their main post (this was the chief nurse, Dr Karen Dunderdale). The Trust Board considered a number of options and risks before deciding to create a substantive post. Any additional costs incurred by the Trust as a result of the change will be funded by the HLHF programme. Following an internal recruitment process the post was appointed to the chief nurse/deputy chief executive.

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

Our Trust Board, and in particular our non-executive directors, may reasonably wish to challenge assurances received from the executive management team. The executive directors ensure, wherever possible, that the non-executives directors receive sufficient information and understanding to enable challenge and to take decisions on an informed basis. Our Board minutes reflect any challenges of the executive management. There is also in place a schedule of non-executive director challenge roles whereby individual non-executives provide challenge in respect of specific areas of risk eg risk management, mortality, sustainability and quality.

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

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

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

Directors, governors and members are supported by the Trust Secretary, the assistant Trust secretary and a membership officer.

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

Appointment and termination of non-executive directors

The Appointments and Remuneration Committee (ARC) identifies suitable candidates to fill non-executive director vacancies as they arise. This is carried out by advertisement and open competition. The ARC evaluates the skills of the candidates against the description of capabilities required and makes a recommendation on the appointment to the Council of Governors (CoG).

Candidates for non-executive director positions are required to provide the CoG with details of other significant commitments, with a broad indication of time involved, and also to provide an undertaking that they will have sufficient time to fulfil their role. Additionally, the Trust Constitution specifies that non-executive directors must be members of the Trust and so candidates must live within one of the specified public constituencies.

It is only the CoG that has the authority to appoint non-executive directors. In making such appointments, however, the CoG must have regard to the recommendations of the ARC, the other commitments of candidates, and the views of the Board of Directors on the qualifications, skills and experience required for the position.

The normal term of office of a non-executive director is three years. They are eligible for reappointment for one further term of three years. Any terms beyond six years shall be subject to particularly rigorous review, and shall take into account the need for progressive

refreshing of the board. The Council of Governors at a general meeting of the CoG can remove the chairman and the other non-executive directors. It requires the approval of three quarters of the members of the CoG. This will only be done after it has exhausted all means of engagement with the Trust Board.

How we evaluate the performance of the Board of Directors and its committees

We undertake an annual evaluation of the performance of the Trust Board and its sub-committees. A separate review of performance of the chairman is also undertaken by the lead governor and senior independent director and is reported to the Council of Governors and Trust Board.

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

The Board is developed in a number of ways including ‘time out’ sessions, board briefings and development days.

In accordance with the requirements of good corporate governance and in order to ensure their continuing effectiveness, the Board undertakes a formal and rigorous annual evaluation of its own performance and that of its sub-committees.

An assessment tool has been developed to evaluate the performance of the Trust Board across the whole range of its activities, including strategy and operational performance. The outcomes from this process complement the forward plan self-certification assurance process and also informs both the Board’s annual work programme and the board development programme. The evaluation exercise is an annual event and the results are reported to the Council of Governors.

An annual self-certification event is undertaken in support of submission to Monitor of the corporate governance declaration.

Review of effectiveness of Board internal controls

The Board has conducted a review of its effectiveness of its systems of internal controls as outlined in the Annual Governance Statement.

Relationship between Board of Directors and the Council of Governors

The Board works closely with the Trust's CoG. The Trust chairman is also chairman of the CoG and is supported at every meeting by the chief executive or deputy chief executive. The chairman works closely with the lead governor to review all relevant matters. The chairman, chief executive, Trust secretary and membership manager meet before each meeting of the CoG to set the agenda and review key issues. The non-executive and executive directors of the Board attend the CoG as observers and take part in open discussions that form part of each meeting.

Executive directors or their deputies, and non-executive directors, are assigned to and are integral members of each of the CoG sub-groups. Participation in each quarterly sub-group ensures an understanding of the views of the governors and subsequently members of the public. Details of the attendance of Trust Board members at the CoG can be found on page 100.

Measuring the Trust's effectiveness

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

- The submission of a monthly report of compliance against key performance targets and specific licence/contractual obligations
- The submission of a monthly report of compliance against key quality objectives
- The submission of a monthly mortality report.

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

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

The Scheme of Delegation, which defines accountabilities for the delivery of performance, is monitored via the performance management framework led by the chief executive. We have also adopted a 'zero tolerance framework' which includes non-compliance with relevant performance targets and supports the performance management framework.

The Board ensures that relevant metrics, measures, milestones and accountabilities are developed and agreed so as to understand and assess progress and delivery of performance. The Trust Board receives assurance through a suite of financial and non-financial performance metrics this includes such things as the monthly quality report, mortality report and monthly finance report.

Trust Board approach to clinical governance

We adhere to Monitor's Code of Governance and the Board is satisfied that the Trust applies those principles, systems and standards of good corporate governance which reasonably would be regarded as appropriate for a supplier of health care services to the NHS.

The existing organisational management structure illustrates the Trust's commitment to effective governance and quality governance including risk management processes. A directorate of clinical and quality assurance was created on September 17 2012 following an extensive consultation exercise. The directorate's name was changed to performance assurance in 2014, reflecting changes to the executive director structure and responsibilities. The key aims of the proposal to introduce the directorate were:

- To continue to raise the profile of governance by ensuring governance (and quality governance) and assurance remain on an equal footing with other organisational priorities
- To ensure that governance, quality and safety are seen as the responsibility of all staff who, in discharging those responsibilities, have access to, and support from, an appropriately skilled and responsive governance support team
- To ensure that the Trust's governance, quality and infection control resource is targeted in the right place at the right time with an emphasis on outcomes rather than process and improved quality and safety

- To ensure that during a period of inevitable increased emphasis on cost effectiveness in healthcare, that this is not at the expense of reduced quality or poor governance in our organisation. A devolved management structure describes lines of accountability at appropriate levels with clear clinical and managerial leadership roles being defined.

The effectiveness of the Trust governance structures continued to be tested during 2015/16 via internal and external testing including internally via the annual internal audit programme and externally via the follow-up review of the Trust's quality governance arrangements at clinical group level undertaken by KPMG, which did not identify any significant concerns.

The chief executive as the Accountable Officer for NLaG follows the procedures set out by Monitor in advising the Board and the CoG and for recording and submitting objections to decisions.

We ensure there is regular reporting to and dialogue with Monitor. This includes performance review meetings (PRM) in respect of the Trust's financial situation and any new developments which are not public knowledge and sustainability.

Code of conduct for the Trust Board

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

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

In May 2013 the Trust Board formally signed up to these standards. The Trust Board also agreed at that time to annual affirmation of sign up to these standards and this requirement is incorporated within the Trust's corporate timetable.

All Board directors meet the 'fit and proper persons' test as described in the provider license. As outlined within the annual chairman's declaration to the Trust Board.

The Trust Board has maintained its support of the Nolan Principles of public life and has continued to make the majority of its decisions at Board meetings held in public. To support this there is the Directors Code of Conduct, which applies to all directors and has been adopted by all Board members. This Code of Conduct builds on the NHS Code of Conduct and includes the Nolan principles of public life.

The Trust held 12 formal meetings of the Board during 2015/16, with a part of each meeting held in public. Though parts of the meeting were held in private, this was because the items being considered were either commercially or patient sensitive. The Board held a number of strategic events. The majority of Board decisions and discussions were held in public.

The Council of Governors receives the agendas and minutes of all meetings held in public.

The Board of Directors participates in announced and unannounced clinical visits whereby executive and non-executive directors, together with governors, team up to visit clinical areas.

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

Should this meeting not resolve the issue then the chairman shall have the authority to make a decision on behalf of the Trust. This decision, and the reasons supporting it, will be communicated in writing to all members of both the Board of Directors and the Council of Governors. This has not happened in 2015/16.

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

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

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

Senior independent director

Monitor's Code of Governance (Para A3.3) recommends that the Board of Directors should appoint a non-executive director as the senior independent director. The senior independent director of the Board of Directors is Neil Gammon.

The primary function of the role is to be available to members and governors if they have concerns which, contact through the normal channels of chairman, chief executive or director of finance, has failed to resolve or for which such contact is inappropriate.

While the Code of Governance assigns the authority to appoint the senior independent director to the Trust Board it also makes it clear that this is to be done in consultation with the Council of Governors. This is achieved via the following process:

- The Council of Governors is asked to consider and approve the overall process
- The appointment process for a forthcoming vacancy commences approximately three months prior to the vacancy arising
- The Chairman invites expressions of interest in serving as the senior independent director from all of the non-executive directors of the Trust who may nominate themselves or a non-executive director colleague. The chairman's invitation will specify a closing date for those expressions of interest
- Expressions of interest are accompanied by a short biography (no more than a single side of A4) including a resume of career history and experience of working with or within an NHS organisation(s)
- The chairman submits the expressions of interest received to the Trust Board. If a vote is required this will be by secret ballot
- The name of the proposed senior independent director is then submitted to the Appointments and Remuneration Committee who will be asked to make a

- recommendation to the next full meeting of the Council of Governors occurring after the closing date. The Council of Governors will be asked to ratify the appointment
- The senior independent director is then appointed for a period determined by the Trust Board, but not exceeding the time remaining of his or her term of office as a non-executive director.

Process for the evaluation of performance of the chairman

The process for evaluating the performance of the chairman is periodically reviewed by the Appointments and Remuneration Committee for Non-Executive Directors.

Evaluations are currently conducted annually by April 30 each year. The senior independent director is responsible for co-ordinating/leading this (Monitor Code of Governance, paragraph D2), and as part of this process seeks feedback from the chief executive, non-executive directors and the Council of Governors.

The evaluation takes the form of assessment against agreed objectives and agreement of a personal development plan linked to achievement of the objectives for the coming year. The chairman undertakes self-assessment of his performance against the objectives, providing examples/evidence to support this. The senior independent director seeks feedback from the Board of Directors on the chairman's performance, ensuring that there are no specific areas of concern from executive or non-executive directors, and produces a summary of this feedback.

The lead governor, who is also the chairman of the Appointments and Remuneration Committee, seeks feedback from the Council of Governors through the Council of Governors Steering Group, ensuring that there are no specific areas of concern, and produces a summary of this feedback.

The senior independent director and the lead governor then meet to discuss and agree a final report. Once it has been prepared, the senior independent director and the lead governor meet with the chairman to conduct the evaluation, by reviewing both the self-assessment and feedback from colleagues, and agree a personal development plan and an overall assessment rating to describe the contribution of the chairman as set out below:

Performance Level Description

Level 1 – outstanding performance, making a critically important contribution to the work of the Trust, Trust Board of Directors and Council of Governors.

Level 2 – a full satisfactory performance, demonstrating the range of skills and qualities required.

Level 3 – a generally satisfactory performance with some room for improvement.

Level 4 – a performance giving cause for concern across a significant number of areas requiring prompt improvement.

A final report setting out the conclusions of the evaluation of past performance, objectives for the coming year and key components of the future personal development plan is shared with the Appointments and Remuneration Committee for non-executive directors, who are then asked to consider the results and recommendations prior to submission of a summary report to the full Council of Governors for ratification.

The lead governor, in conjunction with the senior independent director, present the summary report to the full Council of Governors which is asked to ratify the outcome of the evaluation including recommendations for further action (see Monitor Code of Governance, paragraph D.2). The chairman excuses himself from the meeting for the duration of this discussion.

Following receipt of the summary report by the Council of Governors, the senior independent

director also shares the summary report with the Trust Board. The chairman excuses himself from the meeting for the duration of this discussion.

Chairman's interaction with non-executives

The chairman meets monthly with the non-executive directors without the executive directors present. These meetings are held immediately prior to the Trust Board meeting.

Process for the evaluation of performance of the non-executive directors

The process for evaluating the performance of the non-executive directors is periodically reviewed by the Appointments and Remuneration Committee for Non-Executive Directors. Evaluations of each non-executive director are conducted annually by April 30 each year.

Each non-executive director undertakes a self-assessment of his/her performance against agreed objectives, providing examples/evidence as required and submits this to the chairman in advance of the evaluation. The chairman invites comments on the performance of the non-executives from the chief executive and, as part of this discussion, will determine whether any specific areas of concern have been raised by the executive directors.

Once the initial information has been gathered, the chairman meets with each non-executive director to conduct the evaluation, validate or otherwise the self-assessment and agree an overall assessment rating to describe the overall contribution of the individual as set out below:

Performance level description

Level 1 – outstanding performance, making a critically important contribution to the work of the Trust and the Trust Board of Directors.

Level 2 – a full satisfactory performance, demonstrating the range of skills and qualities required.

Level 3 – a generally satisfactory performance but with some room for improvement.

Level 4 – a performance giving cause for concern across a significant number of areas requiring prompt improvement.

The role of non-executive directors is to provide independence, balance and challenge to the executive element of the Board of Directors. The agreement of the overall assessment rating should consider the extent to which individual non-executive directors have fulfilled this responsibility. The chairman uses the performance evaluation as the basis for determining an individual personal development plan for each non-executive director relevant to their duties as Board members.

The chairman, assisted by the Trust secretary, prepares a draft summary report of the outcome of the evaluation process for all non-executive directors which is shared with the Council of Governors Appointment and Remuneration Committee, who are asked to consider the results and recommendations prior to submission of a summary report to the full Council of Governors for ratification.

The chairman or the chairman of the Council of Governor's ARC presents the summary report to the full Council of Governors who are asked to ratify the outcome of the evaluation including recommendations for further action. The chairman also shares the summary report with the Trust Board.

Third parties

The Code of Governance (paragraph E.2) outlines that the Board of Directors of a Foundation Trust is responsible for ensuring that the Trust co-operates with other NHS bodies, local authorities and other relevant organisations with an interest in the local health economy.

We have a clear policy on the third party bodies with whom we have a duty to co-operate – Schedule of Third Parties with whom the Trust has a duty to co-operate. This document provides a schedule of third party organisations in relation to whom we have a specific duty of co-operation. Overall, the responsibility for ensuring co-operation with third parties lies with the chief executive. Nevertheless, for specific organisations, that responsibility may be delegated to the appropriate director or senior manager.

This list is split into third parties with a remit specific to healthcare, and those with a more general remit. The principal functions of the bodies are shown, along with the delegated responsibility within the trust to ensure co-operation, if applicable. We have effective mechanisms in place to co-operate with relevant third party bodies and that collaborative and productive relationships are maintained with relevant stakeholders at appropriate levels of seniority. These arrangements are audited.

Directors' responsibilities statement

Under the NHS Act 2006, Monitor has directed Northern Lincolnshire and Goole NHS Foundation Trust to prepare, for each financial year, a statement of accounts in the form and on the basis set out in the Accounts Direction. The directors are responsible for preparing the accounts on an accrual basis, which gives a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the directors are required to comply with the requirements of Monitor's NHS Foundation Trust Annual Reporting Manual 2015/16 and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance
- Prepare the financial statement on a going concern basis.

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

The directors have taken all the steps they ought to as a director, in order to make themselves aware of any relevant audit information and to establish that the NHS foundation trust's auditor is aware of that information.

The directors consider that the annual report and the accounts taken as a whole, are fair, balanced and understandable and provide the necessary information for patients, regulators and other stakeholders to assess the NHS foundation trust's performance, business model and strategy.

Ensuring the Board of Directors maintains high standards of governance

The Board of Directors recognises the importance of the principles of good corporate governance and is committed to improving the standards of corporate governance within the organisation.

The formal Scheme of Delegation outlines how decision making within the Trust is regulated through the executive director structure.

The Board of Directors and Council of Governors have a number of guidance documents: standing orders for Council of Governors and Board of Directors meetings, directors and governors responsibilities and Code of Conduct and the Trust Constitution, detailing how any disagreements between the Council and Board are resolved.

Statement of compliance with the NHS Foundation Trust Code of Conduct

Northern Lincolnshire and Goole NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The Code, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Committees of the Board of Directors

The Board of Directors has established a number of committees to support it in discharging its responsibilities. In addition to meeting the statutory requirements of having an Audit Committee and a Remuneration Committee, the Trust has also established a Resources Committee, Trust Governance Assurance Committee, Quality Patient Experience Committee, Mortality Performance and Assurance Committee and Charitable Funds Committee.

Minutes of the sub-committees are presented to the Trust Board and a front cover sheet highlights issues for the Board to note and items for escalation. Further details of the sub-committees are below:

Remuneration Committee

The Board of Directors has established a Remuneration Committee. Its responsibilities include consideration of matters pertinent to the nomination, remuneration and associated terms of service for executive directors (including the chief executive), matters associated with the nomination of non-executive directors and remuneration of senior managers/clinical leaders.

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

It also has delegated responsibility for recommending and monitoring the level and structure of remuneration for the executive directors, including the chief executive. Where an interim

appointment is made the chief executive or chairman, as appropriate, makes a recommendation to the Remuneration Committee prior to the implementation for consideration and approval as appropriate.

The chief executive attends the committee in relation to discussions about Board composition, succession planning, remuneration and performance of executive directors. She also has in place a suitable framework for the appraisal of the performance of each executive director, and she reports to the committee on her assessment of performance of each director. The chief executive was not present during discussions relating to her own performance, remuneration and terms of service.

The director of organisational development and workforce and chairman also attended meetings during 2015/16 to offer guidance and advice. The director of organisational development and workforce were also responsible for advising the committee on the appointment of the external independent consultants.

For full details of the Remuneration Committee please refer to the remuneration report in the accountability section of the annual report.

Audit Committee

The Audit Committee is a standing committee formally established by the Trust Board. The Audit Committee's remit is to ensure that effective internal controls and systems are in place, and compliance with law, guidance and codes of conduct. It also oversees the establishment and maintenance of an effective system of internal control that supports the achievement of the organisation's objectives and monitors the integrity of the financial statements of the Trust.

The committee, which meets seven times per annum, is appointed by the Trust Board from amongst the non-executive directors of the Trust and consists of three core members. There is cross membership with other standing committees. Minutes of Audit Committee meetings are submitted to the Resources Committee, Trust Governance and Assurance Committee, Quality and Patient Experience Committee and the Trust Board.

Following a formal competitive mini-tendering exercise in early 2014 the Trust awarded its internal audit contract to KPMG for an initial period of three years, with the option to extend for a further year. The new service commenced on the June 1 2014. Internal audit's role is to provide an independent and objective opinion to the chief executive, the Audit Committee and the Board on the degree to which risk management, control and governance arrangements support the effective operation of the Trust. The head of internal audit produces an annual audit opinion on the effectiveness of the system of internal control. The head of internal audit and/or the internal audit manager for the Trust will normally attend Audit Committee meetings and has a right of access to all Audit Committee members, the chairman and chief executive of the Trust.

The head of internal audit is accountable to the director of finance. During 2015/16 the Audit Committee received regular written progress reports from its internal auditors outlining the status of the planned audit work for the year and the outcome of individual reviews performed, along with associated recommendations where appropriate. There were no 'no assurance' reports issued during 2015/16. The internal auditors also provided regular useful technical update reports which highlighted to the committee the main technical issues impacting on the health sector at the time of each report. The Audit Committee also monitors the implementation of all internal audit recommendations made, and has duly received regular progress reports to enable monitoring of these actions.

The Trust's external auditor is PwC, who were appointed in 2012 following a mini-tendering exercise. Representatives of the Audit Committee acted as advisors to the Council of Governors in relation to the tendering exercise, and the Council of Governors convened a sub-committee to oversee the process and make a recommendation to the full Council of Governors. The external audit contract was awarded for a period of three years with the option for a one year extension. The value of external audit services is disclosed in the Trust's financial statements at note 5.1.

The February 2015 Audit Committee meeting considered the issue of the external auditors re-appointment for a further one year extension option (in line with the original contract award) and made a formal recommendation regarding this to the Council of Governors who considered and approved the recommendation at their formal meeting in May 2015. The audit of the Trust's financial statements for 2015/16 will therefore be the final year of the existing contract. A new mini-tendering exercise commenced in early 2016 in order to ensure that a new external auditor is appointed by September 1 2016, and the process adopted for this exercise is the same as that applied in 2012.

The Audit Committee assess the effectiveness of its external auditor by completing the annual PwC client satisfaction survey, and held a private discussion (without either external or internal audit present) at the end of its February 2015 meeting to review their performance prior to recommending the one year contract extension for 2015/16 to the Council of Governors. PwC also provides non-audit services to the Trust. It is important that the independence of our external auditors in reporting to governors, non-executive directors and Northern Lincolnshire and Goole NHS Foundation Trust is not, or does not appear to be, compromised in terms of the objectivity of their opinion on the financial statements of the Trust. Equally the Trust should not be deprived of expertise where it is needed.

The Trust has a formal policy for the engagement of the external auditor for non-audit work to ensure that their objectivity and independence are safeguarded, and this is subject to annual review by the Audit Committee and the Council of Governors. The value of non-audit services utilised during 2015/16 is disclosed in the Trust's financial statements at note 5.1.

The committee also received and reviewed the draft financial statements and the audited accounts, as well as the Annual Governance Statement. Due to the financial position of the Trust at the end of 2015/16, as with the previous year, one of the significant issues given full consideration by the Audit Committee as part of the accounts preparation process was the Trust's ability to continue as a going concern. The Audit Committee considered this in detail and note 1.1 of the financial statements refer to the accounts being prepared on a going concern basis, which the Audit Committee endorsed as appropriate.

As part of the committee's regular review of its own governance arrangements it conducted a self-assessment workshop in December 2015, in line with the latest NHS Audit Committee Handbook (HFMA, 2014). A review of its formal terms of reference was also undertaken to ensure that they remain up to date and fit for purpose, and as a result of this review no specific changes were considered necessary following a complete refresh the previous year.

In line with the Foundation Trust Code of Governance, the Audit Committee also has a role in reviewing the organisations arrangements for staff and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The Audit Committee therefore reviewed and considered the Trust's Speaking Out Policy at its meetings in August and October 2015 in order to discharge this function.

Schedule of attendance at Audit Committee meetings during 2015/16

Name	Apr 15	May 15	Jun 15	Aug 15	Oct 15	Dec 15	Feb 15	Attend.
Members:								
Stan Shreeve – chair	Y	Y	Y	Y	Y	Y	Y	100%
Neil Gammon – NED	Y	Y	Y	Y	Y	N	Y	85%
Linda Jackson – NED	Y	N	Y	Y	Y	Y	Y	85%
Regular attendees:								
Alan Bell – NED	Y	Y	Y	Y	N/A*1	N/A*1	N/A*1	100%
Marcus Hassall – DoF	Y	Y	Y	Y	Y	Y	Y	100%
Wendy Booth – DoPA	Y	Y	Y	Y	N	Y	Y	85%
Ass. DoF – compliance and counter fraud	Y	Y	Y	Y	Y	N	Y	85%
Internal audit	Y	Y	Y	Y	Y	Y	Y	100%
External audit	Y	Y	Y	Y	Y	Y	Y	100%
LCFS	Y	N/A*2	Y	Y	Y	Y	Y	100%
Ad-hoc attendees:								
Deputy DoF	Y	Y	Y	-	-	-	-	-
Ass. DoF – process and control	Y	Y	-	-	-	-	Y	-
Chief executive	-	Y	-	-	-	-	-	-
Deputy chief operating officer	-	-	-	Y	-	Y	-	-
Interim HR director	-	-	-	Y	-	-	-	-
HR improvement lead	-	-	-	Y	-	Y	-	-
Assoc. medical director – S&CC	-	-	-	-	Y	-	-	-
HR manager	-	-	-	-	Y	-	-	-
Strategic procurement mgr	-	-	-	-	-	Y	-	-

Notes:

¹ Alan Bell – NED - not a formal AC member, but advised that he would no longer be able to attend wef Oct15

² Nicki Foley, LCFS - not required to attend, as final accounts meeting only

Mortality Performance and Assurance Committee

Is a sub-committee of the Trust Board of Directors and oversees all of the work streams identified in the mortality action plan. It meets monthly and is chaired by the Trust chairman. Minutes are submitted to the Trust Board as well as the Quality and Patient Experience Committee.

Resources Committee

Is a sub-committee of the Trust Board and has responsibility for oversight, challenge and assurance in respect of generation, application and use of resources and sustainability. It is chaired by a non-executive director and minutes are shared with the Trust Board.

Trust Governance and Assurance Committee

Is a sub-committee of the Trust Board and is responsible for assuring executive directors that the organisation has in place the necessary controls to manage its risk exposure, meet

statutory and other governance/performance and regulatory requirements and achieve its principal objectives. It is chaired by a non-executive director.

Quality and Patient Experience Committee

Is a sub-committee of the Trust Board and is responsible for overseeing the development of the Trust's overarching Quality Strategy, Patient Experience Strategy and both embedding and enactment of its services through its Vision and Values to ensure that the quality of care provided meets national and best practice guidance. It is chaired by a non-executive director.

Charitable Funds Committee

Is a sub-committee of the Trust Board, under the Trust Constitution Part IV Section 6.8d, and is responsible for overseeing the management of the affairs of the Northern Lincolnshire and Goole NHS Foundation Trust charity. It is chaired by the Trust chairman. The working name of the charity is the Health Tree Foundation (HTF). For further information about HTF please refer to the Health Tree Foundation section of the annual report.

Infection Prevention and Control Committee

Is a sub-committee of the Trust Board. Its purpose is to provide strategic direction for the prevention and control of healthcare acquired infections. It performance manages the Trust against its infection prevention and control strategy and ensures there is a strategic response to new legislation and national guidelines.



Council of Governors

The role of the Council of Governors and statutory requirements

The Council of Governors (CoG) links the Foundation Trust to its members and community to ensure local people are engaged and involved in our services.

On joining the Trust, each new governor receives an induction and ongoing training in the business of the Trust.

The Trust has developed a governor role requirements document which details the role and responsibilities of governors and incorporates the statutory mandatory duties defined in the Health and Social Care Act (2012). This information is also set out in the Trust Constitution. Their key responsibility it to:

- Hold the non-executive directors (individually and collectively) to account for the performance of the Board of Directors, which includes ensuring the Board does not breach the terms of its Licence, and
- Represent the interests of the members of the NHS Foundation Trust as a whole, the interests of the public and partner organisations in the local health economy in the governance of the Trust.

Governors receive details of Trust Board meetings a week in advance of each meeting. These include agendas, approved minutes and a link to the full set of public papers available on the Trust website <http://www.nlq.nhs.uk/about/board-meetings/>. A Trust Board highlights report is also provided and delivered by the Trust chairman at each CoG meeting.

Governors also monitor the performance of our Trust via quarterly key reports on quality, mortality, finance and Trust Board sub-committees to allow a review the performance of the Board of Directors and ensure high standards are maintained.

Other governor duties include:

- Providing a response when consulted by the Board of Directors
- Appointment and dismissal of the chairman and other non-executive directors
- Setting the salary and conditions of employment of the chairman and non-executive directors
- Appointment of, and if appropriate, removal of the Trust's external financial auditors
- Acceptance of the Trust's Annual Accounts and the auditor's report on them and the Annual Report
- Approving the appointment of the chief executive. However, the CoG does not make the appointment.

Further details in relation to the role, responsibilities and powers of governors are detailed below:

Statutory roles and responsibilities of the council of governors	Additional powers
2006 Act	<ul style="list-style-type: none">• Appoint and, if appropriate, remove the chair• Appoint and, if appropriate, remove other non-executive directors• Decide the remuneration and allowances and other terms and <p>In preparing the NHS Foundation Trust's forward plan, the Board of Directors must have regard to the views of the Council of Governors</p>

	<p>conditions of office of the chair and the other non-executive directors</p> <ul style="list-style-type: none"> • Approve (or not) any new appointment of a chief executive. • Appoint and, if appropriate, remove the NHS Foundation Trust's auditor 	
Amendments to the 2006 Act made by the 2012 Act	<ul style="list-style-type: none"> • Hold the non-executive directors, individually and collectively, to account for the performance of the Board of Directors • Represent the interests of the members of the Trust as a whole and the interests of the public • Approve significant transactions • Approve an application by the Trust to enter into a merger, acquisition, separation or dissolution • Decide whether the Trust's non-NHS work would significantly interfere with its principal purpose, which is to provide goods and services for the health service in England, or performing its other functions • Approve amendments to the Trust's Constitution 	The CoG may require one or more of the directors to attend a governors' meeting to obtain information about performance of the Trust's functions or the directors' performance of their duties, and to help the CoG to decide whether to propose a vote on the Trust's or directors' performance.

Source: *Your Statutory Duties: A Reference Guide for NHS Foundation Trust Governors (Monitor – August 2013)*

Governors are responsible for sharing information about the Trust, such as our vision and values, forward plan (including our objectives, priorities and strategy) and our performance to members and the public. In the case of nominated governors, this information is fed back to the stakeholder organisations that nominated them. Governors are, in return, also responsible for communicating back to the Board of Directors the opinions canvassed. In order to facilitate this process, this is a part of our annual governor and non-executive director engagement and consultation session held each year where views and opinions are invited and considered in relation to the Trust's forward plans.

The public version of our forward plan is available on our website as part of the Board papers and is a standing agenda item at the CoG annual members' meeting. Each year at a CoG annual members' meeting, held each September, the following materials are provided by Trust Board directors:

- Annual Accounts
- Any report from the auditors
- Annual Report
- Trust priorities for the future.

As part of this reporting process, the Trust Board clearly sets out its financial, quality and operating objectives and discloses sufficient information, both quantitative and qualitative, of the Trust's business and operation including clinical outcome data so members and governors can evaluate our performance.

At every annual members' meeting, the Board of Directors invites questions from governors, members and the public, and formal minutes are taken to capture questions raised and actions to be taken forward. Copies of previous minutes are published on our website <http://www.nlq.nhs.uk/about/membership/governors-meetings/>

Our governors continue to play a vital role in representing the interest of the communities we serve. They actively canvass the views and opinions of Trust Members and the public

Declaration of interests

All governors are required to comply with the Trust's code of conduct and declare any material, commercial, political or other interests which may result in a potential conflict of interest in their governor role. Governors sign a declaration of interest on election that indicates that they meet the 'fit and proper persons' test as described in the provider license. No governor is able to be a director or governor in another NHS foundation trust.

The majority of governors have no external directorships or interests that are relevant and material to NHS business matters. Membership of political parties and declarations that may be material are recorded and updated in the Register of Governors' interests retained by the Trust Secretary. The full Register of Interests for governors and directors (which includes the chairman), is available on the Trust website at www.nlq.nhs.uk Revised documents will be added during the year with any changes.

Appointed governors represent their organisation and connect the Trust and their appointing organisation, so their position within that organisation is not considered as a material interest.

Elected governors are subject to re-election by the members of the Trust constituency at regular intervals not exceeding three years. The names of the governors submitted for election or re-election are accompanied by biographical details and any relevant information to enable members to make an informed decision on their election.

All governors are required to comply with the Trust's code of conduct and declare any material, commercial, political or other interests which may result in a potential conflict of interest in their governor role.

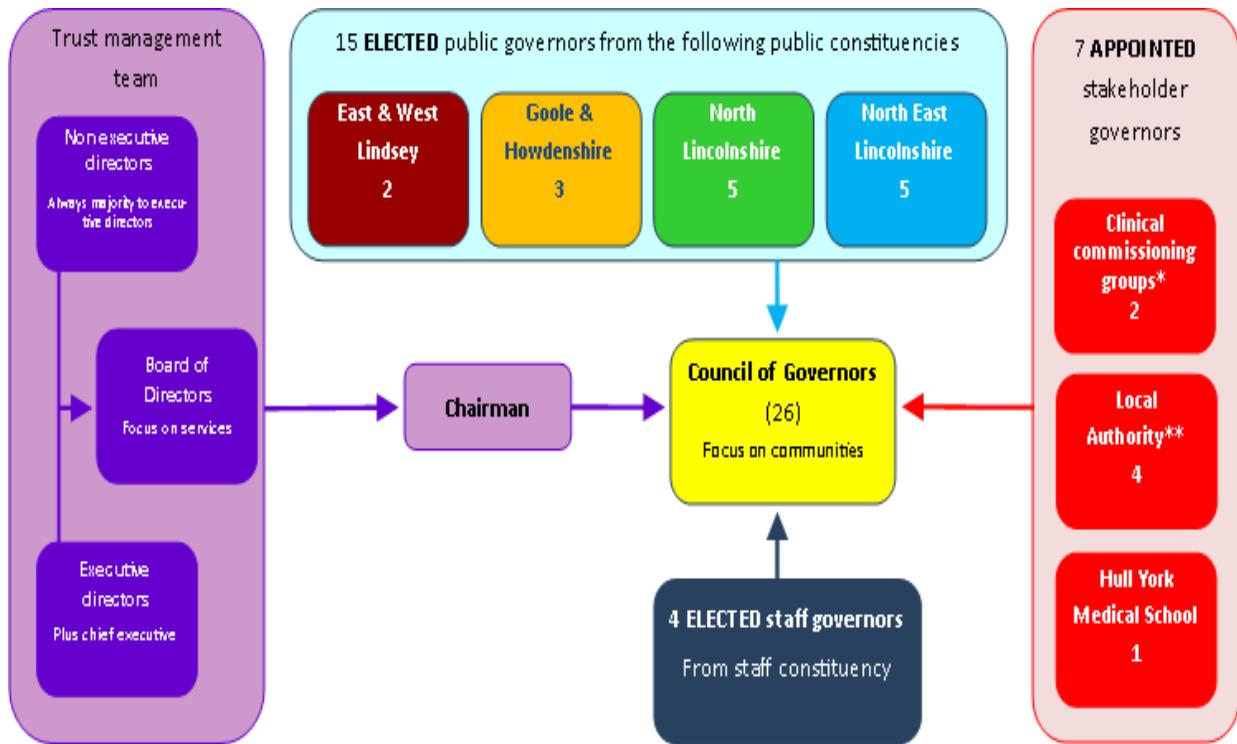
Our Constitution, as agreed and adopted by the CoG, outlines the clear policy and fair process for the removal from our CoG, of any governor who has an actual or potential conflict of interest which prevents the proper exercise of their duties.

Chairman's commitments

The chairperson's other significant commitments are disclosed to the CoG prior to appointment. This information is captured in the Declaration of Interests form on an annual basis and forms part of the Register of Interests document for the Trust Board. Any changes to such commitments are updated in a revised Declaration of Interests and an updated Register of Interests will be reported to the next CoG meeting, Trust Board meeting and is captured in the annual report.

Composition of the Trust's Council of Governors

The composition of the CoG, as detailed in the Trust Constitution, is demonstrated in the diagram below, which details the public and staff constituencies, and the governor representation on the CoG:



***Clinical commissioning groups** – North East and North Lincolnshire

****Local authorities (LA)** - East Riding of Yorkshire, Lincolnshire, North East Lincolnshire and North Lincolnshire

The current composition of the CoG is considered by governors and directors to be effective, without being so large as to be unwieldy. Work continues through the Governor Steering Group and CoG to ensure all nominated stakeholder governors are identified within partner organisations to fill current vacancies.

Lead governor

The lead governor is Paul Grinell, a public governor for North Lincolnshire. He was elected as lead governor on July 3 2013, and recently re-elected on January 14 2016.

Council of Governor meetings

The Trust is locally accountable to its members through the CoG which represents the interests of the members, members of the public and partner organisations. Governors exercise statutory duties and hold the non-executive directors of the Trust Board to account, who in turn hold the directors to account for the performance of the Trust. Governors are encouraged to act in the best interests of the Trust and are bound to adhere to its vision and values and code of conduct.

The CoG discharges its duties at its formal CoG meetings in public on a quarterly basis to make decisions and to ensure the views and priorities of local people inform the Trust's decisions on strategy. Members of the Board of Directors are invited to attend to update the

governors on specific items, and ensure appropriate high-quality information is provided appropriate to the governor respective functions to enable them to make decisions and discharge their duties.

Governors also hold meetings without executive directors present to discuss matters among themselves and attend informal meetings with executive directors to develop their own knowledge of the services the Trust provides and discuss issues as they arise. Governors held a series of quarterly governor and member forums and drop-in sessions throughout 2015/16, and use the Trust's staff and members newsletter, Trust website, membership portal website, media releases and emails to communicate with members. During the financial year, governors also attended a number of community engagement and member recruitment events.

The chairperson is responsible for the leadership of both the Board and the Council of Governors. The chair ensures that the views of governors and members are communicated to the Board as a whole, and the interaction between the Board and the CoG is primarily a constructive partnership. The CoG adopts a policy to proactively engage with the Board in circumstances when they have concerns. The CoG is encouraged to ensure its interaction and relationship with the Board is appropriate and effective, with the Trust's Constitution outlining the process to resolve any disagreements between the Council of Governors and Board of Directors. Governors also have the right to refer a question to the Independent Panel for Advising Governors if more than 50 per cent of governors who vote, approve the referral.

A review of the collective performance of the CoG is held annually in June and members of the Board of Directors are invited to attend and support this process. The review is led by the Trust chairman, supported by the Trust secretary and membership manager, and utilises a framework document that incorporates Monitor's Code of Governance.

A full set of CoG papers are always available on the Trust website ahead of the meeting, and all meetings are detailed here. The website is <http://www.nlg.nhs.uk/about/membership/governors-meetings/>, and this allows members and the public to be kept informed of the work of the CoG and how they discharge their responsibilities. Members and the public are invited to attend these public meetings and the information is on the members' portal, the website, in the members' annual calendar of events and on posters around the Trust. A number of committee and working groups of the CoG have been formed, although responsibility for all decisions is retained by the full CoG. The CoG sub-groups review and implement the governor training and development programme, review and plan membership engagement, retention and recruitment, review and challenge patient quality information and practices etc. In addition to this governors undertake ward review visits, PLACE assessments and participate in membership engagement and recruitment activities.

To help the chair and non-executive directors gain a greater understanding of the view of governors and the Trust's membership, they regularly discuss the affairs of the organisation with governors at frequent formal and informal meetings. Non-executive directors are invited to attend these meetings with governors and there is an expectation of attendance should governor's request this. A timetable of non-executive director attendance at CoG sub-groups and committees ensures feedback, to and from Trust board sub-committees to the CoG sub-groups. In 2015/16 non-executive directors attended a number of CoG committee and working group meetings.

Meetings of the Council of Governors in 2015/16

During 2015/16, there were six formal meetings of the CoG, including the annual members meeting. Governors are encouraged to attend by varying the times of meetings and the venues across the constituencies. Travelling expenses to and from meetings are reimbursed.

Information about our governors

Name	Initial date elected	Date re-elected	Term of office	Term of office ends	Date of retirement	Political party
Public governors – East and West Lindsey						
Sheila Fisher	23.11.06	-	9 years	3.12.15	3.12.2015	-
Iona Scott	31.10.13	-	3 years	30.10.16		-
Public governors – Goole and Howdenshire						
Susan Diack	8.2.11	-	5 years	30.10.16	1.11.15	-
John Frost	25.4.13	-	3 years	24.4.16	-	-
Robert Pickersgill	3.12.15	-	3 years	3.12.18	-	-
Roy Taylor	23.11.11	3.12.15	6 years	3.12.18	-	-
Public governors – North East Lincolnshire						
Ian Davey	3.12.12	-	3 years	2.12.15	2.12.15	-
Brian Page	3.12.15		3 years	3.12.18		
Jeff Shaw	23.11.08	30.10.12	4 years	30.10.16	-	-
Esther Smith	31.10.13	-	3 years	30.10.16	1.9.15	-
Liz Stones	23.11.11	22.11.14	3 years	3.12.17	-	-
Public governors – North Lincolnshire						
Beryl Allison	21.11.14	-	3 years	21.11.17	-	-
Maureen Dobson	28.11.07	30.10.12	4 years	30.10.16	-	-
Harold Edwards	23.11.11	3.12.15	3 years	3.12.18	-	-
Paul Grinell	4.11.09	3.12.15	3 years	3.12.18	-	
Max Witherington	31.10.13	-	3 years	30.12.16	-	-
Staff governors						
Sid Goel	28.7.14	-	3 years	28.7.17	-	-
Makani Hemadri	28.7.14	-	3 years	28.7.17	-	-
Louise Salt	28.7.14	-	3 years	28.7.17	-	-
Tony Whyte	28.7.14	-	3 years	28.7.17	-	-
Nominated governors						
Hull York Medical School						
Vacancy						
North Lincolnshire Clinical Commissioning Group						
Caroline Briggs	12.1.14	-	3 years	11.2.17	-	-
North East Lincolnshire Clinical Commissioning Group						
Jan Haxby	20.7.15	-	3 years	20.7.18	-	-
North Lincolnshire Council						
Peter Clark	20.7.15	-	3 years	20.7.18	-	conservative
North East Lincolnshire Council						
Melanie Dickerson	20.7.15	-	3 years	20.7.18	-	conservative
Goole and Howdenshire Council						
John Barrett	20.7.15	-	3 years	20.7.18	-	conservative
East and West Lindsey Council						
Vacancy						

Attendance of governors at Council of Governor meetings

The names of the members of the CoG, their public, staff or stakeholder governor status, and the time they served during the year are captured in the CoG attendance table below:

Name	6.5.15	25.6.15 *	22.7.15	30.9.15 **	5.11.15	14.1.16	Total	Other meetings
Sheila Fisher	0	Y	Y	Y	-	N/a	3 of 5	0
Iona Scott	0	0	0	0	0	0	0 of 6	0
Susan Diack	0	Y	0	Y	N/a	N/a	2 of 4	3
John Frost	0	0	Y	0	Y	0	2 of 6	0
Robert Pickersgill	N/a	N/a	N/a	N/a	N/a	Y	1 of 1	0
Roy Taylor	Y	Y	Y	Y	Y	Y	6 of 6	3
Ian Davey	Y	Y	Y	0	0	N/a	3 of 5	0
Brian Page	N/a	N/a	N/a	N/a	N/a	Y	1 of 1	0
Jeff Shaw	Y	Y	Y	Y	0	0	4 of 6	2
Esther Smith	Y	Y	0	N/a	N/a	N/a	2 of 3	0
Liz Stones	0	0	Y	Y	0	Y	3 of 6	0
Beryl Allison	Y	Y	0	Y	Y	Y	5 of 6	2
Maureen Dobson	Y	Y	Y	Y	Y	Y	6 of 6	6
Harold Edwards	Y	Y	Y	Y	Y	Y	6 of 6	10
Paul Grinell	Y	Y	Y	Y	Y	Y	6 of 6	7
Max Withrington	Y	Y	Y	Y	0	0	4 of 6	3
Sid Goel	0	Y	0	0	0	0	1 of 6	0
Makani Hemadri	0	0	0	0	Y	0	1 of 6	0
Louise Salt	0	0	Y	0	0	0	1 of 6	1
Tony Whyte	0	0	0	Y	0	Y	2 of 6	1
Caroline Briggs	Y	0	0	Y	0	0	2 of 6	0
Jan Haxby	N/a	N/a	0	0	0	0	0 of 4	0
Peter Clark	N/a	N/a	Y	0	0	Y	2 of 4	0
Melanie Dickerson	N/a	N/a	0	Y	0	Y	2 of 4	0
John Barrett	N/a	N/a	0	Y	0	0	1 of 4	0

*Annual review meeting

**Annual members meeting

Y - attended

0 not attended

N/A – person not in post

Directors' attendance at Council of Governors meetings

The number of attendances by directors at meetings of the CoG is recorded and is shown below:

Council of Governor meetings	6.5.15	25.6.15	22.7.15	30.9.15	5.11.15	14.1.16	Total
Directors							
Dr Jim Whittingham, chairman	Y	0	Y	Y	Y	Y	5 of 6
Karen Jackson, chief executive	Y	Y	Y	Y	Y	A*	5 of 6
Karen Griffiths, chief operating officer	A*	A*	A*	Y	Y	Y	3 of 6
Wendy Booth, director of performance assurance and Trust secretary	A*	A*	A*	Y	A*	A*	1 of 6
Pam Clipson, director of strategy and planning	A*	0	0	0	0	Y	1 of 6
Dr Karen Dunderdale, chief nurse (until June 2015) and deputy chief executive (from June 2015)	Y	A*	0	Y	0	A*	2 of 6
Tara Filby, chief nurse	**	**	**	**	Y	A*	1 of 2
Marcus Hassall, director of finance	A*	0	A*	A*	Y	Y	2 of 6
Jane Heaton, interim director of human resources	**	**	**	Y	Y	Y	3 of 6
Jug Johal, director of estates and facilities	A*	Y	0	Y	0	Y	3 f 6
Mr Lawrence Roberts, medical director	**	0	Y	A*	Y	Y	3 of 5
Dr Neil Pease, director of OD and workforce	A*	**	**	**	**	**	0 of 1
Non-executive directors							
Alan Bell	0	Y	Y	Y	0	Y	4 of 6
Neil Gammon	0	0	Y	Y	Y	Y	4 of 6
Linda Jackson	Y	Y	0	Y	Y	Y	5 of 6
Anne Shaw	0	Y	0	Y	0	0	2 of 6
Stan Shreeve	0	Y	Y	Y	Y	Y	5 of 6

Y - attended

0 - apologies

A* - deputy covered for director absence

** - not in post

Governor training and development

The Health and Social Care Act (2012) states that foundation trusts must take steps to ensure governors are equipped with the skills and knowledge in order to fulfil their role. The Trust encourages governor development which is captured in the annual governor development plan, the key areas being:

- Detailed induction training for all new governors including the establishment of a governors' resource pack that includes an indepth governor handbook and additional support arrangements for governors
- Governor mentor/buddy assigned to our newly elected governors, which includes support provided in preparation for CoG meetings
- Attendance at CoG meetings and participating in the annual review of the CoG
- Equality and diversity training (available through e-learning packages)
- Safeguarding adults and children training (available through a course or e-learning packages)
- Information governance training (available through a course or completion of a workbook)
- Completion of a governor skill set questionnaire, compiled in to the CoG skills matrix which helps to identify individual and common training and development requirements
- Chairman-led monthly governor group sessions
- Monthly chairman and governor one-to-ones available for all governors
- Monthly chief executive-led private governor briefings on the Healthy Lives, Healthy Futures sustainability review
- Governor attendance at external events – clinical commissioning group information and engagement events, patient participation groups, carer events etc
- Governor led member recruitment and engagement events internally in the Trust and externally utilising local health and social care events
- Governors are encouraged to attend Trust Board meetings (open to the public) to directly observe non-executive directors' scrutiny, challenge and support of executive directors. They are supplied with the agenda, approved minutes and website link for the full papers in advance of each meeting
- Quarterly governor and non-executive director briefings on topical health matters, which have included:
 - Healthy Lives, Healthy Futures – sustainability review updates
 - Forward plan
 - Morale barometer
 - Staffing levels and nursing shift patterns
 - CoG retail catering presentation
 - Patient experience (including Friends and Family Test)
 - Sustainability and sustainable services update
 - Quality priorities 2016/17
 - Update on the proposed developments at Grimsby site
 - Clinical administrative review (and later update)
 - Charitable Funds Committee
 - Mortality
 - Trust policy of female genital mutilation
 - Health Tree Foundation
 - PALS and complaints
 - Chaplaincy.

Keeping governors informed and involved

It is the chairman's role to lead the CoG as well as the Trust Board. Governors receive the agenda, all papers and minutes of the Board of Directors meetings held in public and are able to be present for the public sessions of these meetings.

Visits to different areas across the Trust provide board members and governors with assurance of the quality of clinical care and areas for improvement both from the patient experience and staff perspective.

The chairman is available to members and governors through the Trust secretary if they have concerns through which the normal channels have failed to resolve, or for which such contact is inappropriate.

Members of the Board of Directors attend meetings of the CoG to provide information on the Trust's performance, update them on strategy and key operational issues and to ensure that the governors have access to directors when required. Governors also meet regularly with non-executive directors at CoG sub-groups and sub-committees.

Regular briefings are held for governors for information, consultation and training sessions which are often delivered by directors and include the quality priorities and forward plan. In addition to this, monthly private briefings by the chief executive have been set up for governors on the Healthy Lives, Healthy Futures sustainability review.

Governors have been kept informed about stakeholder and regulatory scrutiny through updates sent by the chairman, chief executive, the Trust secretary, the communication and marketing team, and at informal meetings between governors and directors. They have also been involved in site inspections by regulators, and have had the opportunity to meet in private with regulators.

Governors took part in the PLACE (patient-led assessment and care environment) assessments during 2015/16. These looked at the hospital environments, across all three sites, and an action plan was produced to address areas of improvement.

Governor engagement with Trust members and the public

Governor details and biographies are available via the Trust's website – “Meet the Council of Governors” webpage <http://www.nlg.nhs.uk/about/membership/governors/>, which also has a link for the membership office to enable contact with governors, being <http://www.nlg.nhs.uk/about/membership/membership-office/>, or e-mail nlg-tr.FoundationTrustOffice@nhs.net or call (01724) 387946.

Governors canvass Trust members' views and opinions and those of the public in relation to our forward plans. Governors canvass such views and opinions during their attendance at key membership and Trust events. These include our annual members' meeting and the governor and member forums which are held at each hospital area on a quarterly basis and are hosted by local governors. Details of these forums are provided to members and the public via the:

- Members' calendar of events on the website at <http://www.nlg.nhs.uk/about/membership/dates-diary/>
- The Trust's website <http://www.nlg.nhs.uk/about/membership/governor-member-forum-meetings/>
- The bi-monthly Staff and Members' Magazine “News@NLaG” available on the website at <http://www.nlg.nhs.uk/about/membership/members-newsletter/>

The canvassed views and opinions of members and the public are fed back to the board members via a bi-annual specific governor and non-executive director briefing, quarterly CoG meetings (where the forward plan is on the agenda at appropriate times throughout the year), CoG sub-group meetings with non-executive director attendance and on an ad-hoc basis direct to key directors.

The governors provide a direct interface between members, the public and local groups and feed back to the relevant sub-committee, Council of Governors meeting, or to the chairman directly in order for him to liaise with the directors.

Membership

There are two categories of membership – public and staff.

Public membership

Public members are individuals who live in one of the four constituencies – East and West Lindsey, Goole and Howdenshire, North Lincolnshire and North East Lincolnshire – and are aged 16 and above and have registered to become members. Becoming a public member of the Trust is voluntary and free of charge and open to anyone meeting the criteria above (subject to the additional grounds for eligibility or disqualification of members described in annex 8 of the Trust Constitution).

Membership to the public constituency is through application to the Foundation Trust membership office, by the following methods:

Website: <http://www.nlg.nhs.uk/about/membership/join/>

Telephone: (01724) 387946

Email: nlg-tr.FoundationTrustOffice@nhs.uk

Staff membership

Staff membership is open to individuals who are employed by the Trust under a contract of employment provided that:

- He or she is employed by NLaG under a contract of employments which has no fixed term or has a fixed term of at least 12 months
- He or she has been continuously employed by NLaG under a contract of employment for at least 12 months.

Staff members are ‘opted in’ to membership, although they retain the right to opt out of membership if they wish to.

Levels of member engagement

Some members will choose to have a very active membership, while others will choose to only receive a newsletter. The level of engagement is up to the individual, and they can choose their level of engagement with the Trust, such as:



Membership strategy

The governance structure for foundation trusts is explained in the membership strategy, which was rewritten in 2013 and is currently under review. This document outlines the:

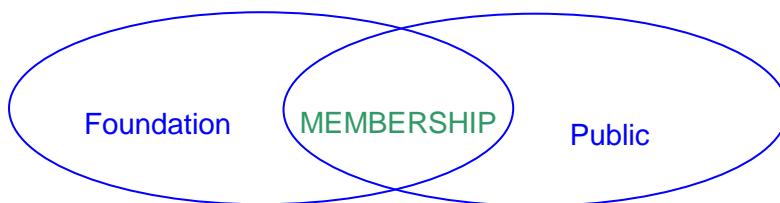
- Significance of membership for Foundation Trust
- The Trust constituencies (as referenced under the CoG section)
- Communication with members
- Member benefits
- Member recruitment
- Member engagement.

The membership strategy is reviewed and updated by the governors' Membership Working Group. The full document is available at the following link:

<http://www.nlg.nhs.uk/content/uploads/2014/01/NLG13394-Membership-Strategy.pdf>

People living in the constituencies that are served by the Trust can become members, as well as staff who work at the Trust (see above). It is the members who elect the governors who sit on the CoG and represent members' interests in the running of the organisation. In this way members are given a say in the management and provision of services at the Trust. Members are able to engage in establishing the direction of services provision and ensure that hospital services more accurately reflect the needs and expectations of local people (patient-led NHS service).

The diagram below demonstrates this relationship:



All foundation trusts have a duty to engage with their local communities and encourage local people to become members of the organisation (ensuring that membership is representative of the communities that they serve). By this method, foundation trusts provide greater accountability to patients, service users, local people and NHS staff with the overriding principle being that Trust members have a sense of ownership over the services that they provide.

As governors are elected/appointed by public and staff members they are accountable to those members. In turn, the non-executive directors are accountable to the governors; this chain of interlocking relationships drives the performance of the organisation and is the mechanism of local accountability.

Governors face both directions. On the one hand they are the link between the local community and its needs and views on the delivery of services, and the directors making the decisions about services and the responsibility for delivery. On the other hand governors need to transmit information from the Board of Directors to the local community about affordability and other constraints. The governors, therefore, at all times link the community and the Trust, and the success of a Foundation Trust very much lies in the success of the governors role in linking the Trust to the community.

Key priorities of the strategy

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

Current public membership by constituencies

The public constituencies are divided into four main areas as detailed in the table below, together with details of the relevant electoral wards:

Name of the public constituency	Area of the public constituency by electoral wards	Minimum number of members	Number of governors to be elected
North Lincolnshire	The wards of: Ashby; Axholme Central; Axholme North; Axholme South; Barton; Bottesford; Brigg and Wolds; Broughton and Appleby; Brumby; Burringham and Gunness; Burton upon Stather and Winterton; Crosby and Park; Ferry; Frodingham; Kingsway/Lincoln Gardens; Ridge and Town.	500	5
North East Lincolnshire	The wards of: Croft Baker; East Marsh; Freshney; Haverstoe; Heneage; Humberston and New Waltham; Immingham; Park; Scartho; Sidney; South; Sussex; Waltham; West Marsh; Wolds; Yarborough.	500	5
Goole and Howdenshire	The Wards of: Goole North; Goole South; Howden; Howdenshire; Snaith, Airmyn and Rawcliffe and Marshlands.	200	3
East and West Lindsey	The Wards of: Binbrook; Grimoldby; Holton Le Clay; Legbourne; Ludford; Mablethorpe Central; Mablethorpe East; Mablethorpe North; Marsh Chapel; North Holme; North Somercotes; North Thoresby; Priory; Skidbrook with Saltfleet Haven; St Mary's; St Michaels; Sutton on Sea North; Sutton on Sea South; Tetney; Trinity; Trusthorpe/Mablethorpe South; Withern with Stain. Caistor; Gainsborough East; Gainsborough North; Gainsborough South West; Hemswell; Kelsey; Scotter; Thonock; Waddingham and Spital; Wold View; Yarborough.	200	2

Membership numbers

The Trust's membership for 2015/16 and the planned membership for 2016/17 are shown below:

	2015/16 plan	2015/16 actual	2016/17 planned
Public constituency: At year start (April 1)	5,300,	5,485	5,500
New members	200	197	250
Leaving members	120	154	200
Minimum required under Constitution	1,400	5,485	5,500
Staff constituency: At year start (April 1)	6,745	7,348	7,400
New members	850	1,453	850
Members leaving	800	807	800

As at March 31 2016, the Trust had a membership of 12,835. The number of new members for the period of 2015/16, including staff members was 1,550. The number of members leaving was 961, again, including staff. This is an overall increase of 589 members. The tables below provide a detailed breakdown:

Figures as at March 31 2016

Total membership overview	
Public members	5,485
Staff members	7,348
(no DOB)	
Total members	12,833

Age group – public members	Number	Percentage	Population*
0 to 16		0	0.00%
17 to 21	260	4.7%	
22 +	5,208	95%	
(Not stated)	16	0.30%	n/a
Total	5,486	100%	100%

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

Breakdown by constituency

Constituency	Male	Female	Not stated	Total
Goole and Howdenshire	198	277	2	477
North East Lincolnshire	704	1,500		2,206
North Lincolnshire	788	1,388		2,178
East and West Lindsey	239	387		626
Staff	1,441	5,907	0	7,348
Total	3,370	9,459	2	12,835

Breakdown by ethnicity

Ethnicity – public members	Number	Percentage	Population	Percentage
White	5,136	93.63%	381,788	97.63%
Mixed	19	0.35%	1,854	0.48%
Asian or Asian British	94	1.71%	5,529	1.45%
Black or Black British	19	0.35%	882	0.23%
Other	0	0%	786	0.21%
Not stated	217	3.96%	0	0%

The current Trust membership generally reflects the demographic of the population served, and is representative for the majority of categories. Membership recruitment events will be undertaken in 2016/17, some of which will target various groups to further ensure representative membership (eg 16-year-olds through schools and colleges etc).

Work to recruit new members

A number of initiatives were put in place to maintain membership during 2015/16, particularly targeting the under-represented areas. Governors attended a number of events to engage with the public, and to support and encourage Trust membership. These membership recruitment initiatives included:

- Governor and membership office staff held recruitment events at each hospital site
- Governor and membership office staff attended health and social care events to target new members and engage with existing members and the public
- Members' portal now available for all Trust members and provides quick enrolment for new members
- Regular updates on the Trust website (including how to join)
- Encouraged staff to inform family/friends and people within their local communities about becoming a member
- Membership posters and application forms forwarded to each Trust group/directorate and reception areas
- Production of combined staff and members' newsletters for existing members with details of how to become a member for family and friends
- Promotional 'become a member' materials promoted around the Trust and made available at events
- Poster campaigns.

The current membership recruitment initiatives have proved to be quite effective, with limited or no cost associated, and this approach will be replicated in 2016/17.

Engaging and communicating with members

Ensuring effective two-way communication and appropriate engagement with our members via a combination of Trust and governor managed formal and informal communications is very important to our governors and the Trust.

A 'welcome pack' is the first step for our new members and assists with the initial communications, guidance and support.

The membership office maintains regular contact with members using a variety of methods, including:

- Trust website with a designated section for members

- Members' portal – a specialist tool for member engagement
- Email – for newsletters, invites to meetings and volunteer opportunities
- Face-to-face through informal governor drop-ins at each site
- Face-to-face through governor and members' forums
- E-newsletter produced bi-monthly (joint staff and members' newsletter)
- Twitter and Facebook
- News releases for local media
- Poster campaigns around the Trust and with our key partners.

There are various opportunities for members to become more involved with the Trust, below are some examples:

- Attending quarterly governor and members' forums
- Attending Council of Governors meetings
- Attending the Annual Members Meeting
- Attending the Board of Director meetings
- Helping to recruit new members
- Voting in governor elections
- Standing for election as a governor
- Fundraising activities
- Participating in surveys
- Participating in consultations on Trust plans
- Joining the Trust's volunteer services.

These are advertised in advance in the NLaG staff and member newsletter, on the Trust website and a news release is sent to local media. During 2015/16, members were emailed with details of various events.

Communication with governors and the membership office

A dedicated foundation trust email address and telephone number is available providing contact details for member queries and comments.

Anyone with any queries can contact the membership office. This can be done by:

- Telephoning (01724) 387946
- By emailing nlg-tr.foundationtrustoffice@nhs.net
- By writing to: Membership Office
Modular Building
Scunthorpe General Hospital
Cliff Garden
Scunthorpe
North Lincolnshire
DN15 7BH

Governor's achievements during 2015/16

Governor elections

Governors serve a term of office for up to three years at the end of which time they are able to offer themselves for re-election/re-nomination (serving for a maximum of nine years in total). However, governors cease to hold office if they no longer:

- Live in the area of their constituency (for public governors)
- Work for our Trust (for staff governors)
- Are supported in office by the organisation that they represent (for nominated governors).

In accordance with the Model Rules for Election, the annual governor elections were held in November 2015. This election resulted in a newly elected governor for:

- Goole and Howdenshire, Rob Pickersgill
- North East Lincolnshire, Brian Page.

Two existing governors were also re-elected for North Lincolnshire, Paul Grinell and Harold Edwards. Two seats remained vacant for North East Lincolnshire, and elections were held in April. Detailed reports of the elections are available on the Trust website www.nlg.nhs.uk

Governor activities

Our governors have been busily engaged in member engagement, recruitment and general communication. They have attended and participated at:

- CoG business meetings
- CoG Annual Members' Meeting
- Annual Review of the CoG Meeting
- Serving on CoG sub-groups and board sub-committees
- Governor and non-executive director briefings
- Healthy Lives, Healthy Futures briefings from the chief executive
- Hosting local quarterly governor and member forums
- Hosting governor drop-in sessions at each site
- Undertaking ward review visits
- Undertaking PLACE assessments
- Participating in membership recruitment activities
- Supporting governor election roadshows
- Supporting Trust award ceremonies
- Participating in staff health and wellbeing events.



Regulatory ratings

Monitor governs the Trust ratings based on a system set out in their Risk Assessment Framework. They use a combination of a continuity of service risk rating, based on key financial performance indicators and targets, to assess Trust compliance with core duties set out in their Terms of Authorisation. Plan submissions and in-year performance are evaluated against these measures to grade trusts on compliance and risk of non-compliance.

Where trusts do not remain compliant with the target levels set for either rating, they will be taken through an escalation process by Monitor, who will make their own assessment as to the appropriate actions to take. They may judge the trust to be in breach of its Terms of Authorisation, and sanction intervention which may include removal of the Trust Board.

During quarter two of 2015/16 the regulatory ratings relating to liquidity and debt changes from Continuity of Services Risk Rating to Financial Sustainability Risk Rating. This now covers income and expenditure margins as well as liquidity and debt.

Financial efficiency risk

The Trust delivered in 2015/16 a deficit of £26.035million upon draft accounts, and inclusive of all non-cash balance sheet review adjustments. This clearly represents a material underlying imbalance between income and expenditure. However, this should be viewed in the context of a national picture which shows clearly systemic stress across the acute provider sector – a demonstration of wider market failure, rather than individual organisation failure.

The Trust set out in its 2016/17 plan a projected deficit of £11.82million. This is inclusive of additional Sustainability and Transformational Support income of £11.5million – income derived through central distribution to reflect the necessary support – over and above tariff changes – to the provider sector as a whole. This reflects a national recognition that there is a sector wide issue to resolve.

The projected 2016/17 deficit of £11.82million should also be viewed in the light of a control total, set centrally by the regulator for NLaG, of £12.27million. By setting this control total limit, regulators in effect recognise the organisation has a need for additional support. The current NLaG deficit plan can also be demonstrated to live within centrally set acceptability tolerances.

The Trust has in its plan identified risks to income driven by restrictions on clinical commissioning group allocations. However, the terms of the Operating Framework and tariff for 2016/17 would justify the Trust's income projections in plan.

The Trust may face increased activity levels and hence costs, above plan. However, the terms of the Operating Framework and tariff would dictate that this activity should be funded by commissioners if it is undertaken.

The Trust faces a challenging savings target, but can demonstrate that the projections are deliverable, and also demonstrate equivalent savings delivery in 2015/16, a major improvement on historic delivery.

Other risks around inflation, regulatory pressures, contracting fines and other potential unknowns also exist – but are part of normal operation of the Trust, rather than forming existential threats.

Risks to delivery of a plan within centrally set tolerances are therefore potentially mitigatable, and do not form the basis for a revised view of going concern. However, there remains an imbalance between income and expenditure that forms a degree of future risk to the organisation.

Continuity of services risk

The Trust had year-end cash balances of £5.20million. However, to maintain this level of liquidity, the Trust utilised in full a £15.00million Interim Revenue Support Loan. This was agreed through the regulator with the Department of Health (DoH) and the Independent Trust Financing Facility (ITFF). The Trust was therefore dependent on external liquidity support to maintain operations in 2015/16.

The loan is for a five year term until 2020. At the point of maturity, the lender (the DoH) is obliged to look at the affordability for the position of the organisation before deciding on the next step to take – conversion to PDC support, extension of the loan, or repayment. The Trust Board has stated its reliance upon this clause in the regulations when approving the loan agreement.

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

For the Trust's 2016/17 plan, prior to support a total liquidity shortfall of £42.07million was identified. However, the following liquidity support package can legitimately be justified to support this position.

The Trust has therefore a plan which can be legitimately supported by anticipated cash flows. These flows remain subject to regulator and DoH approval, and this approval process remains in flux, but should regulator approval processes require adjustment to the plan in respect of available liquidity, it should be possible for the Trust to respond and construct a plan that still ensures liquidity and solvency parameters are complied with.

The Trust has also now agreed an additional revolving working capital facility loan with the DoH of £18.9million. This is available for drawdown in the interim, in the absence of a full finalised liquidity support framework for 2016/17. This is also repayable after a five year period, subject to the same affordability caveats set for the Interim Revenue Support Loan described above. Therefore, the Trust has a high degree of liquidity coverage available if needed in 2016/17.

There is no current risk of the Trust having to cease trading within the next twelve months, or face regulator action to cease or modify our trading status in that period. Again, ongoing dialogue with regulators is a feature in justifying the Trust as a going concern entity.

Governance risk

The governance risk rating uses a RAG (red, amber and green) rating system based on a system of penalty points for failing to remain compliant with a set of core performance indicators. A red rating would normally trigger Monitor intervention. Monitor will also in certain circumstances apply an 'override rating' where they judge that the point system alone does not adequately reflect the extent of risk. Any override rating remains in place until removed by Monitor.

The governance risk rating considers the legality of the Trust's Constitution, the development of the membership, the appropriateness of Board roles and structures, the co-operation with

other NHS bodies and the local authority and the risk and performance management processes, particularly to ensure that all core national healthcare targets and standards are met.

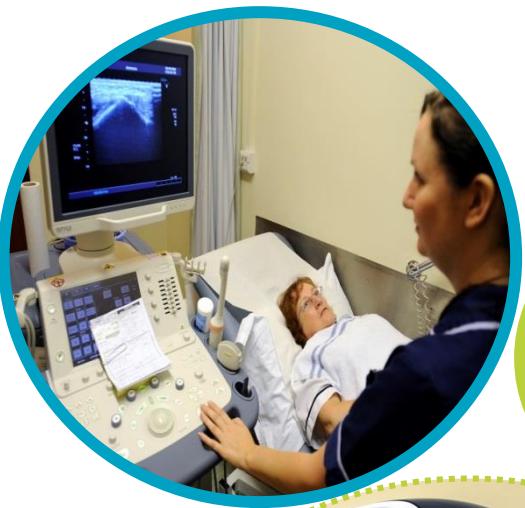
The Trust during 2015/16 retained its red governance override in terms of its governance rating. We have in place a Quality Improvement plan developed in response to the Keogh review process, and revised for subsequent information or findings from Care Quality Commission inspections and other evidence sources. The Trust Board regularly monitors performance against this plan.

Table of analysis

2015/16	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating/financial sustainability risk rating	1	1	2	2	2
Governance rating	Red	Red	Red	Red	Red

2014/15	Annual plan	Q1	Q2	Q3	Q4
Continuity of service rating	3	3	3	3	2
Governance rating	Red	Red	Red	Red	Red





Statement of accounting officer's responsibilities

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

Under the NHS Act 2006, Monitor has directed Northern Lincolnshire and Goole NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Northern Lincolnshire and Goole NHS Foundation Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

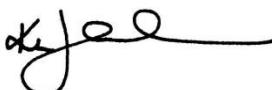
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the *NHS Foundation Trust Annual Reporting Manual* and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- Make judgements and estimates on a reasonable basis
- State whether applicable accounting standards as set out in the *NHS Foundation Trust Annual Reporting Manual* have been followed, and disclose and explain any material departures in the financial statements
- Ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- Prepare the financial statements on a going concern basis.

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

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's *NHS Foundation Trust Accounting Officer Memorandum*. The accounts on the whole are seen as fair, balanced and understandable and provide the necessary information for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy.

Signed:



Name: Karen Jackson

Title: Chief executive

Date: May 20 2016



Annual governance statement 2015/16

1. Scope of responsibility

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

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Northern Lincolnshire and Goole NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northern Lincolnshire and Goole NHS Foundation Trust for the year ended March 31 2016 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Leadership and accountability

The existing organisational management structure illustrates the Trust's commitment to effective governance and quality governance including risk management processes. A directorate of clinical and quality assurance was created on Monday September 17 2012 following an extensive consultation exercise. (The directorate's name was changed to performance assurance in 2014, reflecting changes to the executive director structure and responsibilities).

The key aims of the proposal to introduce the directorate were as follows:

- To continue to raise the profile of governance by ensuring governance (and quality governance) and assurance remain on an equal footing with other organisational priorities
- To ensure that governance, quality and safety are seen as the responsibility of all staff who, in discharging those responsibilities, have access to, and support from, an appropriately skilled and responsive governance support team
- To ensure that the Trust's governance, quality and infection control resource is targeted in the right place at the right time with an emphasis on outcomes rather than process and improved quality and safety
- To ensure that during a period of inevitable increased emphasis on cost effectiveness in healthcare, that this is not at the expense of reduced quality or poor governance in our organisation. A devolved management structure

describes lines of accountability at appropriate levels with clear clinical and managerial leadership roles being defined.

In line with the principles of devolution within the Northern Lincolnshire and Goole NHS Foundation Trust, and in accordance with the Scheme of Delegation, responsibility for the management/control and funding of a particular risk rests with the directorate/group concerned. However, where action to control a particular risk falls outside the control/responsibility of that domain, where local control measures are considered to be potentially inadequate or require significant financial investment or the risk is 'significant' and simply cannot be dealt with at that level, such issues are escalated to the Trust Governance and Assurance Committee, Executive Team or Trust Board for a decision to be made.

Supporting this devolved structure are central non-clinical directorates – including as above the directorate of performance assurance. These directorates have a nucleus of experienced and appropriately qualified staff to lead support and advice staff at all levels across the organisation with the identification and management of risk.

Directors individually and collectively have responsibility for providing assurance to the Trust Board on the controls in place to mitigate risks to compliance with the Trust's licence. The sub-committees of the Trust Board in turn have responsibility for providing assurance in respect of the effectiveness of those controls. A system of 'highlight' reports to the Trust Board is in place to highlight any risks to compliance. A review and strengthening of the Board sub-committees was undertaken during 2014/15 in particular to create a new Resources Committee with a key focus on workforce issues.

The effectiveness of the Trust's governance structures continued to be tested during 2015/16 via internal and external testing including internally via the Annual Internal Audit Programme and externally via the follow-up review of the Trust's quality governance arrangements at clinical group level undertaken by KPMG, which did not identify any significant concerns, and via the re-visit by the CQC in October and November 2015 and January 2016.

Training

Through the provision of a comprehensive mandatory training programme which includes governance and risk management awareness – with training sessions being delivered both centrally and within individual directorates/groups and engaging internal and external trainers, and through individual personal development, staff are trained and equipped to identify and manage risk in a manner appropriate to their authority, duties and experience.

The governance and risk management training programme is reviewed annually by the directorate of performance assurance to ensure that it remains responsive to the needs of Trust staff. There is regular reinforcement of the requirements of the Trust's Mandatory Training Policy and Training Needs Analysis (which as above includes elements of governance and risk management training) and the duty of staff to complete training deemed mandatory for their role and non-compliance is a feature of the Trust's 'Zero Tolerance' Framework. The focus during 2015/16 has remained on ensuring compliance with mandatory training and appraisal requirements and the Trust met the year end targets set. Monitoring and escalation arrangements are in place to ensure that the Trust maintains the good performance seen and can ensure targeted action in respect of areas or staff groups where performance is not at the required level.

Control mechanisms including ‘Learning Lessons’

A single IT Risk Management System (Datix) is in place which links all key risk elements (including incident reporting, complaints/PALS and claims management) and which, in turn, informs the Trust’s Risk Register (which is also held on Datix). Lessons learned when things go wrong are shared throughout the organisation via a range of mechanisms including safety alerts, ‘learning lessons’ newsletters, governance forums and via the dedicated ‘Learning Lessons’ Review Group, which was implemented to ensure that lessons learned following incidents/complaints and PALS and claims are effective and are widely disseminated. The functions and membership of this group were refreshed during 2015/16. Further mechanisms for ensuring the sharing of transferrable lessons – as well as good practice – continue to be explored via this group. During 2015/16 the Trust has continued to develop the group quality and safety days which bring together multi-disciplinary teams to discuss quality and safety issues and ensure the sharing of transferrable lessons from incidents, complaints and claims. The surgery and critical care group has led the way with this development. However, quality and safety days are now also in place within the medicine, clinical support services and community and therapy groups. The arrangements for learning lessons and feedback to staff will be further developed during 2016/17; not least in response to the feedback from the CQC inspection visit.

The Trust Board routinely considers specific risk issues and receives minutes from Board sub-committees including the Audit Committee, Trust Governance and Assurance Committee and the Quality and Patient Experience Committee. The Trust Governance and Assurance Committee, on behalf of the Trust Board, routinely receives information on Serious Untoward Incidents (SIs) including lessons identified and learnt. The Trust is also a member of, and provides assurance to, commissioners on its arrangements for investigating and learning from SIs via a community-wide SI Collaborative Group.

The Trust actively encourages networking and has strong links with relevant central bodies, eg National Health Service Litigation Authority (NHS LA), Health and Safety Executive (HSE), and acts on recommendations/alerts from these bodies as appropriate.

The Trust continues to develop its relationship with the CQC – escalating risks/concerns in respect of patient safety/quality as they occur, together with the actions taken or proposed, and in order to provide assurance that the Trust Board has appropriate oversight of its quality governance/patient safety risks. Quarterly relationship meetings are held.

The Trust also routinely considers and acts upon the recommendations of relevant national high level enquiries through the use and monitoring of robust action plans.

4. The risk and control framework

The management of risk

The Trust has in place a Risk Management Strategy which is reviewed by the Trust Board annually.

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

The Trust's Risk Management Strategy is an integral part of the Trust's approach to continuous quality improvement and is intended to support the Trust in delivering the key objectives within the Quality Strategy as well as ensuring compliance with external standards, duties and legislative requirements.

Risks are identified routinely from a range of reactive and pro-active and internal and external sources including workplace risk assessments, analysis of incidents, complaints/PALS, claims, external safety alerts and other standards, targets and indicators etc. These are appropriately graded and ranked and included on the Trust's Risk Register. A Risk Register – 'Confirm or Challenge' Group is in place to review and monitor risks added to the Risk Register and quarterly reports from the Risk Register are submitted to the Trust Governance and Assurance Committee and Trust Board. The Trust has also identified a non-executive director to lead the challenge in respect of the Risk Register and to report to and provide assurance or escalate risk issues to the Board as part of the submission of the quarterly Risk Register reports. The Trust recognises that, as risks can change and new risks can emerge over time, the review and updating of risks on the risk register is an ongoing, dynamic process.

Risk management is embedded in the activity of the organisation by virtue of robust organisational and committee structures. Of fundamental importance is the Trust's commitment to the ongoing development of a 'fair blame' culture, where incident reporting is openly and actively encouraged and the focus when things go wrong is on 'what went wrong, not who went wrong', and a progressively 'risk aware' workforce. The Trust also has in place long standing 'speaking out' and safeguarding policies and procedures. These arrangements ensure that staff can raise issues of concern regarding care and safety – outside of the line management relationship where this is felt to be required.

The Trust agrees annual governance/risk management objectives/key performance indicators (KPIs), which are shared through the business planning and performance management frameworks. Business planning and service development proposals do not proceed without an appropriate assessment of and therefore recognition/acceptance of the risks involved and the involvement of the relevant risk management, health and safety and fire expertise.

The Trust also has in place an Assurance Framework, which is designed to assist the Trust in the control of risk. The framework incorporates and provides a comprehensive evidence base of compliance against a raft of internal and external standards, targets and requirements including CQC registration requirements, Information Governance Toolkit Standards, Safety Alerts etc. Assurance to the Trust Board on compliance with these requirements is provided via quarterly Trust Assurance Framework reports and is supported by a robust Internal Audit Programme.

The Trust currently holds Level 2 Accreditation in respect the NHSLA Risk Management Standards for Acute Trusts and was awarded Level 2 Accreditation in respect of the CNST Maternity Standards following assessment in March 2014. While formal assessment against these standards are no longer undertaken by the NHSLA, the Trust continues to refer to these standards as good practice. Plans to reissue these standards, albeit in a revised format, are in development.

The Trust also has in place a range of mechanisms for managing and monitoring risks in respect of quality including:

- The Trust has in place a Quality Strategy which has been endorsed by the Trust Board. The Trust Board also agrees annual quality objectives

- The Trust has in place a Quality and Patient Experience Committee (a sub-committee of the Board) which meets monthly and is chaired by a non-executive director. The Quality and Patient Experience Committee is responsible for monitoring performance against the agreed annual quality objectives. The minutes of the Quality and Patient Experience Committee are submitted to the Trust Board
- The Trust has published Annual Quality Accounts in 2008/09, 2009/10, 2010/11, 2011/12, 2012/13, 2013/14, 2014/15 and is preparing its 2015/16 Quality Account
- A Quality Report, which reports progress against the above-mentioned key quality objectives in year is prepared and submitted monthly to the Quality and Patient Experience Committee and the Trust Board. This monthly report in turn informs the annual Quality Account. The submission of this monthly report ensures that the Trust Board focuses on quality in the same way that it has historically considered finance and performance
- The Trust has in place arrangements and monitoring processes to ensure ongoing compliance with other service accreditation standards eg bowel screening, colposcopy, cancer, CPA, MHRA (for blood products) and HTA licences for mortuary and post mortems etc
- The Trust Governance and Assurance Committee monitors performance with NICE guidance implementation and minutes of that committee are submitted to the Trust Board. Compliance with NICE guidance is also monitored, internally via the performance review process and externally via the Commissioner Quality Contract Group
- The medical director has the lead for mortality. The Mortality Performance and Assurance Committee, a sub-committee of the Trust Board chaired by the Trust's chairman, monitors mortality and morbidity statistics and provides a monthly update to the Trust Board. While historically, mortality information was included on a quarterly basis within the monthly Quality Report, a separate monthly Mortality Report has been in place since 2012 and is submitted to the Mortality Performance Committee, the Quality and Patient Experience Committee and the Trust Board. The Quality and Patient Experience Committee retains a challenge/assurance role. A refresh of these arrangements was undertaken during 2014/15 not least to ensure the required level of clinical engagement
- Ward standards have been introduced and are monitored via a programme of unannounced ward reviews
- A programme of announced and unannounced (executive and non-executive) director visits is also in place to all wards and departments – clinical and non-clinical – in order to ensure that there is 'Board to Ward' oversight and ownership of quality and safety issues. Director forums were also introduced during 2013 and these arrangements have continued to be reviewed and refined. The purpose of these forums is to allow staff to raise concerns or showcase good practice directly with Board members
- The Trust has identified non-executive directors to lead the challenge in respect of specific aspects of governance including HCAI, risk management and the risk register, mortality, falls, pressure ulcers, quality and patient experience and complaints. These challenge roles are reviewed annually
- The chief nurse has responsibility for focusing on the quality of the patient experience and is the Board lead for quality and the patient experience
- A nursing dashboard is in place to monitor the nursing contribution to safety and quality
- The Trust routinely considers and acts upon the recommendations of national quality benchmarking exercises, eg national patient surveys
- The Trust acts upon patient feedback from complaints and concerns and from feedback from patient and public involvement (PPI) representatives (eg Health Watch)

- Patient stories are presented to QPEC and the Trust Board monthly and actions and lessons learnt are widely shared.

CQC: Registration and essential standards of quality and safety

During October and November 2015 and January 2016, the Trust received announced and unannounced visits by the CQC. The Trust responded to the initial feedback received in respect of the issues identified including review and follow-up of the backlog of OPD follow-up patients, which the Trust was aware of and already dealing with prior to the CQC inspection, and in respect of the environment in A&E for the management of patients with a mental health problem, and has provided assurances to the CQC on the implementation and delivery of plans to address the issue. The final report of the inspection was published on April 15 2016. An action plan in response to the additional findings and recommendations is currently being drafted and will be submitted to the CQC by the deadline of May 6 2016.

As at the date of finalising this report, the Trust was not therefore fully compliant with the registration requirements of the Care Quality Commission (CQC). The Trust expects a further re-visit within six months.

Information Governance (IG) and data security (including serious IG incidents)

The Trust continues to strengthen its arrangements for information governance and has the following arrangements in place:

- An Information Governance Steering Group, a sub-committee of the Trust Governance and Assurance Committee
- An Information Security Policy
- Compliance with the requirements of the IG Toolkit at Level 2.

In respect of data security the following arrangements are in place:

- A security feature at login to the Trust network, giving guidance to users and requiring acceptance of 'rules of use'
- IT policies which take account of updated national requirements
- A 'best practice' IT security awareness leaflet
- The encryption of all removable/portable devices including laptops, USB pens and CDs, specifically:
 - Laptop encryption has been completed on all laptops/clinical tablets
 - Encrypted USB pens have been allocated to staff
 - Support for the use of staff who own PDA devices has been removed
 - Floppy drives have been blocked from use, no machines are purchased with floppy drives as standard and port blocking software has been implemented
 - CD/DVD writers are not issued as a standard piece of equipment. Where the use of these writers is required, the creation of data on these devices is covered by Trust policies
 - The creation of data on PACs CDs is governed by Trust policy and encryption ability is available. Tracking procedures are in place for CDs sent off site.

During 2015/16, the Trust reported one serious incident relating to a confidentiality breach. This incident was classified as Level 2 in the Information Governance Reporting Tool and will be reported to the Information Commissioner's Office (ICO).

Patient and public involvement (PPI)

The Trust ensures that public stakeholders are involved in understanding the risks which impact upon them by a variety of means: the principal amongst these being the operation of the Council of Governors and during 2012/13 the introduction of Board meetings held in public. The Council meets at least five times per year in public and receives a comprehensive report on performance (and risks of non-delivery) on each occasion. These reports are published along with the rest of the council papers on the Trust internet site.

A PPI policy and procedure is also in place and reflects the requirements of the DOH guidance 'Real Involvement' and the comments from PPI representatives.

Additionally, the Trust engages actively with three overview and scrutiny committees (OSCs) and continues to collaborate closely with the three local Health Watch organisations. A protocol for joint working with Health Watch is in place and is reviewed annually and opportunities for joint working have been agreed.

The Trust's comprehensive internet website provides the public with ready access to information across all areas of Trust activity and the organisation also uses its newsletter for members to inform the public of new developments and items of interest.

NHS Pension Scheme

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

Equality, diversity and human rights

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

Carbon reduction

The Trust has undertaken a review of its carbon emissions in line with the NHS Carbon Reduction Strategy and Climate Change Act. The Trust has a Carbon Trust approved Carbon Management Plan in place which sets out reduction delivery plans. The Trust's estates and facilities group oversees work to reduce emissions, ensures compliance with the Climate Change Act and how these impact on emergency preparedness. The group also ensures the Trust is compliant with the Carbon Reduction Commitment and Energy Performance Directive.

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

The Trust's clinical activities are managed under a devolved management structure, governed by a Scheme of Delegation renewed and refreshed annually. The Trust has in place a clinical management structure to support effective leadership of clinical services and ensure effective care.

The medical director is supported by two part time deputy medical directors (who will continue to be engaged in clinical front line work), and six associate medical directors (AMD), covering each clinical group. Each AMD will lead a team of clinical leads for

individual service areas.

The finance directorate provides dedicated support to clinical groups and to non-clinical directorates through nominated business accountants. They support management teams in these areas.

Support to the clinical and non-clinical structure of the organisation on business planning, performance and information technology support is provided by the directorate of strategy and planning. This directorate was created in 2014/15 to more closely link strategy development across the wider health economy with service planning in clinical service areas.

In 2014 PwC undertook a holistic review of underlying financial performance, in the context of the whole local health economy, which has underpinned the significant collective work and financial modelling and planning with other providers and commissioners undertaken in 2015/16 to support the over-arching Healthy Lives, Healthy Futures programme.

With initial support from PwC, the Trust has adopted a more project based approach to savings delivery and established a PMO-style approach with the formation of the Sustainability Programme Governance (SPG) Team. This enabled a refocused and comprehensively documented 2015/16 savings plan, with enhanced governance oversight arrangements through a regular stocktake group comprising directors and work stream leads. The SPG team's capacity is currently under review, to further improve its leadership and to allow closer support to teams in 2016/17 in effectively delivering new controls, processes and ways of working.

In 2015/16, the Trust commenced a Business Governance Review programme to review and update all Trust Board policies which fall under the financial governance remit. This has reported to Resources Committee and Audit Committee and built upon the normal annual review of the SFIs and Scheme of Delegation.

The Trust maintains a strong focus on performance management. All directorates and groups are explicitly made responsible for the delivery of financial and other performance targets through a system of performance agreements which are agreed and documented as part of the annual business planning cycle and monitored through a series of regular performance meetings chaired by the chief executive.

The Financial Framework adopted annually by the Trust Board contains an overarching assessment of the strategic planning climate within which the framework has been constructed and sets out the mechanisms by which the key risks emanating from the strategic context are to be managed. This assessment reflects both the national planning context and the local context; and recognises the financial planning context for the public sector as a whole; especially the expectation for significant efficiencies on an ongoing basis.

The Trust conducts a comprehensive review of the in-year progress of the Business and Financial Framework in the form of a mid-year review report – any issues or emerging risks not previously identified within the original framework are identified and mitigating actions recommended and actioned during this process.

The Trust Resources Committee provides assurance to the Trust Board as to the achievement of the Trust's financial plan and priorities and, in addition, acts as the key forum for the scrutiny of the robustness and effectiveness of all cost efficiency opportunities. It interfaces with the other Trust Board committees and the Trust Executive Team and also has particular regard to the work of the Strategy and Planning Group, which sets the agenda and co-ordinates the process of business planning, specific business case development, and capital programme management.

Compliance is further assured through quarterly monitoring and annual planning processes with auditors. The Trust has developed an improved internal audit programme, based on key business governance themes with internal audit providers KPMG, designed to enhance focus on business governance process and support improved compliance.

In order to further enhance the level of assurance in respect of economy, efficiency and effectiveness of resources, Trust Board commissioned in 2014 a review of all financial governance arrangements. This was undertaken in two stages. The first was carried out by KPMG, and concentrated on the compliance of systems with financial governance best practice. Positive assurance was received from this process, with a number of follow up actions agreed.

The Trust, building upon the lessons learnt following the 2013 Keogh review process, understands that robust frontline clinical services are the real purpose of the organisation, delivering effective quality outcomes for patients. The Trust is proactive and continuously reviews and realigns its structure where necessary, to allow it to adapt and respond to the rapidly changing business environment brought about by the changes in the economy, the NHS environment, competitive markets and patient pathway best practice.

The Trust has also enhanced its focus on workforce planning in order to secure a more consistent supply of appropriately skilled and qualified staff to carry out front line service delivery, specifically to review plans for future workforce numbers and to oversee implementation processes, working jointly with commissioners and other local provider organisations. In support of this work the Trust has developed an Organisational Development and Workforce Strategy and an Employment Framework sustainability work stream, covering both retention and recruitment, which have been endorsed by the Trust Board.

Following the Keogh Review in June 2013, Monitor, the regulator of Foundation Trusts, found the Trust in breach of its licence (specifically the requirement to secure economy, efficiency and effectiveness) and in August 2013 the Trust was placed in 'special measures'. Following the review process, and the visit of the CQC team to carry out a full inspection, the specific 'special measures' sanction was removed in July 2014.

However, on April 8 2015 Monitor advised the Trust that it had retained its red governance override on financial sustainability grounds and that it intended to work with the Trust to understand its financial situation, recognising this was "within the context of a wider sustainability gap across the local health economy, in which work is ongoing to address sustainability in the longer term". Monitor issued enforcement undertakings stating that the Trust had not demonstrated that it has established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively. The Trust remains subject to these undertakings.

While noting the above qualification, the Trust is satisfied that it otherwise has robust internal control mechanisms in place and these are subject to robust and regular internal and external review.

The processes and review work established by the Trust have been designed to supply corrective actions for any failures in delivery of services in an economic, effective and efficient manner. The Financial Governance Review work undertaken in 2014 established an outline assessment of structural cost premium facing the Trust because of its configuration and also laid the foundations for a corrective savings programme addressing those issues within the Trust's control. This work was used as the basis for the Trust's Sustainability Programme for 2015/16, which was again subject to external review, covering both scale and content, through the involvement of the regulator and PwC as programme advisors.

During 2015/16 Monitor has visited the Trust twice to review its financial plans, including robustness of savings and efficiency plans and associated governance, for 2015/16 and 2016/17. These direct dialogues with the regulator have helped shape financial plan submissions in the context of stretch savings targets, Carter Review, opportunities for regulatory support to maximise income from commissioners available under the operating framework and cashflow optimisation to satisfy criteria for access to additional funding support from the Department of Health.

6. Annual Quality Report

The Directors of Northern Lincolnshire and Goole NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the *NHS Foundation Trust Annual Reporting Manual*.

The following arrangements are in place within Northern Lincolnshire and Goole Hospitals NHS Foundation Trust to assure the Board that the Quality Account presents a balanced view and that there are appropriate controls in place to ensure the accuracy of data:

Governance and leadership:

- The Trust has appointed a member of the Board, the chief nurse, to lead on quality. The chief nurse, supported by the medical director and director of performance assurance, advises the Trust Board on all matters relating to the preparation of the Trust's annual Quality Account
- The Trust's director of strategy and planning is responsible for providing the information and performance data which informs the Annual Quality Account. An information services manager, to whom this responsibility is delegated, is also in post
- The Trust's director of performance assurance is responsible for ensuring that there are mechanisms in place for assuring the quality and accuracy of the performance data which informs the Annual Quality Account including external testing as appropriate. A head of performance, to whom this responsibility is delegated, is also in post.

Policies and plans in ensuring quality of care provided:

- Policies and procedures are in place in relation to the capture and recording of patient data
- Clinical coding follows national guidelines in addition to a local policy, as per the Audit Commission's guidelines.

Systems and processes:

- Systems and processes are in place for the audit and validation of performance data both centrally (through the data quality team) and at operational level. Weekly meetings are held to review waiting time data.

People and skills:

- All staff involved in collecting and reporting on quality metrics are suitably trained and experienced
- All PAS users have to receive training before being issued a password, and individual user activity is auditable
- Clinical coding is regularly audited both internally and externally and audits also take place with individual clinicians.

Data use and reporting:

- As above, monthly Quality Reports, which outline the Trust's performance against key quality objectives including benchmarking and comparative data, and are the subject of discussion and challenge at every monthly Quality and Patient Experience Committee and Trust Board meeting, inform the annual Quality Account
- The Trust also considers and acts upon information received via the Dr Foster alerts and relevant CQC alerts and reports and the information also informs the relevant Trust action plans eg mortality.

In preparation for the requirement for a published audit opinion in the 2015/16 Quality Account, the purpose of which is to provide assurance on the arrangements in place to ensure Quality Accounts are fairly stated and in respect of the accuracy of the information and indicators within the report, audit review will be undertaken. This will involve sample testing in respect of a number of mandated quality indicators.

The report arising from the audit review, including any gaps in assurance and remedial actions required, will be agreed through the Trust's Audit Committee and submitted internally to the Trust Board and Council of Governors and externally to Monitor. As with the 2014/15 remedial actions, the action plan will be monitored via the Quality and Patient Experience Committee.

The Trust Board also now receives quarterly data quality reports via the monthly quality report.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the Northern Lincolnshire and Goole NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Annual Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Trust Board, the Audit Committee, the Trust Governance and Assurance Committee and the Quality and Patient Experience Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work (**Appendix A** refers). The Assurance Framework and the monthly performance reports provide me with evidence that the effectiveness of the controls in place

to manage the risks to the organisation achieving its principal objectives have been reviewed.

Gaps in controls

The following control issues arose during 2015/16:

Monitor red governance rating

As outlined in section 5 above, in April 2015, the Trust was formally found to be in breach of its Licence, specifically conditions CoS3(1)(a) and (b), CoS3(2)(c), and FT4(5)(a),(d), and (f), and therefore retained the red Monitor governance override (previously in place post Keogh and special measures), although Monitor confirmed, and the Enforcement Undertakings which have been agreed, reinforce that this position relates to the financial position/wider system sustainability and not to any concerns regarding the Trust's leadership and governance systems and processes.

In respect of internal sustainability, savings plans were agreed and have been progressed during 2015/16 resulting in savings delivery of £13.8million. Risks to delivery have been identified throughout the year and mitigating actions agreed via the programme governance arrangements in place. Plans for 2016/17 have been developed.

In respect of wider system sustainability (Health Lives, Healthy Futures - HLHF), the NLaG chief executive was released part-time to lead on the delivery of the HLHF sustainability plan. During 2015/16, the Trust Board approved the appointment of a substantive deputy chief executive to support release of the NLaG chief executive to lead this work and to ensure no loss of leadership capacity at executive team/Board level. The way forward in respect of HLHF remains in discussion at the time of finalising this report.

CQC inspection visit

As outlined in section 4 above, as at the time of finalising this report, the Trust is not fully compliant with the registration requirements of the Care Quality Commission (CQC). Actions were taken in response to the high level feedback received following the announced and unannounced visits in October and November 2015 and January 2016. An action plan in response to the additional findings and recommendations from the recently published CQC report is currently being drafted and will be submitted to the CQC by the deadline of May 6 2016.

A&E performance

The Trust breached its A&E target in quarters one, three and four. This reflects the considerable activity pressures locally and is also consistent with the position nationally. While the Trust aims to meet this target during 2016/17 and will take all actions within its control, there remains a risk to delivery due to factors / system issues outside the Trust's control. A number of actions have already been taken and plans are in place including work with other local providers. Performance against all targets is monitored on an ongoing basis by the Trust Board as part of scrutiny of the monthly performance compliance reports.

Cancer performance

The Trust breached the 62 day GP referral to treatment target in quarters one, two, three and four 2015/16. To improve performance and ensure the Trust is on track to achieve the target from quarter one onwards, a number of actions have been implemented including an analysis of breaches to date in order to understand key themes and required actions which

in turn have been incorporated in to a trustwide cancer action plan which is being progressed via and a weekly Task and Finish Group led by the chief operating office. A weekly CEO challenge meeting is also in place. The root cause analysis (RCA) process has also been strengthened.

Eliminating mixed sex accommodation

The Trust reported breaches against the eliminating mixed sex accommodation guidance for November and December 2015. A review of the Trust's policy and reporting and escalation processes have been undertaken and strengthened and the Trust has adopted a 'zero tolerance' approach to such incidents. No further incidents have been reported since.

Maintenance and review of the effectiveness of the system of internal control has been provided by comprehensive mechanisms already referred to in this statement. Further measures include:

- Regular reports to the Trust Board from the Trust's Risk Register including non-executive director review/challenge
- Regular risk management activity reports to the Trust Board covering incidents, complaints/PALS and claims analysis and including details of lessons learnt/changes in practice
- Receipt by the Trust Board of minutes/reports from key forums including the Audit Committee, Trust Governance and Assurance Committee, Mortality Performance Committee and the Quality and Patient Experience Committee
- The ongoing development of the Trust Assurance Framework
- Further independent external review by KPMG of the Trust's board assurance and self certification processes. While no significant control issues were identified arising from that review, some actions were identified for further strengthening the Trust's arrangements and these have been implemented during 2015/16
- Consideration of a monthly quality report, allowing the Trust Board to monitor performance in respect of agreed quality objectives. The information contained within this monthly report, in turn, informs the Trust's Annual Quality Account
- The provision and scrutiny of a monthly performance compliance report to the Trust Board, which covers a combination of specific licence and key contractual obligations and including the identification of key risks to future performance and mitigating actions
- The provision of the monthly trading report to the Trust Board. As with the compliance report this report includes the identification of key risks to future performance and mitigating actions
- A follow-up review by KPMG was also undertaken in March 2015 and reported in April 2015 in respect of quality governance at clinical group level. No significant concerns were identified from that review.

The validity of the Corporate Governance Statement has been provided to me by the relevant Board sub-committees – most notably the Trust Governance and Assurance Committee and the Audit Committee, both of whom have considered and commented on this statement, and by the external auditors.

All of the above measures serve to provide ongoing assurance to me, the Executive Team and the Trust Board of the effectiveness of the system of internal control.

8. Conclusion

In conclusion, where issues have been identified during 2015/16, action has been taken or action plans are in place to address the gaps in control identified. The Trust Board is satisfied that plans are adequate to ensure delivery of these targets or improvements during 2016/17. Where appropriate these action plans will be tested via relevant external scrutiny and review processes.

Signed:



Name: Karen Jackson

Title: Chief executive

Date: May 20 2016



APPENDIX A

Head of internal audit opinion on the effectiveness of the system of internal control at Northern Lincolnshire and Goole NHS Foundation Trust for the year ended March 31 2016

Basis of opinion for the period April 1 2015 to March 31 2016

Our internal audit service has been performed in accordance with KPMG's internal audit methodology which conforms to Public Sector Internal Audit Standards. As a result, our work and deliverables are not designed or intended to comply with the International Auditing and Assurance Standards Board (IAASB), International Framework for Assurance Engagements (IFAE) or International Standard on Assurance Engagements (ISAE) 3000.PSIAS require that we comply with applicable ethical requirements, including independence requirements, and that we plan and perform our work to obtain sufficient, appropriate evidence on which to base our conclusion.

Roles and responsibilities

The Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement (AGS) is an annual statement by the Accountable Officer, on behalf of the Board, setting out:

- How the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives
- The purpose of the system of internal control as evidenced by a description of the risk management and review processes, including the Assurance Framework process; and
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control failures together with assurances that actions are or will be taken where appropriate to address issues arising.

The Assurance Framework should bring together all of the evidence required to support the AGS.

The head of internal audit (HoIA) is required to provide an annual opinion in accordance with Public Sector Internal Audit Standards, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (ie the system of internal control). This is achieved through a risk-based programme of work, agreed with management and approved by the Audit Committee, which can provide assurance, subject to the inherent limitations described below.

The purpose of our HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the system of internal control. This Opinion will in turn assist the Board in the

completion of its AGS, and may also be taken into account by other regulators to inform their own conclusions.

The opinion does not imply that the HoIA has covered all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and Management-led Assurance Framework. As such it is one component that the Board takes into account in making its AGS.

Opinion

Our opinion is set out as follows:

- Basis for the opinion
- Overall opinion; and
- Commentary.

The basis for forming our opinion is as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes
- An assessment of the range of individual assurances arising from our risk-based internal audit assignments that have been reported throughout the period. This assessment has taken account of the relative materiality of these areas; and
- An assessment of the process by which the Trust has assurance over its registration requirements of its regulators.

Overall opinion

For the period April 1 2015 to March 31 2016 our opinion is that:

Significant assurance with minor improvement opportunities can be given on the overall adequacy and effectiveness of the organisation's framework of governance, risk management and controls with the exception of the operating effectiveness of the controls in relation to a number of the 'risk based' reviews for which partial assurance with improvements required is given.

Key issues arising from the 'risk based' reviews with partial assurance, in summary, are as follows:

- Issues around the comprehensiveness and operational management of sickness absence policies/procedures
- The absence of an effective and appropriately resourced leadership and development strategy
- Issues of rapid response to specific weaknesses identified in the pre-CQC review work
- Continuing issues in the effective utilisation and booking processes in the outpatients department; and
- The need to further develop the strategy in relation to complaints management, following a full review of systems and processes.

Management actions have however been agreed and are progressing to address the issues identified.

Commentary

The commentary below provides the context for our opinion and together with the opinion should be read in its entirety.

Our opinion covers the period April 1 2015 to March 31 2016 inclusive, and is based on the 17 audits that we completed in this period.

Our audits consist of 'core' reviews and 'risk based' reviews. Core reviews are those that are required under PSIAS to be completed on an annual basis or where the organisation requires assurance on an annual basis. Risk based reviews are those where we have worked with management to provide assurance on areas of perceived high risk and therefore we would anticipate lower assurance ratings. We also undertake follow up reviews to ensure management are taking appropriate actions where necessary.

The design and operation of the Assurance Framework and associated processes.

Overall our review found that the Assurance Framework in place is founded on a systematic risk management process and does provide appropriate assurance to the Board. The Assurance Framework does reflect the organisation's key objectives and risks and is reviewed on a quarterly basis by the Board. It was reviewed by the Board on March 29 2016.

The range of individual opinions arising from risk-based audit assignments, contained within our risk-based plan that have been reported throughout the year.

We carried out six 'core' reviews and 11 'risk based' reviews during 2015/16. These are detailed in the sections below, and include a summary on the assurance rating and how that relates to the design and operating effectiveness of the controls relating to each review. We also provide details on the high priority recommendations raised, which were noted on the following risk based reviews:

- Management of SLAs
- Sickness absence
- Leadership development
- Review of Fit and Proper Persons Requirement for Directors
- CQC Compliance; and
- Complaints management.

Core reviews

- *Core financial systems*: We issued an overall assurance rating of 'significant assurance with minor improvement opportunities' for both the design and operating effectiveness of controls. No high priority recommendations were made.
- *Information governance (IG) Toolkit*: We issued an overall assurance rating of 'significant assurance'.
This rating applied to both the design and operating effectiveness of controls. No high priority recommendations were made.
- *Governance arrangements*: We issued an overall assurance rating of 'significant assurance with minor improvement opportunities' for both the design and operating effectiveness of controls. No high priority recommendations were made.
- *Risk Management and Trust Assurance Framework*: We issued an overall assurance rating of 'significant assurance with minor improvement opportunities' for both the design and operating effectiveness of controls. No high priority recommendations were made.

- *Reference costs*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’ for both the design and operating effectiveness of the controls however. No high priority recommendations were made.
- *Data quality*: We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. Our review identified some good practice in relation to the design of data quality processes and we were satisfied that the majority of our recommendations from the previous year had been implemented. However, our testing identified a number of weaknesses in the operating effectiveness of the sample of indicators tested leading to six medium priority recommendations being made, all of which have been agreed by management.

In summary, all the core reviews received ‘significant assurance’ or ‘significant assurance with minor improvement opportunities’ ratings with the exception of the data quality review, which received a rating of ‘partial assurance with improvements required’.

Risk based reviews

- *Asset safeguarding*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’ to both the design and operating effectiveness of controls. All recommendations, none of which were high priority, were agreed with management and are in the process of being implemented.
- *Management of SLAs*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’. Our testing identified areas for improvement regarding the operating effectiveness relating to the standardisation of implementing processes across the Trust. We made one high priority recommendation relating to the Trust being unable to provide signed SLAs for a number of its contracts and for three of these, payments in line with the contract had not been paid for at least three months, leaving the Trust at risk of losing income. The Trust agreed that all SLAs should have signed agreements in place for 2015/16 and, as new SLAs are created, procedures would be implemented to ensure SLAs are signed by both parties prior to services commencing.
- *Serious Incidents Requiring Investigation*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’ for the design of the serious incident process. No detailed testing was performed during this review so the assurance rating for the operating effectiveness of controls does not apply. No high priority recommendations were made.
- *Job planning (Part 1)*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’ relating to the design of the controls in relation to job planning. The implementation of job planning process remains work in progress and will be tested at a later date. No high priority recommendations were made.
- *Bed management/Review of operating centres*: We issued an overall assurance rating of ‘significant assurance with minor improvement opportunities’. This rating applies to the design of controls in relation to bed management and operations centres. No detailed testing was performed during this review so the assurance rating for the operating effectiveness of controls does not apply. No high priority recommendations were made.
- *Sickness absence*: We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. This rating applies to both the design and operating effectiveness of controls. We raised one high priority and four medium priority recommendations. We identified a number of discrepancies in the sickness data held on HR files creating a risk that the appropriate documentation in relation to sickness absence is not completed and retained in line with the policy

and procedure. The Trust agreed to remind line managers of their responsibilities and the training available to them in this respect. Following the review and ratification of the Sickness Absence Policy and Procedure, the Trust agreed to an implementation plan to communicate the new policy and procedure and to complete training. Spot audits would also be performed as part of the implementation plan and would be included in the Policy under compliance and monitoring.

- *Leadership development:* We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. This rating applies to both the design and operating effectiveness of controls. We raised three high priority recommendations relating to the absence of a clear leadership development strategy (LDS), lack of resource to support delivery of the strategy and the need to develop a system for identifying future leaders. We also raised a further five medium priority recommendations relating to improving processes and information to measure talent potential, refreshing Board skills assessment, supporting the role of the medical director, sharing learning amongst clinical leaders and developing clinical lead KPIs. A Leadership and Development Management Group is being established and this group will be responsible for developing the Trust’s LDS. The development of the LDS is one of four core strands of the People and Organisational Development Strategy. One of the considerations of the group will be the development of a framework to support the “talent pipeline”.
- *Review of Fit and Proper Persons Requirement for Directors:* We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. Our review confirmed that although the design of controls merits an assurance rating of ‘significant assurance with minor improvement opportunities’, our testing of a sample of directors’ files and the two high priority recommendations that were made relating to gaps in evidence on a number of the files, a ‘partial assurance with improvements required’ assurance rating applied to the operating effectiveness of controls. Management agreed all our recommendations and all have now been implemented.
- *CQC compliance:* We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. 28 recommendations were made in this review, of which one was high priority and 19 were medium priority. Our main area of concern related to the weekly checks on controlled drugs stocks not occurring consistently across all wards. While our review did not identify any discrepancies, the Trust agreed that controlled drugs stocks stored in wards and departments should be checked weekly in line with the Trust’s medicines management policy and that compliance would be supported by an effective audit plan which facilitates staff learning to improve practice. The majority of the medium and high priority recommendations related to the operating effectiveness of controls rather than their design. Management agreed all our recommendations and is in the process of implementing them however, some of our findings on this review were replicated by the actual CQC inspection that took place at a later date.
- *Complaints management:* We issued an overall assurance rating of ‘partial assurance with improvements required’ to this review. This rating applies to both the design and the operating effectiveness of the controls in relation to complaints management and builds on the points made in the CQC inspection in relation to the management of complaints. One high priority recommendation and five medium priority recommendations were made, collectively covering both the design and operating effectiveness of the complaints management system.

The Trust is considering staged stretch targets regarding its response timescales for all complaints with a view to reducing the target to 50 days by March 2017. However, from our

experience working with other Trusts this is still an extended framework. For the period April to September 2015, only 77 per cent of the complaints closed were within the original timeframe agreed with the complainant; this is below the 95 per cent target specified in the contract with commissioners. In addition, we reported inaccuracies in data reported to the Trust Governance and Assurance Committee in respect of complaints being responded to within agreed timescales. The Trust has agreed to improve its complaints management procedures and outcomes by:

- Undertaking a review of the design of the complaints process to ensure that it is efficient, provides a positive complainant experience and captures learning to inform quality improvement
 - Considering the reporting lines for complaints within the Trust to ensure clear accountability for actions, with expected completion dates and responsible officers; and
 - Using the outcomes of this review to inform further development of the Complaints Strategy reflecting any changes in the Trust's policy and standard operating procedures, supported by a staff education and training plan, and monitoring compliance by a regular audit plan.
- *Outpatients department follow up:* We issued an overall assurance rating of 'partial assurance with improvements required' to this review. The Trust has undertaken significant work to develop its clinical administration processes in response to the outcome of the clinical administration review and the concerns raised by the Care Quality Commission (CQC) which would provide for an assurance rating of 'significant with minor improvement opportunities' in relation to the design of controls in this area. However, we identified a number of opportunities to improve the operating effectiveness of the Trust's outpatient processes and procedures and raised eight medium priority recommendations, relating mainly to the following: clinic utilisation; the process for cashing up clinics; and the Trust's capacity to deliver a sustainable validation approach. No high priority recommendations were made.

In summary, of the 11 risk based reviews carried out in 2015/16; six received an assurance rating of 'partial assurance with improvements required'. The findings of the risk based reviews supported our opinion of 'significant assurance with minor improvement opportunities' for the design of controls. However, there were weaknesses in some areas in relation to people management and the development and delivery of implementation plans which has drawn us to provide an opinion of 'partial assurance with improvements required' in relation to the operational effectiveness of controls for a number of the risk based reviews.

KPMG LLP

KPMG LLP
Chartered
Accountant
Leeds
April 27 2016

Sustainability report

Introduction

As an NHS organisation, and as a spender of public funds, we have an obligation to work in a way that has a positive effect on the communities we serve. Sustainability means spending public money well, the smart and efficient use of natural resources and building healthy, resilient communities. By making the most of social, environmental and economic assets we can improve health both in the immediate and long term, even in the context of rising costs of natural resources.

In order to fulfil our responsibilities for the role we play, NLaG has the following sustainability mission statement located in our sustainable development management plan (SDMP):

“The Trust is committed to long term sustainability, it also recognises its corporate responsibility both as one of the largest employers in the local economy and as an emitter of carbon in to the local environment. It seeks to use this position to engage, inform, persuade and influence staff, visitors, patients and contractors to reduce emissions of carbon.”

As part of the NHS, public health and social care system, it is our duty to contribute towards the level of ambition set in 2014 of reducing the carbon footprint of the NHS, public health and social care system by 34 per cent (from a 1990 baseline) equivalent to a 28 per cent reduction from a 2013 baseline by 2020. It is our aim to supercede this target by reducing our carbon emissions by 34 per cent by 2020 using 2007/08 as the baseline year.

Policies

In order to embed sustainability within our business it is important to explain where in our process and procedures sustainability features.

Area	Is sustainability considered?
Travel	Yes
Procurement (environmental)	No
Procurement (social impact)	No
Suppliers' impact	Yes

One of the ways in which an organisation can embed sustainability is through the use of SDMP. The board approved our SDMP in the last 12 months so our plans for a sustainable future are well known within the organisation and clearly laid out.

As an organisation that acknowledges its responsibilities towards creating a sustainable future, we help achieve that goal by running awareness campaigns that promote the benefits of sustainability to our staff.

Climate change brings new challenges to our business both in direct effects to the healthcare estates, but also to patient health. Examples of recent years include the effects of heat waves, extreme temperatures and prolonged cold, floods, droughts etc. Our Trust Board approved plans to address the potential need to adapt the delivery of the organisation's activities and infrastructure to climate change and adverse weather events.

Partnerships

The NHS policy framework already sets the scene for commissioners and providers to operate in a sustainable manner. Crucially for us as a provider, evidence of this commitment will need to be provided in part through contracting mechanisms. We have not currently established any strategic partnerships. Further information on these measures is available here: <http://www.sduhealth.org.uk/policy-strategy/reporting/sdmp-annual-reporting.aspx>

Performance

Organisation

Since the 2007 baseline year, the NHS has undergone a significant restructuring process and one which is still ongoing. Therefore in order to provide some organisational context, the following table may help to explain how both the organisation and its performance on sustainability has changed over time.

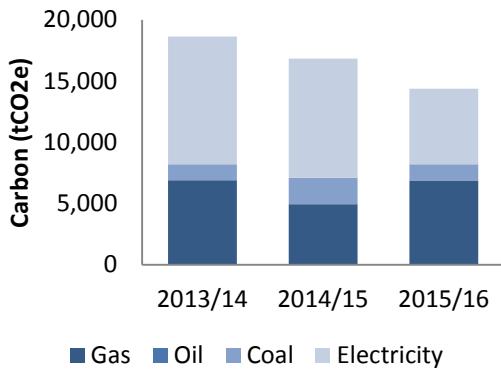
Context info	2007/08	2013/14	2014/15	2015/16
Floor Space (m ²)	142148	136,860	142,522	147,524
Number of Staff	4700	4,800	5,375	6,500

Energy

We have spent £3,574,947 on energy in 2015/16, which is a 10.8 per cent increase on energy spend from last year.

Resource		2013/14	2014/15	2015/16
Gas	Use (kWh)	32,470,283	23,559,266	32,795,885
	tCO ₂ e	6,888	4,943	6,881
Oil	Use (kWh)	33,342	82,532	56,976
	tCO ₂ e	11	26	18
Coal	Use (kWh)	3,544,150	5,803,531	3,582,240
	tCO ₂ e	1,296	2,127	1,313
Electricity	Use (kWh)	18,654,683	15,717,738	10,709,689
	tCO ₂ e	10,445	9,734	6,157
Green electricity	Use (kWh)	0	0	0
	tCO ₂ e	0	0	0
Total energy CO ₂ e		18,640	16,830	14,369
Total energy spend	£	3,755,578	3,225,824	3,574,947

Carbon Emissions - Energy Use



Performance

Comparing 2014/15 to 2015/16 there has been an overall reduction in carbon by approximately 15 per cent. Gas consumption has increased from last year which was primarily due to using more degree days because of the cooler weather compared to the previous year. There has been a significant reduction in electricity which can be attributed to the trustwide internal and external light fitting replacement project. Additionally the photovoltaic solar panels at the Grimsby and Goole sites are proving to be very effective and reduce electricity consumption from the main grid.

The Energy Performance Contract between the Trust and British Gas has seen the installation of an internal lighting programme from a T12 to a higher efficiency T5 fitting which include daylight and presence detection control where appropriate. External LED fittings have been installed trustwide and optimisation of the Trust's Building Management System is also in progress. The installation of a combined heat and power unit at the Grimsby hospital that will meet the majority of the hospitals demands for electricity and at the same time generate heat in the form of steam and hot water is also nearing completion.

Travel

We can improve local air quality and improve the health of our community by promoting active travel to our staff and to the patients and public that use our services.

Every action counts and we are a lean organisation trying to realise efficiencies across the board for cost and carbon (CO₂e) reductions. We support a culture for active travel to improve staff wellbeing and reduce sickness.

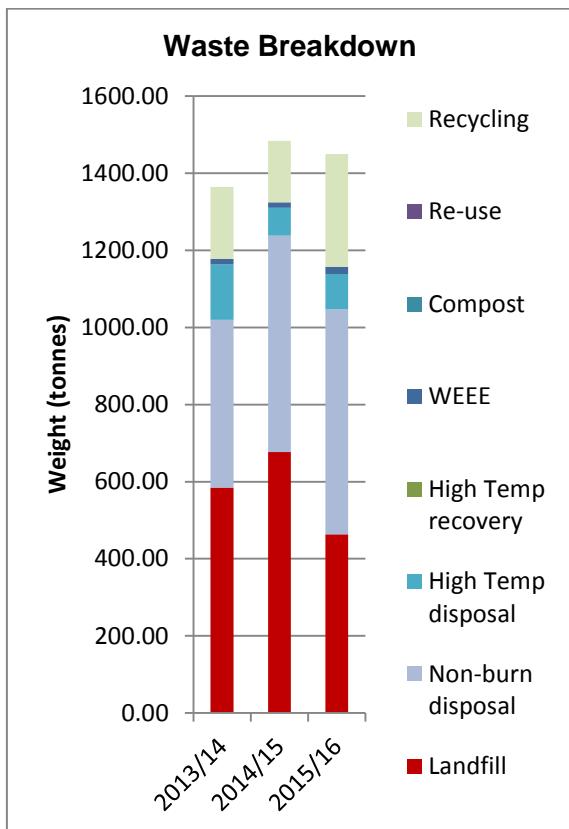
Category	Mode	2013/14	2014/15	2015/16
Patient and visitor travel	km	0	0	6,066,995
	tCO ₂ e	60	0	1,363
Business travel and fleet	km	0	940,185	997,382
	tCO ₂ e	2,334,554	199	224
Staff commute	km	6,326,400	8,309,557	10,048,767
	tCO ₂ e	1,452	1,897	2,258

Performance

We are continually working towards a more carbon efficient fleet. We have already introduced four electric vehicles and are planning to replace the main pool car fleet with further EV's and hybrid vehicles. Staff are actively encouraged to consider alternatives to travelling by car with cycling promotion heavily on the agenda. We also run a cross-site shuttle service for staff to utilise for cross site travel which contributes to reducing our carbon footprint.

Waste

Waste		2013/14	2014/15	2015/16
Recycling	(tonnes)	187.00	160.00	293.00
	tCO ₂ e	3.93	3.36	6.15
Re-use	(tonnes)	0.00	0.00	0.00
	tCO ₂ e	0.00	0.00	0.00
Compost	(tonnes)	0.00	0.00	0.00
	tCO ₂ e	0.00	0.00	0.00
WEEE	(tonnes)	14.00	14.00	18.00
	tCO ₂ e	0.29	0.29	0.38
High temp recovery	(tonnes)	0.00	0.00	0.00
	tCO ₂ e	0.00	0.00	0.00
High temp disposal	(tonnes)	143.00	72.00	92.00
	tCO ₂ e	31.46	15.84	20.24
Non-burn disposal	(tonnes)	435.00	561.00	583.00
	tCO ₂ e	9.14	11.78	12.24
Landfill	(tonnes)	585.00	677.00	463.72
	tCO ₂ e	142.98	165.47	113.34
Total waste (tonnes)		1364.00	1484.00	1449.72
% Recycled or re-used		14%	11%	20%
Total waste tCO ₂ e		187.80	196.75	152.36



Performance

We have had a significant reduction in waste going to landfill over the past year and an encouraging increase in recycling. Clinical waste tonnage has increased slightly in line with activity and the addition of some community clinics but autoclave is still the predominant disposal method as oppose to incineration. Overall there has been a 25 per cent reduction in carbon over the past year.

Currently projects underway over the next year are the possible use of reusable sharps bins and metal recovery from clinical waste.

Finite resource use - water

Water		2013/14	2014/15	2015/16
Mains	m ³	172836	152512	125143
	tCO ₂ e	157	139	123
Water & Sewage Spend	£	359,503	343,284	323,655

Performance

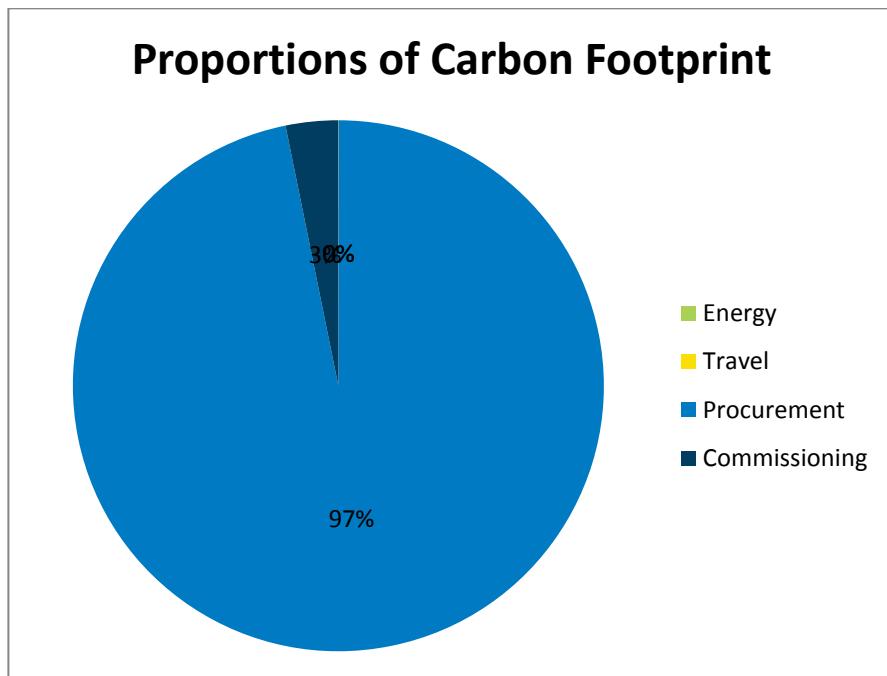
Despite a stringent flushing regime in place which has increased the baseline of water consumption there has been a decrease in the overall consumption. This has allowed a reduction of 16 tonnes of carbon. A decrease in sewerage charges has reflected a decrease in overall spend by around £20,000.

Modelled carbon footprint

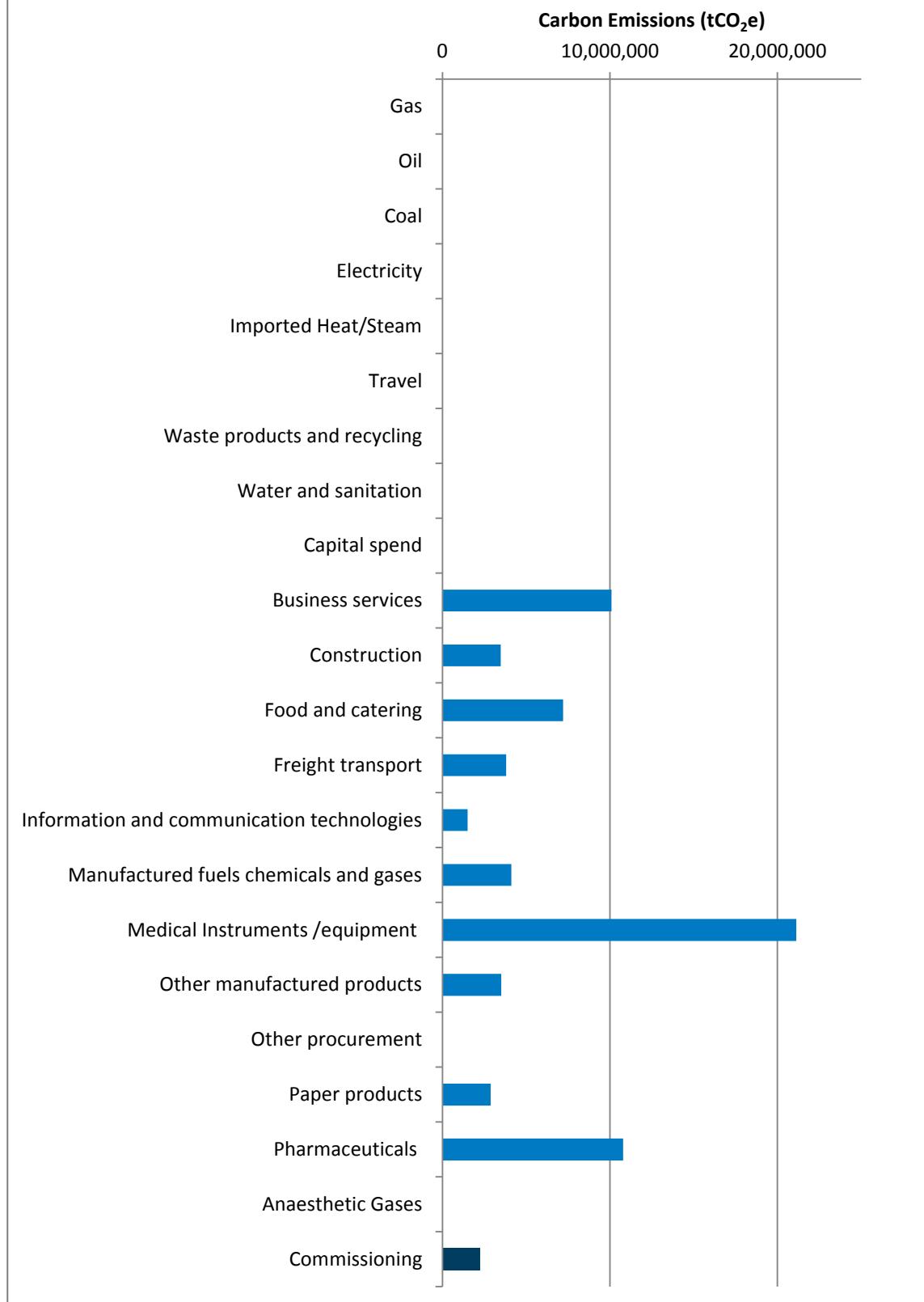
The information provided in the previous sections of this sustainability report uses the ERIC returns as its data source. However, we are aware that this does not reflect our entire carbon footprint. Therefore, the following information uses a scaled model based on work performed by the Sustainable Development Unit (SDU) in 2009/10. More information available here: <http://www.sduhealth.org.uk/policy-strategy/reporting/nhs-carbon-footprint.aspx>

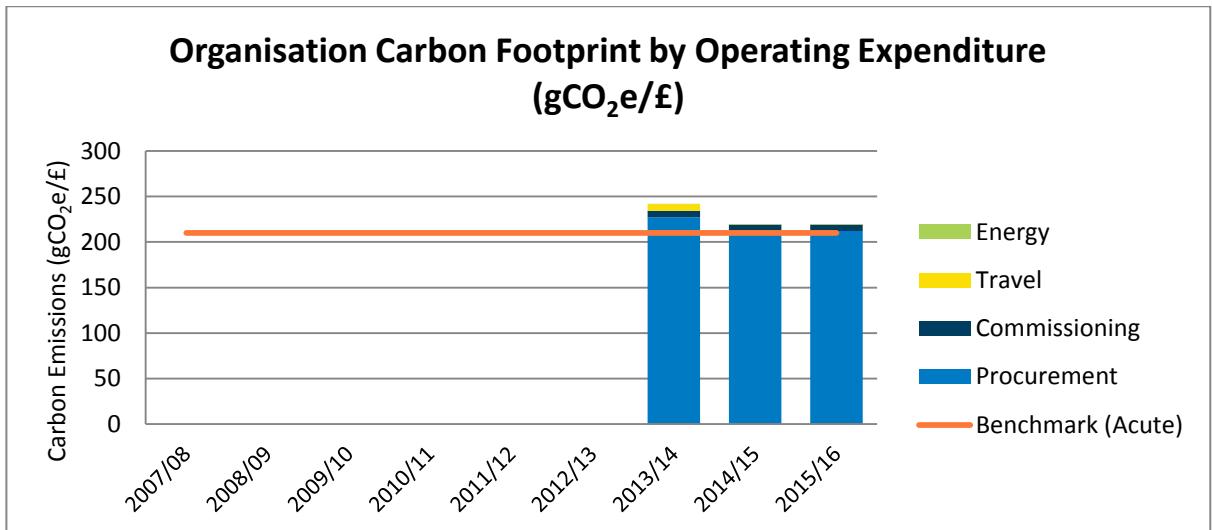
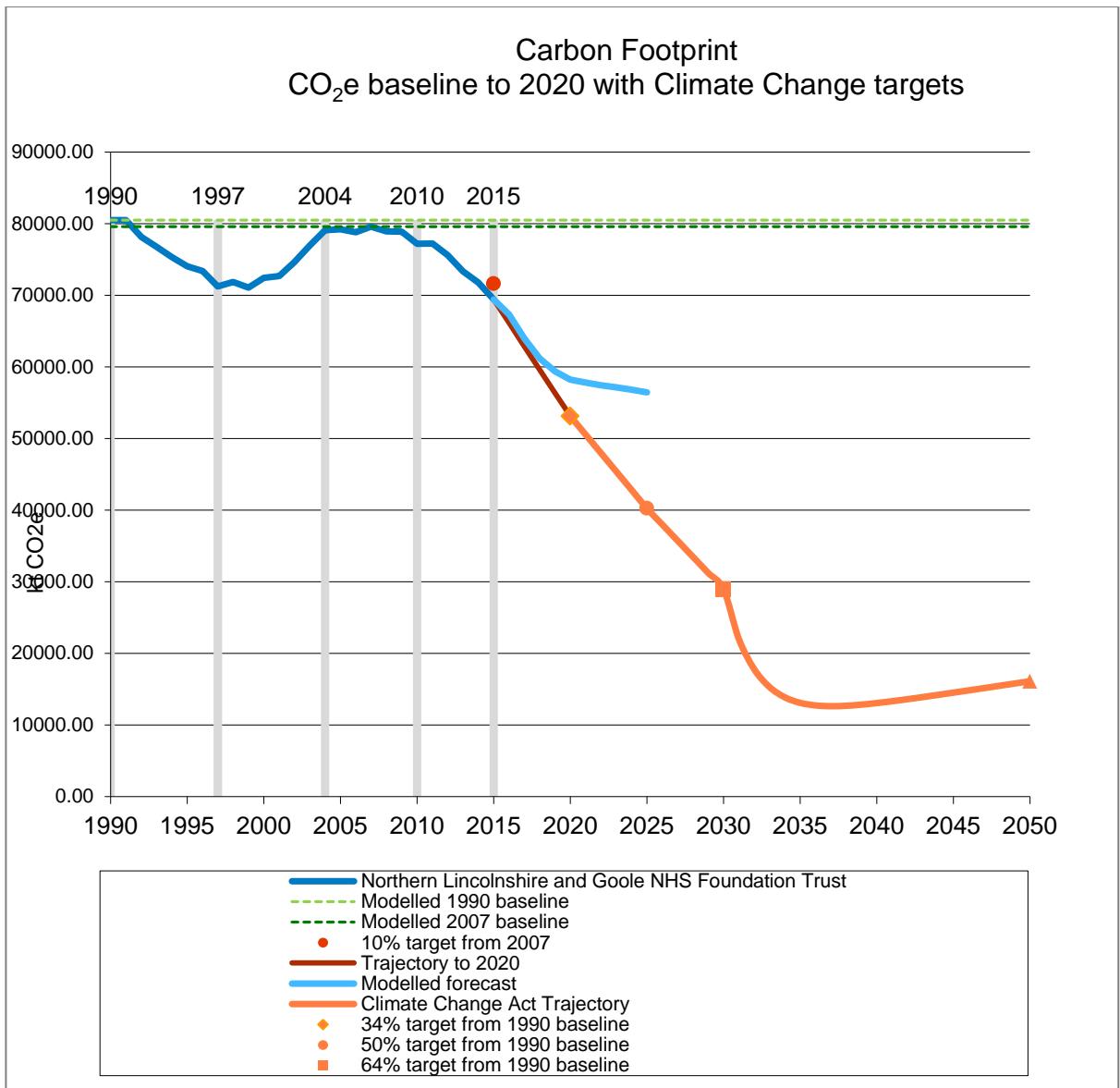
Resulting in an estimated total carbon footprint of 70,782,675 tonnes of carbon dioxide equivalent emissions (tCO₂e). Our carbon intensity per pound is 219 grams of carbon dioxide equivalent emissions per pound of operating expenditure (gCO₂e/£). Average emissions for acute services is 210 grams per pound.

Category	% CO ₂ e
Energy	0%
Travel	0%
Procurement	97%
Commissioning	3%



Organisation Carbon Emissions Profile





Equality report

The promotion of equality is not just a statement about how the Trust will meet its statutory requirements but plays an integral part in the way in which we conduct our business.

The Trust has a zero tolerance in relation to any form of discrimination in employment and service planning and delivery. We will continue to promote a culture of promoting equality, which fits with our Vision and Values, which means:

- We respect the dignity and individuality of each person in our care
- We respect the professionalism, diversity and skills of each person in our team
- We respect the dedication and commitment of those delivering healthcare.

We are committed to promoting equality and embracing diversity and to shaping our services around the needs and preferences of our patients.

We continue to build equality and diversity into the provision of services to our patients and the wider public as well as into policy development and employment practices. Our aim is to ensure everyone with an interest in our Trust including the public, members of staff, managers, patients, clinicians and commissioners, have a clear view of what we are seeking to achieve and equality and diversity is the thread that weaves through the whole of our business.

We continue our commitment to eliminating inequalities in both patient experience and health outcomes while continuing to maintain and improve patient quality and safety.

The Trust's Equality Strategy provides a clear vision on how we continue to promote and develop equality and diversity in respect of all the characteristics contained with the Equality Act (2010).

The equality agenda is embedded into our policy development, employment practices and the services we deliver to our patients, the public and the health community.

We continue to pride ourselves on the professionalism of our staff and the foundations that are in place to eliminate any form of discrimination within our Trust.

The Trust is, and will continue to be, committed to ensuring we meet and go beyond our statutory duties in ensuring our Trust is accessible to all. We are committed to shaping our services around the needs of our patients and continue to progress to eliminate inequalities in our patient experiences and health outcomes.

As a foundation trust we are committed to growing our membership and strive towards ensuring it meets the diversity of staff and the local communities we serve.

During 2015/16 the Equality Strategy and objectives continue to be developed and embedded. These objectives are:

- Raise awareness and promote equality among all our staff
- Train and develop our staff
- Meet our statutory legislative duties under the Equality Act (2010)
- Identify gaps in service provision and promote equality ensuring all have equal access
- Develop our membership to be representative of the population we serve
- Record and monitor key performance indicators against our statutory requirements

- Ensure policies and procedures are non-discriminatory
- Ensure fair and equitable access to training and development for all
- Plan and provide services across the whole population we service
- Promote equality in everything we do.

Equality considerations are reflected in our policies and delivery of services ensuring there are compliant with the General Duties, which is a legal obligation and applies to all public bodies. The protection characteristics under the equality law have nine strands. They are:

- Age
- Disability
- Gender reassignment
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation
- Marriage or civil partnership.

Our Equality Strategy is designed to address equality and diversity between people from all backgrounds. It is an integral part of our recruitment processes, service design and tendering processes. Our strategy also includes any organisation contracted by us and as such must demonstrate their commitment and practice to the equality agenda. Their values should not be in direct conflict with our strategy or our vision and values.

Our vision and values are:

Our Mission

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

Together we care

We care about providing safe, compassionate and attentive services for patients

Together we respect

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

Together we deliver

We will deliver forward thinking services through listening to, learning from, and empowering those I work with.

We will, through the aims of objectives of our Equality Strategy:

- Raise awareness and promote equality among all staff
- Train and develop all staff
- Meet statutory duties as required in the Equality Act (2010), national legislation and guidance
- Identify gaps in service provision and promote equality so that everyone has equal access
- Develop our FT membership to ensure it is representative of the people we serve, particularly focusing on ensuring a diverse membership and provides opportunities for Black and Minority Ethnic (BME) groups
- Record and monitor key indicators of performance against statutory requirements
- Establish a rolling action plan to promote, implement and develop the equality agenda through the organisation

- Challenge and address working practices and identity and celebrate good working practices
- Develop our workforce to ensure it is representative of the people we serve at all levels of the organisation
- Ensure policies and procedures are non-discriminatory
- Ensure fair and equitable access to training and development opportunities
- Plan and provide services across the whole population we serve paying particular attention to their equality needs
- Promote dignity and respect for all our patients
- Promote equality in everything we do, paying particular attention to the service delivery for our patients.



Health Tree Foundation

In the last year the Trust relaunched its charitable funds as The Health Tree Foundation, with support from Hull and East Yorkshire Smile Foundation (Smile).

During 2015/16 Smile has been working with NLaG to develop a new brand and identity for the charity. The name 'The Health Tree Foundation' was inspired by an organisation with routes in the NHS that branches out into the community.

The vision for the charity is: '*A community where everyone can benefit from the best healthcare in the UK.*'

The mission is to inspire, engage and channel the charitable intent of people, helping them to donate and make a real difference to the quality of people's healthcare where it really matters. The new name and brand launched officially in November 2015 with 'The Big Thank You Appeal'.

The Big Thank You Appeal is designed to encourage people to say thank you for the care and service they receive in the hospital or out in the community through monetary donations as opposed to flowers or chocolate on a ward. The idea is the money donated to The Big Thank You Appeal will be used across the Trust benefiting both patients and staff.

The Health Tree Foundation has introduced the 'Circle of Wishes'. This is a process in which any patient, member of staff, relative or public visitor to the Trust can make a wish for a change at one of the hospital sites or in the community.

The Health Tree team will then look into turning their wish into a reality. In the first six months of operation the circle of wishes received 154 wishes. All wishes are uploaded to the website and people can like each wish, the wishes with the most likes rise to the top of the page. The wishes received more than 8,700 individual likes in six months.

In the year 2015/16 The Health Tree Foundation contributed £761,000 to Northern Lincolnshire and Goole NHS Foundation Trust. Highlights include a new theatre table for £51,663 at Goole and District Hospital, supporting the new heart unit at Diana, Princess of Wales Hospital Grimsby for £61,500 and thanks to Scunthorpe League of Friends two new scopes for ENT for £15,430.

As well as large sums of money the Health Tree Foundation supports small changes that make a big difference. For example, an appeal was launched in December 2015 to raise money to buy lamps for the maternity ward to create a nicer environment for breast feeding mothers. Within five days the lamps were funded.

Finally The Health Tree Foundation has spread lots of laughter and cheer throughout the Trust with the new mascot 'Scrubs the Bear'. Scrubs is cuddly, furry and friendly and both staff and patients smile when they see him coming. He is available for photo opportunities, events and smiles.



Independent auditors' report to the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust

Report on the financial statements

Our opinion

In our opinion, Northern Lincolnshire and Goole NHS Group Foundation Trust's Group and Parent Trust financial statements (the "financial statements"):

- Give a true and fair view of the Group's and of the Parent Trust's affairs as at March 31 2016 and of the Group's income and expenditure of the Group's and of the Parent's Trust's cash flows for the year then ended March 31 2016: and
 - Have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.
-

Emphasis of Matter – Going Concern

In forming our opinion on the financial statements, which is not modified, we have considered the disclosures made in note 1(Accounting Policies) to the financial statements concerning the Trust's ability to continue as a going concern and the preparation of the financial statements in a going concern basis. Following the Trust' reporting a £26.1m deficit in the year and being in the fourth successive year of a net outflow of cash, the Trust has developed plans for the continuity of its services. It anticipates that it will receive external financial support from NHS Improvement to ensure that it is able to meet its liabilities and provide ongoing healthcare services.

However, the extent and nature of any financial support from NHS Improvement is dependent on the Trust achieving certain financial targets as described in note 1 to the financial statements and in our Area of Focus 'Going concern/financial sustainability' below.

These conditions indicate the existence of material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern. The financial statements do not include the adjustments that would result if the Trust was unable to continue as a going concern.

What we have audited

The financial statements comprise:

- The Consolidated and Parent Trust's Statements of Financial Position as at March 31 2016;
- The Consolidated Statement if Comprehensive Income for the year then ended;
- The Consolidated and Parent Trust's Statements of Cashflows for the year then ended;
- The Consolidated and Parent Trust's Statements of Changes in Taxpayers' and other Equity for the year then ended, and;
- The notes to the financial statements, which include a summary of significant accounting policies and other explanatory information.

Certain required disclosures have been presented elsewhere in the Annual Report, rather than in the notes to the financial statements. These are cross-referenced from the financial statements and are identified as audited.

The financial reporting framework that has been applied in the preparation of the financial statements in the NHS Foundation Trust Annual Reporting Manual 2015/16 issued by the Independent Regulator of NHS Foundation Trusts (“Monitor”).

Our audit approach

Context

Northern Lincolnshire and Goole NHS Foundation Trust provides services to over 350,000 people. The Trust runs the following hospitals:

- Scunthorpe General Hospital
- Grimsby's Diana, Princess of Wales Hospital; and
- Goole and District Hospital.

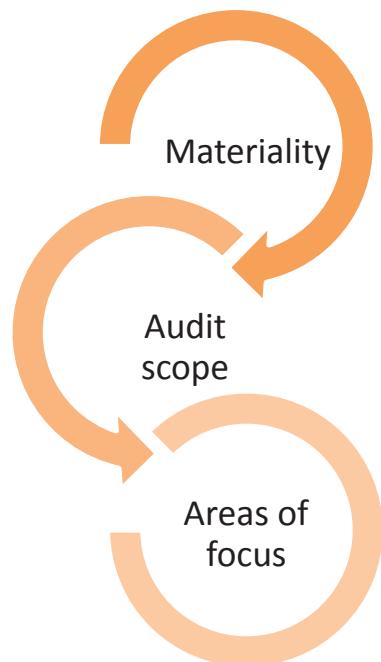
The Trust also provides community health services in North and North East Lincolnshire from a variety of locations.

The Trust's principal commissioners are North Lincolnshire Clinical Commissioning Group (CCG) and North East Lincolnshire Clinical Commissioning Group (CCG). The CCGs represent over 88% of the trust's revenue.

The Trust provides a full range of hospital services to the local community including emergency and intensive care, medical and surgical care, elderly care, paediatric and maternity care as well as diagnostic and clinical support.

Our 2016 audit was planned and executed having regard to the fact that the Trust's operations and financial stability were largely unchanged in nature from the previous year. In light of this, our approach to the audit in terms of scoping and areas of focus was largely unchanged.

Overview



- Overall materiality: £6,601,000 which represents 2% of total revenue
- The audit was conducted at the trust's Grimsby site, the Diana Princess of Wales Hospital, where the Trust's finance function is based, and all three Hospitals sites are in scope. The group includes the Trust's Charitable Funds, a fully-owned subsidiary
- Going concern/financial sustainability;
- Risk of fraud in revenue and expenditure recognition; and
- Valuation of land and buildings

The scope of our audit and our areas of focus

We conducted our audit in accordance with the National Health Service Act 2006, the Code of Audit Practice and relevant guidance issued by the National Audit Office on behalf of the Comptroller and Auditor General (the “Code”) and, International Standards on Auditing (UK and Ireland) (“ISAs (UK and Ireland)”).

We designed our audit by determining materiality and assessing the risks of material misstatement in the financial statements. In particular, we looked at where the directors made subjective judgements, for example in respect of significant accounting estimates that involved making assumptions and considering future events that are inherently uncertain. As in all of our audits, we also addressed the risk of management override of internal controls, including evaluating whether there was evidence of bias by the directors that represented a risk of material misstatement due to fraud.

The risks of material misstatements that had the greatest effect on our audit, including the allocation of our resources and effort, are identified as “areas of focus” in the table below. We have set out how we tailored our audit to address these specific areas in order to provide an opinion on the financial statements as a whole, and any comments we make on the results of our procedures should be read in this context. This is not a complete list of all risks identified by our audit.

Area of focus	How our audit addressed the area of focus
Going concern/financial sustainability	
As part of our audit work, we are required to consider the appropriateness of the going concern principle.	In considering the financial performance of the Trust we: <ul style="list-style-type: none">- Obtained a list of material balances owing to and from other health bodies through the national balance agreement exercise at March 31 2016 and assessed their recoverability by considering historic patterns;- Understand the Trust’s budget, cash flow forecasts and levels of resources, and the impact on the Trust’s ability to meet its liabilities as they fall due; and- Challenged the assumption behind the Trust’s financial forecasts by comparing them to the NHS Improvement’s forecasting guidelines, including the potential for further downsides.
The NHS Foundation Trust Annual Reporting Manual 2015/16 requires that the financial statements should be prepared on a going concern basis unless management either intends to supply the Secretary of State for the dissolution of the NHS foundation trust without the transfer of services to another entity, or has no realistic alternative but to do so.,	
The Trust’s overall position at year end is a £26.6m deficit which was behind the originally planned deficit of £25.8m.	The financial plan for 2016/17 indicates that the Trust will require external financial support in order to meet its liabilities and provide ongoing services.
The Trust’s budget for 2016/17 includes the needs for external finance support in order for the Trust to remain solvent.	The Trust was given a proposed “control total” deficit by NHS Improvement to which it has agreed, whilst pointing out the significant risks
The deterioration of the Trust’s financial position has led to NHS Improvement placing a licence condition on the Trust. NHS Improvement is also investigating the Trust’s in respect of financial governance and sustainability.	

We have focused on reviewing assumptions within and consequences of the Trust's forecasted financial performance.

to the achievement of this total. The Trust is only able to commit to delivery if there is support on key significant risk issued to income. There remain expenditure risks due to the likelihood of not achieving a challenging cost improvement programme.

Additionally, the Trust has not yet confirmed its income contract for the 2016/17 year, meaning there remains uncertainty in relation to the true value of income for 2016/17.

As the Trust is dependent upon receiving additional financial support, and currently has no agreement for this, there is a material uncertainty, which may cast significant doubt about the Trust's ability to continue as a going concern.

Risk of fraud in revenue and expenditure recognition

- Under ISA (UK&I) there is a rebuttable presumption that there are risks of fraud in revenue recognition. There is a risk that the Trust could adopt accounting policies or treat income transactions in such a way as to lead to material misstatements in the reported revenue position. We extend this presumption to the recognition of expenditure in the NHS.

We focused on this area because there is a heightened risk due to:

- The significant majority of the Trust's income (88%) is received from Clinical Commissioning Groups and NHS England, which are in effect, related parties to the Trust. As such, there is an increased risk that this income could be fraudulently recognised, and this could result in:
 - Material amounts of fictitious revenue being recognised; and/or
 - Material amounts of revenue being recorded in the incorrect period.
- The inherent complexities contractual arrangements entered into by the Trust; and

Revenue and expenditure

We evaluated the accounting policy for income recognition to ensure that it is consistent with the requirements of the NHS Annual Reporting Manual and noted no issues in this respect.

For Clinical Commissioning Group income, we obtained and reconciled the income to a signed contract and correspondence between the Trust and the CCG. We also tested a sample of reconciling items to confirm they related to agreed contract variations.

We tested a sample of revenue transactions recognised after the year end to confirm that the amount of revenue recognised was accurately and appropriately recognised in 2015/16.

We tested a sample of transactions before and after the year-end, confirming that the cut off procedures had been appropriately applied, that transactions and the associated income or expenditure had been posted to the correct financial year.

Intra – NHS balances

We obtained the Trust's mismatch reports received from NHS Improvement, which identified balances (debtor, creditor, income or expenditure balances) that were disputed by the counterparty. We then checked that management had investigated all disputed amounts over the investigation threshold

The Trust being under increasing financial pressures. The deficit for the Trust in £26.1m, and whilst the Trust is looking at ways to maximise revenue and reduce cost, there is an incentive for management to manipulate its financial position in order to achieve a favourable financial position.

We consider the key areas of focus are:

- Recognition of revenue and expenditure;
- Manipulation of journal postings;
- Management estimates (revaluation of plant, property and equipment, accruals, provisions, deferred income, and bad debt provision).

set by NHS Improvement, namely £0.25m, and discussed with them the results of their investigations and the resolution.

We also read correspondence with the counterparties, which validated these explanations. We then considered the impact, if any, that the remaining disputed amounts would have on the Trust's financial statements and determined that there was no material impact.

Journal postings

We selected a sample of manual and automated journal transactions that had been recognised in both income and Expenditure, focusing in particular, on those with a higher risk rating when considering the following factors:

- Materiality; and
- Key word assessment, eg description includes "error"

We used data analysis techniques to identify a sample of journals that had higher risk characteristics. We traced these journal entries to the supporting documentation (for example, invoices, and cash receipts and payments).

Recognition and measurement of estimates

We evaluated and tested management's accounting estimates focusing on:

- Provisions;
- Deferred revenue; and
- Plant, property and equipment evaluation.

We evaluated and challenged the accounting estimates and the basis of their calculation by:

- Compared assumptions used by management in the calculation if their estimation against independent assumptions for reasonableness; and
- Tested the data used to calculate the estimate against source data.

From the testing performed we did not note any material issues.

We also performed a 'look back' test to compare the estimate made at March 31 2015 to the actual outturn in the year in order to test the Trust's historical estimating accuracy.

Valuation of land and buildings

We have focussed on this area because property, plant and equipment ("PPE") represents the largest balance in the Trust's financial position. PPE is valued at £143.0m.

All property, plant and equipment assets are measured initially at cost with land and buildings being subsequently measured at fair value base on periodic valuations. The valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual, and performed with sufficient regularity to ensure that the carrying value is not materially different from fair value at the reporting date.

A full variation was undertaken during 2015/16 by the Trust's valuation expert. This valuation has resulted in an impairment of the Land and Buildings balance of £1.9m.

The valuation of Land and Buildings requires significant levels of judgement and technical expertise in choosing appropriate assumptions therefore our work has focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied.

From this testing we have not identified any indication of material management bias.

We obtained and read the relevant sections of the full valuation performed by the Trust's Valuers. We have utilised our valuations expertise and evaluated and challenged the assumptions and methodology applied in the valuation exercise. We found the assumptions and methodology applied to be consistent and in line with our expectations.

We assessed the competence and objectivity of the Trust's valuers by obtaining evidence of their qualifications, resources, objectivity and approach, which didn't identify any issues.

We tested the underlying data upon which valuation was based back to floor plans for a sample of properties. We found the valuation to have been based on appropriate and up to date floor space data. We tested a sample of new additions to land and buildings in the year to confirm they had been appropriately valued – this involved agreement back to supporting invoice.

We physically verified a sample of assets to confirm existence and in doing so assessed whether there was any indication of physical obsolescence which would indicate potential impairment.

We considered the disclosure in the financial statements and were satisfied they appropriately reflected the valuation undertaken in the period.

We reviewed whether the change in valuation as appropriately disclosed in the annual report and correctly reflected in management's corresponding entries.

How we tailored the audit scope

We tailored the scope of our audit to ensure that we performed enough work to be able to give an opinion on the financial statements as a whole, taking into account the structure of the Group, the accounting processes and controls, and the environment in which the Group operates.

Materiality

The scope of our audit was influenced by our application of materiality. We set certain quantitative thresholds for materiality. These, together with qualitative considerations, helped us to determine the scope of our audit and the nature, timing and extent of our audit procedures and to evaluate the effect of misstatements, both individually and on the financial statements as a whole.

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Based on our professional judgement, we determined materiality for the financial statements as a whole as follows:

Overall Group Materiality	£6,601,000 (2015: £6,609,140)
How we determined it	2% of revenue (2015: 2% of revenue)
Rationale for benchmark applied	Consistent with last year, we have applied this benchmark, a generally accepted auditing practice, in the absence that an alternative benchmark would be appropriate.

We agreed with the Audit Committee that we would report to them misstatements identified during our audit above £330,000 (2015: £330,457) as well as misstatements below that amount that, in our view, warranted reporting for qualitative reasons.

Other reporting in accordance with the Code

Opinions on other matters prescribed by the Code

In our opinion:

- The information given in the Performance Report and the Accountability Report for the financial year for which the financial statements are prepared is consistent with the financial statements;
- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16; and
- The part of the Staff Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Other matters on which we are required to report by exception

We required to report to you if, our opinion:	
<ul style="list-style-type: none">• Information in the annual report is:<ul style="list-style-type: none">- Materially inconsistent with the audited information in the audited financial statements; or- Apparently materially incorrect based on, or materially inconsistent with, our knowledge of the Group and Parent Trust acquired in the course of performing our audit; or- Otherwise misleading.	We have no exceptions to report.
<ul style="list-style-type: none">• The statement given by the directors in accordance with provision C.1.1 of the NHS Foundation Trust Code of Governance, that the consider the Annual Report taken as a whole to be fair, balanced and understandable and provides the information necessary for members to assess the Group and Parent Trust's performance, business model and strategy is materially inconsistent with our knowledge of the trust acquired in the course of performing our audit.	We have no exceptions to report.
<ul style="list-style-type: none">• The section of the Annual Report as required by provision C.3.9 of the NHS Foundation Trust Code of	We have no exceptions to report.

Governance, describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee.	
<ul style="list-style-type: none"> The Annual Governance Statement does not meet the disclosure requirement set out in the NHS Foundation Trust Annual Reporting Manual 2015/16 or is misleading or inconsistent with information of which we are aware from our audit. We have not considered whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls. 	We have no exceptions to report.
We are also required to report if:	
<ul style="list-style-type: none"> We have referred a matter to Monitor under paragraph 6 of Schedule 10 to the NHS Act 2006 because we had reason to believe that the Trust, or a director or officer of the Trust, was about to make, or had made, a decision which involved or would involve the incurring of expenditure that was unlawful. Or was about to take, or had taken a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss of deficiency; or We have issued a report in the public interest under paragraph 3 of schedule 10 to the NHS Act 2006. 	We have no exceptions to report.

Arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code we are required to report to you if we are satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended March 31 2016;

Although the Trust was not in special measures at any point during the year, the license condition issued on August 6 2013 to the Board of Directors and the Council of Governors remains in place, triggered by a deterioration in the Trust's financial position. On April 8 2015, NHS Improvement issued enforcement undertakings stating that the Trust had demonstrated that it is established and effectively implemented systems and/or processes to ensure compliance with its duty to operate economically, efficiently and effectively.

The Care Quality Commission issued its full inspection report on April 5 2016 and categorised the Trust as 'requires improvement', with Scunthorpe General Hospital being deemed 'inadequate'.

As a result of the matters summarised above, we have been unable to satisfy ourselves that the Trust has made proper arrangement for securing economy, efficiency and effectiveness in the use of its resources for the year ended March 31 2016.

Responsibilities for the financial statements and the audit

Our responsibilities and those of the directors

As explained more fully in the Directors' Responsibilities Statement, the directors are responsible for the preparation of the financial statements and for being satisfied that they

give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2015/16.

Our responsibility is to audit and express an opinion on the financial statements in accordance with the National Health Service Act 2006, the Code, and ISAs (UK & Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Northern Lincolnshire and Goole NHS Foundation Trust as a body in accordance with paragraph 24 of schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by prior consent in writing.

What an audit if financial statement involves

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatements, whether caused by fraud or error.

This includes an assessment of:

- Whether the accounting policies are appropriate to the Group's and Parent Trust's circumstances and have been consistently applied and adequately disclosed;
- The reasonableness of significant accounting estimates made by the directors; and
- The overall presentation of the financial statements.

We primarily focus our work in these areas by assessing the directors' judgements against available evidence, forming our own judgements, and evaluating the disclosures in the financial statements.

We test and examine information, using sampling and other auditing techniques, to the extent we consider the necessary to provide a reasonable basis for us to draw conclusions. We obtain audit evidence through testing the effectiveness of controls, substantive procedures or a combination of both. In addition, we read all the financial and non-financial information in the Annual Report to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Responsibilities for securing economy, efficiency and effectiveness in the use of resources

Our responsibilities and those of the Trustees

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. We are required under paragraph 1(d) of Schedule 10 to the NIIS Act 2006 to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources and to report to you where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our work in accordance with the Code, having regard to the criterion determined by the Comptroller and Auditor General as to whether the Trust has proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary.

Certificate

We certify that we have completed the audit of the financial statements in accordance with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Code.

**Ian Looker (Senior Statutory Auditor)
for and on behalf of PricewaterhouseCoopers ILP
Chartered Accountants and Statutory Auditors
Leeds
26 May 2016**

(a) The maintenance and integrity of the Northern Lincolnshire and Goole NI IS foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

The Trust annual accounts 2015/16

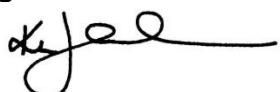
Foreword to the accounts

Northern Lincolnshire and Goole NHS Foundation Trust

The Trust achieved Foundation status in May 2007. These accounts for the year ended March 31 2016 have been prepared by Northern Lincolnshire and Goole NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 of the NHS Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006 in the form which the Independent Regulator of NHS foundation trusts (Monitor) has, with the approval of the Treasury directed.

Northern Lincolnshire and Goole NHS Foundation Trust's Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) of the National Health Service Act 2006.

Signed:



Name: Karen Jackson

Title: Chief executive

Date: May 20 2016

Northern Lincolnshire and Goole NHS Foundation Trust

**Annual accounts for the year
ended 31 March 2016**

Foreword to the Accounts

Northern Lincolnshire and Goole NHS Foundation Trust

These accounts, for the year ended March 31 2016, have been prepared by Northern Lincolnshire and Goole NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 within the National Health Service Act 2006.

Signed:



Name: Karen Jackson, chief executive

Date: May 20 2016

Consolidated statement of comprehensive income for the year ended 31 March 2016

		2015/16	2014/15
	Note	£000	£000
Operating income from patient care activities	3	302,019	296,044
Other operating income	4	34,747	34,413
Total operating income from continuing operations		336,766	330,457
Operating expenses	5.1,7	(359,497)	(346,449)
Operating Deficit before Restructuring/Impairments relating to Market Value Changes		(22,731)	(15,992)
 Restructuring costs		 771	 (436)
Impairments of Property, Plant and Equipment		(2,464)	(2,031)
Reversal of previous Impairments of Property, Plant and Equipment		1,695	603
Operating deficit for the financial year		(22,729)	(17,856)
 Finance income	10	113	144
Finance expenses	11.1	(553)	(346)
PDC dividends payable		(2,764)	(3,318)
Net finance costs		(3,204)	(3,520)
Share of loss of Joint Ventures accounted for using equity method of accounting		(54)	(43)
Movement in the fair value of investment property and other investments	20.1	(108)	142
Deficit for the year from continuing operations		(26,095)	(21,277)
Result on discontinued operations and the result on disposal of discontinued operations	14	-	-
Deficit for the year		(26,095)	(21,277)
 Other comprehensive income/(expense)			
Will not be reclassified to income and expenditure:			
Losses on revaluations on Property, Plant and Equipment	6,16.1	(1,893)	(2,009)
Gains on revaluations on Property, Plant and Equipment	16.1	774	817
Total comprehensive expense for the financial year		(27,214)	(22,469)
 Deficit for the financial year attributable to:			
the Foundation Trust		(26,095)	(21,277)
 Total comprehensive income / (expense) for the financial year attributable to:			
the Foundation Trust		(27,214)	(22,469)
 Breakdown of Deficit			
Trading Deficit		(26,037)	(19,202)
Restructuring costs		771	(436)
Impairments or reversal of previous impairments		(769)	(1,428)
Deficit after impairments		(26,035)	(21,066)
Consolidation of Charity Net Expenditure		(60)	(211)
Accumulated Deficit		(26,095)	(21,277)

Statements of financial position as at 31 March 2016

		Group		Trust	
	Note	31 March 2016	31 March 2015	31 March 2016	31 March 2015
		£000	£000	£000	£000
Non-current assets					
Intangible assets	15.1,15.2	1,152	1,435	1,152	1,435
Property, plant and equipment	16,17	143,044	138,373	143,044	138,373
Other investments	20.1 20.2	1,787	1,995	-	-
Trade and other receivables	24.1	11	15	11	15
Total non-current assets		145,994	141,818	144,207	139,823
Current assets					
Inventories	23	2,489	2,685	2,489	2,685
Trade and other receivables	24.1	16,079	16,325	16,037	16,310
Cash and cash equivalents	29.1	5,316	21,177	5,201	21,156
Total current assets		23,884	40,187	23,727	40,151
Current liabilities					
Trade and other payables	30.1	(38,202)	(35,043)	(38,146)	(34,960)
Other liabilities	31	(1,473)	(1,307)	(1,473)	(1,307)
Borrowings	32	(1,886)	(1,807)	(1,886)	(1,807)
Provisions	35.1	(2,391)	(4,105)	(2,391)	(4,105)
Total current liabilities		(43,952)	(42,262)	(43,896)	(42,179)
Total assets less current liabilities		125,926	139,743	124,038	137,795
Non-current liabilities					
Borrowings	32	(32,517)	(19,403)	(32,517)	(19,403)
Provisions	35.1	(5,494)	(5,255)	(5,494)	(5,255)
Total non-current liabilities		(38,011)	(24,658)	(38,011)	(24,658)
Total assets employed		87,915	115,085	86,027	113,137
Financed by					
Public dividend capital		126,039	125,995	126,039	125,995
Revaluation reserve		11,908	13,027	11,908	13,027
Available for sale investments reserve		-	-	-	-
Other reserves		-	-	-	-
Merger reserve		-	-	-	-
Income and expenditure reserve		(51,920)	(25,885)	(51,920)	(25,885)
Non-controlling interest		-	-	-	-
NHS Charitable funds reserves	21	1,888	1,948	-	-
Total taxpayers' and others' equity		87,915	115,085	86,027	113,137

The notes on pages 166 to 217 form part of these accounts.

Name **Karen Jackson**
 Position **Chief executive**

**Consolidated statement of changes in taxpayers' and other equity for the year ended
31 March 2016**

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Total Taxpayers' and other equity
Group	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2015 – brought forward	125,995	13,027	(25,885)	1,948	115,085
Surplus (deficit) for the year	-	-	(26,795)	700	(26,095)
Impairments	-	(1,893)	-	-	(1,893)
Revaluations	-	774	-	-	774
Public dividend capital received	44	-	-	-	44
Other reserve movements	-	-	760	(760)	-
Taxpayers' and others' equity as 31 March 2016	126,039	11,908	(51,920)	1,888	87,915

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	NHS charitable funds reserves	Total Taxpayers' and other equity
Group	£000	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2014 – brought forward	123,914	14,219	(4,819)	2,159	135,473
Surplus (deficit) for the year	-	-	(21,819)	542	(21,277)
Impairments	-	(2,009))	-	-	(2,009))
Revaluations	-	817	-	-	817
Public dividend capital received	2,081	-	-	-	2,081
Other reserve movements	-	-	753	(753)	-
Taxpayers' and others' equity as 31 March 2015	125,995	13,027	(25,885)	1,948	115,085

Information on reserves

NHS charitable funds reserves

This balance represents the ring-fenced funds held by the NHS charitable funds consolidated within these accounts. These reserves are classified as restricted or unrestricted.

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. Additional PDC may also be issued to NHS Foundation Trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable to the Department of Health as the public dividend capital dividend.

Revaluation reserve

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

Available-for-sale investment reserve

This reserve comprises changes in the fair value of available-for-sale financial instruments. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure.

Income and expenditure reserve

The balance of this reserve is the accumulated surpluses and deficits of the NHS Foundation Trust.

Consolidated statement of cash flows for the year ended 31 March 2016

	Note	2015/16 £000	2014/15 £000
Cash flows from operating activities			
Operating Deficit		(22,729)	(17,856)
Non-cash income and expense:			
Depreciation and amortisation	5.1	7,780	7,113
Impairments and reversals of impairments	6	769	1,428
Loss on disposal of non-current assets	4.1,5.1	20	38
Income recognised in respect of capital donations	17	(519)	(332)
Decrease in receivables and other assets		416	708
Decrease in inventories		196	56
Increase in payables and other liabilities		2,245	1,153
Decrease in provisions		(1,544)	(608)
NHS charitable funds - net movements in working capital, non-cash transactions and non-operating cash flows		(54)	45
Other movements in operating cash flows		(57)	(41)
Net cash used in operating activities		(13,477)	(8,296)
Cash flows from investing activities			
Interest received		43	65
Purchase of intangible assets		(151)	(747)
Purchase of property, plant, equipment and investment property		(12,736)	(10,840)
Sales of property, plant, equipment and investment property		13	228
Receipt of cash donations to purchase capital assets		519	332
Investing cash flows of NHS charitable funds		170	279
Net cash used in investing activities		(12,142)	(10,683)
Cash flows from financing activities			
Public dividend capital received		44	2,081
Movement on loans from the Department of Health		13,316	15,301
Capital element of finance lease rental payments		(123)	(219)
Interest paid on finance lease liabilities		(7)	(26)
Other interest paid		(477)	(264)
PDC dividend paid		(2,995)	(3,350)
Net cash generated from financing activities		9,758	13,523
Decrease in cash and cash equivalents		(15,861)	(5,456)
Cash and cash equivalents at 1 April		21,177	26,633
Cash and cash equivalents at 31 March	29.1	5,316	21,177

1 Accounting Policies and Other Information

Basis of Preparation

Monitor is responsible for issuing an accounts direction to NHS Foundation Trusts under the NHS Act 2006. Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the Foundation Trust Annual Reporting Manual (FT ARM) which shall be agreed with the Secretary of State. Consequently, the following financial statements have been prepared in accordance with the FT ARM 2015/16 issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual (FReM) to the extent that they are meaningful and appropriate to NHS Foundation Trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting Convention

These accounts have been prepared on a going concern basis, under the historical cost convention modified to account for the revaluation of land and buildings. Plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities have been reviewed to represent fair value as at 31st March 2016.

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. In accordance with the NHS Foundation Trust's Annual Reporting Manual the financial statements have been prepared on a going concern basis as we do not either intend to apply to the Secretary of State for the dissolution of the NHS Foundation Trust without the transfer of the services to another entity, or consider that this course of action will be necessary.

We are also required to disclose material uncertainties in respect of events or conditions that cast doubt upon the going concern ability of the NHS Foundation Trust and these are disclosed below.

The Trust's performance in year showed a deficit of £26.035m inclusive of all non-cash balance sheet review adjustments. The Trust had year end cash balances of £5.20m. However, to maintain this level of liquidity, the Trust utilised in full a £15.0m Interim Revenue Support Loan. The Trust is forecasting a further deficit of £11.82m in 2016/17 after Sustainability and Transformational Fund income of £11.5m. The projected 2016/17 deficit of £11.82m should be viewed in the light of a Control Total for 2016/17, set centrally by the regulator for the Trust, of a £12.27m deficit. The Trust to date agreed an Interim Revenue Support Loan for 2016/17 of £18.9m.

The Trust has the following material financial risks in 2016/17:

- There is a risk to contract income which at the point of writing is partially mitigated but not fully resolved, arising from affordability and allocation concerns for key CCG commissioners
- The Trust must deliver sufficient activity through the right sizing of its clinical capacity to deliver upon its service obligations, if it does not core contracting is under threat
- The Trust is reliant upon £11.5m of proposed sustainability and transformational income to deliver its plan. At the time of writing this still has to be fully confirmed by regulators and will be dependent upon acceptable financial and service delivery performance through the year

- The Trust has an ambitious savings target set at around twice the national expectation of 2.0 per cent. This creates significant management challenge and a degree of financial risk
- The Trust has yet to finalise with regulators full sign off of its 2016/17 financial plan and the liquidity support package linked to that plan. It should be noted that progress on this issue is tied to the national planning agenda.

Having considered the material uncertainties the directors have determined that it remains appropriate to prepare these accounts on a going concern basis.

The accounts do not include any adjustments that would result if Northern Lincolnshire and Goole NHS Foundation Trust was unable to continue as a going concern.

1.2 Consolidation

1.2.1 Subsidiaries

The NHS Foundation Trust is the corporate trustee to Northern Lincolnshire and Goole NHS Foundation Trust Charitable Funds. The Foundation Trust has assessed its relationship to the charitable fund and determined it to be a subsidiary because the Foundation Trust has the power to govern the financial and operating policies of the charitable fund so as to obtain benefits from its activities for itself, its patients or its staff.

The charitable fund's statutory accounts are prepared to 31 March in accordance with the UK Charities Statement of Recommended Practice (SORP) which is based on UK Financial Reporting Standard (FRS) 102. On consolidation, necessary adjustments are made to the charity's assets, liabilities and transactions to:

- Recognise and measure them in accordance with the Foundation Trust's accounting policies; and
- Eliminate intra-group transactions, balanced, gains and losses.

Northern Lincolnshire and Goole NHS Foundation Trust Charitable fund accounting policies:

a) Funds structure

Perpetuity funds are funds which are to be used in accordance with specific restriction imposed by the donor. Where the restriction requires the gift to be invested to produce income but the capital cannot be spent, it is classed as a perpetuity fund.

Restricted funds are funds which are to be used in accordance with specific restrictions imposed by the donor. Where the restriction requires the gift to be invested to produce income but the trustees have the power to spend the capital, it is classed as expendable endowment.

Unrestricted income funds comprise those funds which the Trustee is free to use for any purpose in furtherance of the charitable objects. Unrestricted funds include designated funds, where the donor has made known their non-binding wishes or where the trustees, at their discretion, have created a fund for a specific purpose.

The charity does not have any perpetuity funds or expendable endowments.

b) Incoming resources

All incoming resources are recognised once the charity has entitlement to the resources. Provided it is certain that the resources will be received and the monetary value of incoming resources can be measured with sufficient reliability.

c) Incoming resources from legacies

Legacies are accounted for as incoming resources either upon receipt or where the receipt of the legacy is virtually certain; this will be once confirmation has been received from the representatives of the estate(s) that payment of the legacy will be made or property transferred and once all conditions attached to the legacy have been fulfilled.

d) Gifts in kind

Assets given for distribution by the funds are included in the Statement of Financial Activities only when distributed.

In all cases the amount at which the gifts in kind are brought into account is either a reasonable estimate of their value to the funds or the amount actually realised.

e) VAT and tax

Irrecoverable VAT is charged against the category of resources expended for which it was incurred.

The charity is a registered charity, and as such is entitled to certain tax exemptions on income and profits from investments, and surpluses on any trading activities carried on in furtherance of the charity's primary objectives, if these profits and surpluses are applied solely for charitable purposes.

f) Allocation of overhead and support costs

Overhead and support costs have been apportioned on an appropriate basis between all funds. The apportionment is in proportion to the quarterly aggregate balance on each of the funds and is distributed on a quarterly basis.

g) Fixed asset investments

Investments are stated at market value as at the balance sheet date. The Statement of Comprehensive Income includes the net gains and losses arising on revaluation and disposals throughout the year.

The common Investment Fund Units and Brewin Dolphin Ltd portfolio are included in the balance sheet at the closing dealing price at March 31 2016.

h) Realised gains and losses

All gains and losses are taken to the Statement of Comprehensive Income as they arise. Realised gains and losses on investments are calculated as the difference between sales proceeds and opening market value (purchase date if later).

Unrealised gains and losses are calculated as the difference between the market value at the year end and opening market value (or purchase date if later).

1.3 Joint venture

The Foundation Trust has entered into a cooperation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operates from ward 4 at Goole and District Hospital. The joint venture provides both NHS care and care independent to the NHS but within an NHS location.

The commissioners, social services and other agencies commission services from the joint venture and the joint venture is managed on a day to day basis by BIRT. The joint venture accesses support services and have access to NHS facilities from Northern Lincolnshire and Goole NHS Foundation Trust which are governed by appropriate service level agreements. The Trust includes within its financial statements its share of the activities, assets and liabilities.

1.4 Critical Accounting Judgements and Key Sources of Estimation and Accuracy

In the application of the Foundation Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant.

Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

a) Going concern

The accounting rules (IAS 1) require management to assess, as part of the accounts preparation process, the NHS Foundation Trust's ability to continue as a going concern. Please refer to Accounting Policy 1.1.

b) Property valuations and asset lives

Valuations are undertaken by an independent external valuer. These values will therefore be subject to changes in market conditions and marker values. The asset lives are also estimated by the independent external valuer and are subject of professional judgement.

c) Accruals

Accruals included within the accounts are based on the best available information. This is applied in conjunction with historical experience and based on individual circumstances.

d) Annual leave accruals

The Trust had written to all members of staff requesting details of their outstanding annual leave at the end of March 2016. All staff are allowed to carry forward a maximum of five days annual leave. The value of the outstanding amount has been calculated based on the returns received back from staff and their average salary. The Foundation Trust is carrying £0.274m.

e) Provisions

The estimates of outcome and financial effect of provisions are determined by the judgement of the management of the Trust, supplemented by experience of similar transactions and, in some cases, reports of independent experts.

Uncertainties surrounding the amount to be recognised as a provision are dealt with by various means according to the circumstance. Where the provision being measured involves more than one outcome, the obligation is estimated by weighing all possible outcomes by their associated probabilities; the expected value of the outcome. Where there is a range of possible outcomes, and each point in the range is likely as the other, the mid-point of the range is used. Where a single outcome is being measured, the individual most likely outcome may be the best estimate of the liability. However, even in such a case, the Trust considers other possible outcomes.

The Foundation Trust has signed off planning assumptions going forward which will see a continued dependence on pay control in order to deliver a challenging Sustainability Programme. It is inevitable that this process will incorporate some measures which will result in non-recurrent costs – redundancy and early retirement costs, and payments in line with the Foundation Trust pay protection policy. The projected total requirement to support committed sustainability plans made by March 31 2016 derived on this basis is £1.757m. There has been a credit of £0.77m to the Foundation Trust during 2015/16.

1.5 Income

Income is accounted for applying the accruals convention. The income is shown gross except where administrative arrangements exists, whereby the associated income is netted off with the corresponding expenditure in accordance with the NHS Foundation Trust Financial Reporting Manual (FT ARM). In recognising income in the current financial year, the Trust has considered and followed IAS18.

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred. Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Where income has not been received prior to the year end, but the provision of a healthcare service has commenced, ie partially completed patient spells, then the income relating to the patient activity is accrued. The closing accrued income is estimated based on the number of days of incomplete spells at an average daily tariff adjusted to reflect the case mix.

The Foundation Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid eg by an insurer. The Foundation Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts which is 3.01 per cent above the national recommended rate. This rate is based on local trends and experiences of recovery.

1.6 Expenditure

1.6.1 Expenditure on employee benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

1.6.2 Pension Costs

NHS Pension Scheme

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsba.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Foundation Trust commits itself to the retirement, regardless of the method of payment.

1.6.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.7 Property, plant and equipment

Recognition

Property, Plant and Equipment is capitalised if:

- It is held for use in delivering services or for administrative purposes
- It is probable that future economic benefits will flow to, or service potential will be supplied to the Foundation Trust
- It is expected to be used for more than one financial year
- The cost of the item can be measured reliably and
- The item has cost of at least £5,000; or
- Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or

- Items form part of the initial equipping and setting-up cost of a new building, ward or unit irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Borrowing costs associated with the construction of new assets are not capitalised.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Land and buildings used for the Foundation Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses.

Revaluations are performed by professional valuers every five years and in the intervening years by the use of appropriate indices or by interim valuation as necessary to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Freehold Properties – Existing Use Value (EUV)
- Specialised buildings – Depreciated Replacement Cost (DRC) – Modern Equivalent Asset (MEA)
- Others – DRC – EUV
- Land – Modern Equivalent Asset (MEA).

1.7 Property, Plant and Equipment (continued)

For any new acquisition of property, plant and equipment, the following table details the useful economic lives for the main classes of assets and where applicable, sub categories within each

Main Assets	Sub Category	Life in Years
Buildings	Structural engineering	Up to 100 years
Fixtures	Plant, machinery and equipment	5 to 15 years
	Furniture and fittings	5 to 10 years
	IT equipment	Up to 5 years
Vehicles/transport equipment		Up to 7 years
Intangible		Up to 10 years

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

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

viability of the continued occupation and use by the Foundation Trust. The Market Value for readily identifiable alternative uses would not be higher than the existing use. Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

The ultimate objective of the valuation is to place a value upon the asset. In this the value of the land in providing a modern equivalent facility was also considered. The modern equivalent may be located on a new site out of town, or be on a smaller site due to changes in the way services are provided. The site is valued based on the size of the modern equivalent, and not the actual site area occupied at present, which has given rise to reduction in the land values.

The results of these valuations have been incorporated into these financial statements.

Equipment assets are valued using appropriate indices (for 2015/16 no change) and predominantly the Depreciated Replacement Cost is assumed to be the fair value. Annually, an equipment review is also conducted by the department/directorate/equipment specialist and the life of the Equipment assets is reviewed in conjunction with the experts in the field (medical electronics/suppliers/market intelligence). Assets in the course of construction are valued at current cost and they are revalued by professional valuers when they are brought into use or as part of the five or intervening years valuation whichever occurs first. These assets include any existing land or buildings under the control of a contractor.

Subsequent Expenditure

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably.

Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Foundation Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Foundation Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

Revaluation and impairments

At each reporting period end, the Foundation Trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

In accordance with the FT ARM, impairments that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment arising from a loss of economic benefit or service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating income to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.

Other impairments are treated as revaluation losses. Reversals of ‘other impairments’ are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item under “Other Comprehensive Income”.

De-Recognition

Assets intended for disposal, are reclassified as ‘Held for Sale’ once all of the following criteria are met:

- The asset is available for immediate sale in its present condition subject only to terms
- Which are usual and customary for such sales
- The sale must be highly probable ie:
 - Management are committed to a plan to sell the asset
 - An active programme has begun to find a buyer and complete the sale
 - The asset is being actively marketed at a reasonable price
 - The sale is expected to be completed within 12 months of the date of classification as “held for Sale” and
 - The actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significantly changed.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their ‘fair value less costs to sell’. Depreciation ceases to be charged and the assets are not revalued, except where the ‘fair value less costs to sell’ falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as ‘Held for Sale’ and instead is retained as an operational asset and the asset’s economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

1.8 Donated assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

Within these financial statements, the Foundation Trust does not have any donations with conditions attached at this present moment in time.

1.9 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of sale separately from the rest of the Foundation Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Foundation Trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- The project is technically feasible to the point of completion and will result in an intangible asset for sale or use
- The Foundation Trust intends to complete the asset and sell or use it
- The ability to sell or use the intangible asset
- How the intangible asset will generate probable future economic benefits or service potential
- The availability of adequate financial, technical and other resources to complete the intangible asset and sell or use it, and
- The ability to measure reliably the expenses attributable to the intangible asset during its development.

Software

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset.

Measurement

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

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

Economic lives of intangible assets

Intangible assets – internally generated	Min. Life – Years	Max. Life – Years
Information technology	5	5
Intangible assets – purchased		
Software	5	10
Licences and trademarks	5	10

1.10 Government grants

Government grants are grants from Government bodies other than income from clinical commissioning groups (CCG's) or NHS Trusts for the provision of services. Where a Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

1.11 Inventories

Inventories are valued at the lower of cost and net realisable value.

1.12 Private Finance Initiative (PFI) transactions

At 31 March 2016, the Foundation Trust did not have any PFI transactions.

1.13 Leases

The Trust as lessee

Finance Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance Costs in the Statement of Comprehensive Income. The lease liability, is de-recognised when the liability is discharged, cancelled or expires.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

The Foundation Trust as a lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs, Disability Trust etc. renewable on an annual basis. These are operating leases and the rental from these leases is recognized on a straight line basis within these financial statements.

1.14 Cash and cash equivalent

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in three months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

1.15 Clinical Negligence Costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 35.2, but is not recognised in the Trust's accounts.

1.16 Non-clinical risk pooling

The NHS Foundation Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.17 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 1.37% in real terms for early retirement and injury benefit provisions only.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Foundation Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Foundation Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.18 Sustainability and Carbon Reduction Commitment (CRC)

The CRC scheme is a mandatory cap and trade scheme for non-transport CO₂ emissions. The Foundation Trust has registered with the CRC scheme, and therefore, is required to surrender to the Government an allowance for every tonne of CO₂ emitted during the financial year. Accordingly, the Foundation Trust has recognised a liability (and related expense) in respect of this obligation for CO₂ emissions.

The carrying amount of the liability at 31 March 2016 reflects the CO₂ emissions that have been made during this financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year.

The liability will be measured at the amount expected to be paid out at the rate of £15.60 per tonne allowance.

1.19 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 36 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 36, unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.20 Public Dividend Capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5 per cent) on the average relevant net assets of the NHS Foundation Trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) average daily cash balances held with the Government Banking Services (GBS), excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and (iii) any PDC dividend balance receivable or payable.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result of the audit of the annual accounts.

1.21 Value Added Tax (VAT)

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.22 Corporation Tax

The NHS Foundation Trust has carried out a review of corporation tax liability of its non-healthcare activities. At present, all activities are either ancillary to the Trust's patient care activity or are below the de minimis level at which corporation tax is due. Therefore, the Trust has determined that it has no liability for corporation tax. Further guidance is awaited from Monitor, the HM Treasury and the Inland Revenue.

1.23 Foreign exchange

The functional and presentational currencies of the Foundation Trust are sterling. A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

The Foundation Trust does not have any assets or liabilities denominated in a foreign currency at the Statement of Financial Position date.

1.24 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS Foundation Trust has no beneficial interest in them. However, they are disclosed in a separate note (note 45) to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.25 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise.

They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and special payments are charged to the relevant functional headings in the Statement of Comprehensive Income on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However, note 42 is compiled directly from the losses and compensations register which is prepared on an accrual basis with the exception of provisions for any future losses.

1.26 Financial instruments – financial assets and financial liabilities recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Foundation Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs ie when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below.

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred. All other financial assets and financial liabilities are recognised when the Foundation Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Foundation Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are classified into the following categories:

- Financial assets at fair value through income and expenditure
- Loans and receivables
- Available for sale financial assets.

Financial liabilities are classified as:

- Fair value through income and expenditure, or as
- Other financial liabilities.

Financial assets and financial liabilities at fair value through income and expenditure

Financial assets and financial liabilities at “fair value through income and expenditure” are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not “closely-related” to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the Statement of Comprehensive Income. Subsequent movements in the fair value are recognised as gains and losses in the Statement of Comprehensive Income.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

The Foundation Trust's loans and receivables comprise of, cash and cash equivalents, NHS debtors, accrued income and “other receivables”.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments/ receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and charged/credited to the Statement of Comprehensive Income.

Available for sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Foundation Trust intends to dispose of them within 12 months of the date.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of “other

comprehensive income". When items classified as "available-for-sale" are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in "Finance Costs" in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred and measured subsequently at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position date, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

The Foundation Trust has reviewed all its main contracts and any derivatives the contracts many have with other contracts are 'closely-related' and therefore, does not warrant separate accounting or disclosure.

Determination of fair value

For financial assets and financial liabilities carried at fair value, the carrying amounts are determined from using a number of appropriate techniques including quoted market prices, independent professional appraisals, discounted cash flow analysis, and previous trends and experiences.

Impairment of financial assets

At the end of the reporting period, the Foundation Trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly/through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

The Foundation Trust has reviewed its income receivable from the injury recovery unit on an annual basis taking into account local trends of recovery and appropriate top up provision has been made for irrecoverable debtors, over and above the proposed bad debts provision of 21.99 per cent recommended by the Department of Health.

In line with policy, the Foundation Trust has undertaken a review of all outstanding debts and suitable provisions are recognised within these statements for bad and doubtful debts.

1.27 Transfers of functions to/from other NHS bodies/local government bodies

For functions that have been transferred to the Foundation Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain/loss corresponding to the net assets/liabilities transferred is recognised within income/expenses, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation/amortisation balances from the transferring entity's accounts are preserved on recognition in the trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

1.28 Accounting standards that have been issued but have not yet been adopted

The HM Treasury FReM/FT ARM does not require the following standards and interpretations to be applied in 2015/16. The application of the standards as revised would not have a material impact on the accounts for 2015/16, were they applied in that year.

IFRS 9 Financial instruments – assets/liabilities	Expected to be effective from 2018/19
IFRS 15 Revenue from contracts with customers	Expected to be effective from 2017/18
IFRS 11(amendment) Acquisition of an interest in a joint operation	Expected to be effective from 2016/17
IAS 1(amendment) Disclosure initiative	Expected to be effective from 2016/17
IAS 16 and 38 (amendment) Depreciation and amortisation	Expected to be effective from 2016/17
IAS 16 and 41 (amendment) Bearer plants	Expected to be effective from 2016/17
IAS 27 (amendment) Equity method in separate financial statements	Expected to be effective from 2016/17
IFRS 10 and IAS 28 (amendment) Sale or contribution of assets	Expected to be effective from 2016/17
IFRS 10 and IAS 28 (amendment) Investment entities applying the consolidation exception	Expected to be effective from 2016/17
Annual Improvements to IFRS 2012 – 15 cycle	Expected to be effective from 2017/18

2 Operating segments

The Foundation Trust's major activity is healthcare and therefore is treated as a single segment. The operating results of the Foundation Trust are reviewed monthly by the Foundation Trust's chief operating decision maker which is the overall Foundation Trust Board and which includes non-executive directors. For 2015/16, the Board of Directors reviewed the financial position of the Foundation Trust as a whole in their decision making process.

The single segment of healthcare' has therefore been identified consistent with the core principle of IFRS 8 which is to enable users of financial statements to evaluate the nature and financial effects of business activities and economic environments.

	Healthcare		Total	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
Income	334,007	330,457	334,007	33,457
Deficit before impairments and restructuring	26,093	23,141	26,093	23,141
Restructuring costs	771	(436)	771	(436)
Impairment reversals relating to market value included in income	1,695	603	1,695	603
Impairments relating to market value changes charged to expenses	(2,464)	(2,031)	(2,464)	(2,031)
Retained deficit	26,095	21,277	26,095	21,277
Segment net assets	87,915	115,085	87,915	115,085

2.1 Income generation activities

The Foundation Trust undertakes certain activities with an aim of break even or achieving a small profit, which is then used to support patient care. Some of these activities are essential for providing the right level of service the patients and visitors and the profit element, if any, is incidental to the service provision.

The following table provides details of activities for which gross income exceeded £1million.

i) Car Parking Services

	2015/16	2014/15
	£000	£000
Income	2,226	2,159
Direct costs	(930)	(925)
Surplus before indirect costs	1,296	1,234
Indirect Costs	(971)	(898)
Surplus	325	336

Car parking services is a managed service operated by ISS Mediclean. The income is received by the Foundation Trust and is accounted for gross within the financial statements.

ii) Catering services across three sites

Catering income amounted to £1.09million (£0.75million 2014/15) during the year. However, the costs associated with the income generation form part of the costs of the total catering provision for patients, staff and visitors and are not separately identified.

3 Operating income from patient care activities

3.1 Income from patient care activities (by nature)

	Group	
	2015/16 £000	2014/15 £000
Acute services		
Elective income	42,206	46,094
Non elective income	70,293	78,902
Outpatient income	41,621	43,444
A & E income	14,207	13,098
Other NHS clinical income *	126,319	104,789
	294,646	286,327
Private patient income	891	921
Other clinical income	6,482	8,796
Total income from activities	302,019	296,044

* Other NHS Clinical income includes income from non-tariff services relating to activity such as pathology, radiology, imaging, therapy, community etc.

3.2 Income from patient care activities (by source)

	Group	
	2015/16 £000	2014/15 £000
Income from patient care activities received from:		
CCGs and NHS England*	297,144	293,730
Local authorities	1,107	19
Other NHS foundation trusts	1,082	18
Non-NHS: private patients	891	921
Non-NHS: overseas patients (chargeable to patient)	330	140
NHS injury scheme (was RTA) **	1,046	842
Non NHS: other	419	374
Total income from activities	302,019	296,044
Of which:		
Related to continuing operations	302,019	296,044

*This includes £2.759m relating to the Better Care Fund

** Injury cost recovery income is subject to a provision for impairment of receivables of 25 per cent, which is 3.01 per cent more than the recommended Department of Health rate, to reflect expected rates of collection based on historical trend.

3.3 Overseas Visitors (relating to patients charged directly by the NHS Foundation Trust)

	Group	
	2015/16 £000	2014/15 £000
Income recognised this year	330	140
Cash payments received in-year	28	15
Amounts added to provision for impairment of receivables	-	-
Amounts written off in-year	45	47

4 Other operating income

	Group	
	2015/16 £000	2014/15 £000
Research and development	892	843
Education and training	9,362	9,386
Non-patient care services to other bodies *	17,684	18,731
Profit on disposal of non-current assets	13	23
Incoming resources received by NHS charitable funds	817	372
Other income **	5,979	5,058
Total other operating income	<u>34,747</u>	<u>34,413</u>
Of which:		
Related to continuing operations	34,747	34,413

* Non patient care services to other bodies includes £10.0m (£9.7m 2014/15) income from United Lincolnshire Hospitals NHS Trust for pathology services, £1.3m (£2.3m 2014/15) from other providers for pathology services, and £6.1m (£6.2m 2014/15) relates to other provider to provider agreements.

** Other income includes £2.23m (£2.16m 2014/15) for car parking, £1.09m (£0.75m 2014/15) for catering and £1.17m (£0.78m 2014/15) for staff accommodation.

4.1 Income from activities arising from commissioner requested services

Under the terms of its provider license, the Trust is required to analyse the level of income from activities that has arisen from commissioner requested and non-commissioner requested services. Commissioner requested services are defined in the provider license and are services that commissioners believe would need to be protected in the event of provider failure. This information is provided in the table below:

	Group	
	2015/16 £000	2014/15 £000
Mandatory Services	293,990	286,232
Non mandatory	10,078	9,812
Total	<u>304,068</u>	<u>296,044</u>

5.1 Operating expenses

	Group	2015/16 £000	2014/15 £000
Services from NHS Foundation Trusts		584	1,127
Services from NHS Trusts		2,724	2,403
Services from CCGs and NHS England*		2,759	46
Services from other NHS bodies		422	238
Purchase of healthcare from non NHS bodies		2,952	1,350
Employee expenses - Executive Directors		1,464	1,344
Remuneration of Non-Executive Directors		112	112
Employee expenses - staff		236,034	233,792
Supplies and services - clinical		31,770	32,129
Supplies and services - general		4,844	4,607
Establishment		4,179	4,000
Transport		1,218	1,255
Premises		16,280	17,036
Increase/(decrease) in provision for impairment of receivables		(3)	(44)
Drug costs		7,863	4,819
Inventories consumed		22,444	23,061
Rentals under operating leases		580	620
Depreciation on property, plant and equipment		7,346	6,751
Amortisation on intangible assets		434	362
Audit fees payable to the external auditor			
audit services- statutory audit		77	63
other auditor remuneration (external auditor only)		258	610
Clinical negligence		10,253	6,622
Loss on disposal of other Property Plant and Equipment		33	61
Legal fees		463	603
Consultancy costs **		1,344	1,053
Internal audit costs		108	79
Training, courses and conferences		628	808
Patient travel		36	53
Early retirements		31	147
Hospitality		46	56
Insurance		690	658
Losses, ex gratia and special payments		9	15
Other resources expended by NHS charitable funds		79	51
Other ***		1,436	562
Total		359,497	346,449
Of which:			
Related to continuing operations		359,497	346,449

*This includes £2.759m relating to the Better Care Fund

**Consultancy includes expenditure on the Healthy Lives Healthy Futures project.

***Other expenditure includes £0.95m relating to an increase in injury benefit provision.

5.2 Other auditor remuneration

	Group	
	2015/16 £000	2014/15 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	-	-
2. Audit-related assurance services	9	9
3. Taxation compliance services	-	-
4. All taxation advisory services not falling within item 3 above	-	-
5. Internal audit services	-	-
6. All assurance services not falling within items 1 to 5	-	-
7. Corporate finance transaction services not falling within items 1 to 6 above	-	-
8. Other non-audit services not falling within items 2 to 7 above	249	601
Total	258	610

5.3 Limitation on auditors' liability

The limitation on auditors' liability for external audit work is £1million (2014/15: £1million).

6 Impairment of assets

	Group	
	2015/16 £000	2014/15 £000
Net impairments charged to operating deficit resulting from:		
Other	769	1,428
Total net impairments charged to operating deficit	769	1,428
Impairments charged to the revaluation reserve	1,893	2,009
Total net impairments	2,662	3,437

7 Employee benefits

	Group			
	Permanent £000	Other £000	Total £000	2014/15 Total £000
Salaries and wages	181,835	779	182,614	179,975
Social security costs	13,414	-	13,414	13,402
Employer's contributions to NHS pensions	20,791	-	20,791	20,312
Agency/contract staff	-	20,679	20,679	21,447
Total gross staff costs	216,040	21,458	237,498	235,136
Recoveries in respect of seconded staff	-	-	-	-
Total staff costs	216,040	21,458	237,498	235,136

7.1 Retirements due to ill-health

During 2015/16 there were 11 early retirements from the Trust agreed on the grounds of ill-health (17 in the year ended 31 March 2015). The estimated additional pension liabilities of these ill-health retirements is £684k (£1226k in 2014/15).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

7.2 Directors' remuneration

The aggregate amounts payable to directors were:

	Group	
	2015/16	2014/15
	£000	£000
Salary	1268	1172
Employer's National Insurance	147	136
Employer's pension contributions	161	148
Total	1,576	1,456

Further details of directors' remuneration can be found in the remuneration report.

7.3 Management costs

	2015/16	2014/15
	Total	Total
	£000	£000
Management Costs	13,347	11,835
Income	333,938	330,815
Management Costs as a % of income	4.0%	3.6%

The above is excluding charitable income and costs.

8 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it was a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes.

The valuation of the scheme liability as at March 31 2016, is based on valuation data as March 31 2015, updated to March 31 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account its recent demographic experience), and to recommend the contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending March 31 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from April 1 2016.

9 Operating Leases

9.1 Northern Lincolnshire and Goole NHS Foundation Trust as a lessor

The Foundation Trust has made spaces available within the three sites to the local CCGs and the Disability Trust renewable on an annual basis. These are operating leases and the rental from these leases is recognised on a straight line basis within these financial statements.

9.2 Northern Lincolnshire and Goole NHS Foundation Trust as a lessee

The Foundation Trust's operating leases predominantly relate to lease cars.

	Group	
	2015/16 £000	2014/15 £000
Operating lease expense		
Minimum lease payments	580	620
Total	580	620
	31 March 2016 £000	31 March 2015 £000
Future minimum lease payments due:		
- not later than one year;	1,359	1,271
- later than one year and not later than five years;	1,182	1,042
Total	2,541	2,313
Future minimum sublease payments to be received	-	-

10 Finance income

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

	Group	
	2015/16 £000	2014/15 £000
Interest on bank accounts	43	65
Investment income on NHS charitable funds financial assets	70	79
Total	113	144

11.1 Finance expenses

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

	Group	
	2015/16 £000	2014/15 £000
Interest expense:		
Loans from the Department of Health	477	264
Finance leases	7	26
Total interest expense	484	290
Other finance costs	69	56
Total	553	346

11.2 The Late Payment of Commercial Debts (interest) Act 1998

	Group	
	2015/16 £000	2014/15 £000
Amounts included within interest payable arising from claims made under this legislation	-	-
Compensation paid to cover debt recovery costs under this legislation	-	-

Note 12 Revaluation of assets (property, plant and equipment) DTZ valuations summary

	2015/16 £000	2014/15 £000
Impairments		
Impairments charged to Revaluation Reserve	(1,893)	(2,009)
Impairments charged to Statement of Comprehensive income	(2,464)	(2,031)
Total Impairments due to Market Changes	<u>(4,357)</u>	<u>(4,040)</u>
 Revaluation gains	 	
Revaluation gains credited to Revaluation Reserve	774	817
Revaluation gains relating to previous impairments credited to income	1,695	603
Total Revaluation gains due to Market Changes	<u>2,469</u>	<u>1,420</u>

13 Corporation tax

	2015/16 £000	2014/15 £000
UK corporation tax expense	-	-
Adjustments in respect of prior years	-	-
Current tax expense	-	-
Origination and reversal of temporary differences	-	-
Adjustments in respect of prior years	-	-
Change in tax rate	-	-
Deferred tax expense	-	-
Total income tax expense in Statement of Comprehensive Income	<u>-</u>	<u>-</u>

Reconciliation of effective tax charge

Effective tax charge percentage	0%	0%
Tax if effective tax rate charged on surpluses before tax	-	-
Effect of:		
Surpluses not subject to tax	-	-
Non-deductible expenses	-	-
Adjustments in respect of prior years	-	-
Share of results of joint ventures and associates	-	-
Change in tax rate	-	-
Other	-	-
Total income tax charge for the year	<u>-</u>	<u>-</u>

14 Discontinued operations

	2015/16 £000	2014/15 £000
Operating income of discontinued operations	-	-
Operating expenses of discontinued operations	-	-
Result on disposal of discontinued operations	-	-
Result on disposal of discontinued operations	-	-
Total	-	-
	-	-

15.1 Intangible assets - 2015/16

Group	Software licences £000	Total £000
Valuation/gross cost at 1 April 2015 - brought forward	5,978	5,978
Additions	151	151
Gross cost at 31 March 2016	6,129	6,129
Amortisation at 1 April 2015 - brought forward	4,543	4,543
Provided during the year	434	434
Amortisation at 31 March 2016	4,977	4,977
Net book value at 31 March 2016	1,152	1,152
Net book value at 1 April 2015	1,435	1,435

15.2 Intangible assets - 2014/15

Group	Software licences £000	Total £000
Valuation/gross cost at 1 April 2014 - as previously stated	5,226	5,226
Prior period adjustments	-	-
Gross cost at 1 April 2014 - restated	5,226	5,226
Additions	747	747
Reclassifications	5	5
Valuation/gross cost at 31 March 2015	5,978	5,978
Amortisation at 1 April 2014 - as previously stated	4,181	4,181
Prior period adjustments	-	-
Amortisation at 1 April 2014 - restated	4,181	4,181
Provided during the year	362	362
Amortisation at 31 March 2015	4,543	4,543
Net book value at 31 March 2015	1,435	1,435
Net book value at 1 April 2014	1,045	1,045

All intangible assets are purchased and they are not subject to indexation or revaluations.

16.1 Property, plant and equipment - 2015/16

Group	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant machinery & equipment	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2015 – brought forward	9,900	117,823	3,511	4,482	39,774	133	7,797	704	184,124
Additions	-	8,267	-	1,969	2,827	5	827	43	13,938
Impairments	(14)	(1,873)	(6)	-	-	-	-	-	(1,893)
Reclassifications	-	3,804	-	(4,341)	529	-	2	6	-
Revaluations	6	672	96	-	-	-	-	-	774
Disposals/derecognition	-	-	-	-	(2,050)	-	-	-	(2,050)
Valuation/gross cost At 31 March 2016	9,892	128,693	3,601	2,110	41,080	138	8,626	753	194,893
 Accumulated depreciation at 1 April 2015 – brought forward	894	7,553	283	-	30,924	73	5,486	538	45,751
Provided during the year	-	2,736	234	-	3,530	15	774	57	7,346
Impairments	46	2,418	-	-	-	-	-	-	2,464
Reversals of impairments	-	(1,672)	(23)	-	-	-	-	-	(1,695)
Disposals/derecognition	-	-	-	-	(2,017)	-	-	-	(2,017)
 Accumulated depreciation at 1 April 2015 – brought forward	940	11,035	494	-	32,437	88	6,260	595	51,849
 Net book value at 31 March 2016	8,952	117,658	3,107	2,110	8,643	50	2,366	158	143,044
 Net book value at 1 April 2015	9,006	110,270	3,228	4,482	8,850	60	2,311	166	138,373

16.2 Property, plant and equipment - 2014/15

Group	Land	Buildings excluding dwelling	Dwellings	Assets under construction	Plant machinery & equipment	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2014 – as previously stated	9,283	114,507	3,234	870	38,792	92	6,795	683	174,256
Prior period adjustments	-	-	-	-	-	-	-	-	-
Valuation/gross cost at 1 April 2014 – restated	9,283	114,507	3,234	870	38,792	92	6,795	683	174,256
Additions – purchased/leased/grants/donations	588	2,964	1,372	4,361	1,824	41	977	21	12,148
Impairments	(80)	(563)	(1,366)	-	-	-	-	-	(2,009)
Reclassifications	-	712	7	(749)	-	-	25	-	(5)
Revaluations	179	203	435	-	-	-	-	-	817
Disposals /derecognition	(70)	-	(171)	-	(842)	-	-	-	(1,083)
Valuation/gross cost at 31 March 2015	9,900	117,823	3,511	4,482	39,774	133	7,797	704	184,124
Accumulated depreciation at 1 April 2014 – as previously stated	(2)	4,839	124	-	28,188	64	4,702	474	38,389
Prior period adjustments	-	-	-	-	-	-	-	-	-
Accumulated depreciation at 1 April 2014 - restated	(2)	4,839	124	-	28,188	64	4,702	474	38,389
Provided during the year	-	2,281	68	-	3,545	9	784	64	6,751
Impairments	896	1,036	99	-	-	-	-	-	2,031
Reversals of impairments	-	(603)	-	-	-	-	-	-	(603)
Disposals /derecognition	-	-	(8)	-	(809)	-	-	-	(817)
Accumulated depreciation at 31 March 2015	894	7,553	283	-	30,924	73	5,486	538	45,751
Net book value at 31 March 2015	9,006	110,270	3,228	4,482	8,850	60	2,311	166	138,373
Net book value at 1 April 2014	9,285	109,668	3,110	870	10,604	28	2,093	209	135,867

16.3 Property, plant and equipment financing - 2015/16

Group	Land £000	Buildings excluding dwelling	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fitting £000	Total £000
Net book value at 31 March 2016									
Owned	8,952	115,097	3,107	2,110	8,134	50	2,328	151	139,929
Finance leased	-	-	-	-	61	-	-	-	61
Donated	-	2,561	-	-	448	-	38	7	3,054
NBV total at 31 March 2016	8,952	117,658	3,107	2,110	8,643	50	2,366	158	143,044

16.4 Property, plant and equipment financing - 2014/15

Group	Land £000	Buildings excluding dwelling £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Net book value at 31 March 2015									
Owned	9,006	107,672	3,228	4,482	8,152	60	2,285	154	135,039
Finance leased	-	-	-	-	203	-	-	-	203
Donated	-	2,598	-	-	495	0	26	12	3,131
NBV total at 31 March 2015	9,006	110,270	3,228	4,482	8,850	60	2,311	166	138,373

17 Donations of property, plant and equipment

The Foundation Trust received charitable contributions to support capital purchases as follows:

	2015/16 £000	2014/15 £000
Buildings ex Dwellings	359	163
Plant and machinery	140	169
Information Technology	20	-
	519	332

18 Revaluations of property, plant and equipment

The Foundation Trust's Property have been revalued on a Modern Equivalent Asset basis as at March 31 2010 by the District Valuers in accordance with the Treasury's guidelines. At March 31 2016, the Foundation Trust's Valuers (DTZ) completed a revaluation of the estate which resulted in a net downward valuation. The results of this valuation have been included in these financial statements.

The property asset lives are as stated in the revaluation by the Foundation Trust Valuers.

In line with the Foundation Trust's Estates Strategy and Rationalisation program, and some of the non specialised building assets have been declared non-operational and these assets have been valued by the Foundation Trust Valuers to the land value. These are predominantly on the north side of Diana, Princess of Wales Hospital site and have been earmarked for demolition as per the Estates Strategy. The impairments relating to these assets are charged to the Statement of Comprehensive Income.

Basis of valuation

The valuations have been carried out primarily on the basis of Market Value Existing Use using the depreciated replacement cost (DRC) methodology on a modern substitute basis. Non-operational property, including surplus land, has been valued to Market Value Alternate Use.

Unless otherwise stated, the assumption has been made that the properties valued will continue to be in the occupation of the Foundation Trust for the foreseeable future having regard to the prospect and viability of the continuance of that occupation.

Method of valuation

Depreciated Replacement Cost (DRC) is the method of valuation adopted for arriving at the value of specialised operational property for financial accounting purposes as recommended by UK GAAP, the Royal Institution of Chartered Surveyors and HM Treasury.

DRC is based on an estimate of the market value for the existing use of the land, plus the current gross replacement (reproduction) costs of the improvements, less allowances for physical deterioration and all relevant forms of obsolescence and optimisation.

Where the actual use of the property is so special that it proves impossible to categorise it in general market terms, land has been valued assuming the benefit of planning permission for development for a use, or a range of uses, prevailing in the vicinity of the actual site. In these circumstances, the Market Value for the Existing Use (MVEU) of the land has been

arrived at having regard to the cost of purchasing a notional replacement site in the same locality that would be equally suitable for the existing use and of the same size, with normally the same physical and locational characteristics as the actual site, other than characteristics of the actual site that are irrelevant, or of no value, to the existing use.

19 2015/16 - Property valuations summary by the DTZ

The Foundation Trust Valuers (DTZ) completed a valuation of the Property Assets at 31st March 2016 and concluded that there were changes to the Value of Property Assets. The Foundation Trust identified that these changes are material and therefore, the results have been incorporated into these financial statements. The outcome from the valuation was that, on all three sites, some of the assets suffered impairments whilst other assets had revaluation gains. The Foundation Trust continues to progress its Estates Strategy and Rationalisation programme. The approximate net impact of the Foundation Trust's valuations are given below.

Site	Description	Net Change in Valuation (increase) Decrease £000	Charged to expenses £000	Impairment reversals included as income £000	Changes to revaluation reserves £000
Diana, Princess of Wales Hospitals, Grimsby	Land and Buildings	919	2,071	(1,334)	182
Scunthorpe General Hospital	Buildings	(128)	341	(352)	(117)
Goole District Hospital	Buildings	1,097	52	(9)	1,054
Other	Buildings	-	-	-	-
Total		1,888	2,464	(1,695)	1,119

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

20.1 Other investments - 2015/16

Group	Other investments £000
Carrying value at 1 April 2015	1,995
Movement in fair value	(108)
Disposals	(100)
Carrying value at 31 March 2016	1,787

20.2 Other investments - 2014/15

Group	Other investments £000
Carrying value at 1 April 2014	2,053
Prior period adjustment	-
Carrying value at 1 April 2014 - restated	2,053
Movement in fair value	142
Disposals	(200)
Carrying value at 31 March 2015	1,995

The above investments relate to the Foundation Trust's charitable funds which have been consolidated into these accounts.

21 Charitable fund reserves

The Northern Lincolnshire and Goole NHS Foundation Trust Board is the Corporate Trustee of the NHS Charitable Funds and therefore, the Charitable Funds represents a subsidiary of the Foundation Trust on the basis that it:

- Has control over the NHS charitable fund (as determined by IAS 27 (revised))
- Benefits from the NHS charitable fund.

From 2013/14 Northern Lincolnshire and Goole NHS Foundation Trust has consolidated the NHS charitable funds into its accounts.

For 2015/16, the NHS Charitable Funds balances are as follows:

	31 March 2016 £000	31 March 2015 £000
Unrestricted funds:		
Unrestricted income funds	1,851	1,839
Restricted funds:		
Restricted income funds	37	109
	1,888	1,948

Unrestricted income funds are accumulated income funds that are expendable at the discretion of the trustees in furtherance of the charity's objects. Unrestricted funds may be earmarked or designated for specific future purposes which reduces the amount that is readily available to the charity.

Restricted funds may be accumulated income funds which are expendable at the trustee's discretion only in furtherance of the specified conditions of the donor and the objects of the charity. They may also be capital funds (e.g. endowments) where the assets are required to be invested, or retained for use rather than expended.

22 Disclosure of interests in other entities

The Foundation Trust has entered into a co-operation agreement with the Brain Injuries Rehabilitation Trust (BIRT) to form a separate entity Goole Neuro Rehabilitation Centre (GNRC) which operates from Ward 4 at Goole District Hospital. The Joint Venture provides both NHS care and care independent to the NHS but within an NHS location. The Commissioners, Social Services and other agencies commission services from the Joint venture and the Joint Venture is managed on a day to day basis by BIRT. The Joint Venture accesses support services and has access to NHS facilities from Northern Lincolnshire and Goole NHS Foundation Trust which are governed by appropriate service level agreements. The Trust includes within its financial statements its share of the activities, assets and liabilities.

23 Inventories

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Drugs	801	925	801	925
Consumables	1,334	1,359	1,334	1,359
Energy	77	79	77	79
Other	277	322	277	322
Total inventories	2,489	2,685	2,489	2,685

Inventories recognised in expenses for the year were £32,726k (2014/15: £37,164k). Write-down of inventories recognised as expenses for the year were £0k (2014/15: £0k).

24.1 Trade and other receivables

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Trade receivables due from NHS bodies	6,472	6,822	6,472	6,822
Provision for impaired receivables	(733)	(786)	(733)	(786)
Prepayments (non-PFI)	2,394	3,537	2,394	3,537
PDC dividend receivable	136	-	136	-
VAT receivable	583	616	583	616
Other receivables	7,182	6,121	7,182	6,121
Trade and other receivables held by NHS charitable funds	45	15	3	-
Total current trade and other receivables	16,079	16,325	16,037	16,310
Non-current				
Other receivables	11	15	11	15
Total non-current trade and other receivables	11	15	11	15

24.2 Provision for impairment of receivables

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
At 1 April as previously stated	786	890	786	890
Prior period adjustments	-	-	-	-
At 1 April - restated	786	890	786	890
Increase in provision	261	210	261	210
Amounts utilised	(50)	(60)	(50)	(60)
Unused amounts reversed	(264)	(254)	(264)	(254)
At 31 March	733	786	733	786

The provision for bad debt has been calculated following a detailed review of all outstanding invoices as at March 31 2016. The RTA provision for bad debt is 25% based on the recovery trend in the past years and the level of potential cancellations.

24.3 Analysis of impaired receivables

Group	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
	£000	£000	£000	£000
Ageing of impaired receivables				
0 - 30 days	18	-	251	-
30-60 Days	224	-	105	-
60-90 days	90	-	106	-
90- 180 days	289	-	328	-
Over 180 days	1,584	-	1,420	-
Total	2,205	-	2,210	-

Ageing of non-impaired receivables past their due date

0 - 30 days	1,051	-	596	-
30-60 Days	380	-	302	-
60-90 days	357	-	371	-
90- 180 days	1,004	-	943	-
Over 180 days	1,288	-	820	-
Total	4,080	-	3,032	-

Trust	31 March 2016		31 March 2015	
	Trade receivables	Other receivables	Trade receivables	Other receivables
	£000	£000	£000	£000
Ageing of impaired receivables				
0 - 30 days	18	-	251	-
30 -60 Days	224	-	105	-
60 -90 days	90	-	106	-
90 - 180 days	289	-	328	-
Over 180 days	1,584	-	1,420	-
Total	2,205	-	2,210	-

Ageing of non-impaired receivables past their due date

0 - 30 days	1,051	-	596	-
30-60 Days	380	-	302	-
60-90 days	357	-	371	-
90- 180 days	1,004	-	943	-
Over 180 days	1,288	-	820	-
Total	4,080	-	3,032	-

25 Other assets

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Net pension scheme asset	-	-	-	-
Other assets	-	-	-	-
Total	-	-	-	-

26 Other financial assets

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Non-current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	-	-	-	-
Current				
Embedded derivatives held at 'fair value through income and expenditure'	-	-	-	-
Other financial assets held at 'fair value through income and expenditure'	-	-	-	-
Available for sale financial assets	-	-	-	-
Held to maturity investments	-	-	-	-
Loan and receivables	-	-	-	-
Other financial assets held by NHS charitable funds	-	-	-	-
Total	-	-	-	-

27 Non-current assets for sale and assets in disposal groups

At the Statement of Financial Position date the Trust does not have any assets held for sale.

28 Liabilities in disposal groups

Categorised as:	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Provisions	-	-	-	-
Trade and other payables	-	-	-	-
Other	-	-	-	-
Total	-	-	-	-

29.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	Group		Trust	
	2015/16	2014/15	2015/16	2014/15
	£000	£000	£000	£000
At 1 April	21,177	26,633	21,156	26,504
Net change in year	(15,861)	(5,456)	(15,955)	(5,348)
At 31 March	5,316	21,177	5,201	21,156
Broken down into:				
Cash at commercial banks and in hand	361	248	361	227
Cash with the Government Banking Service	4,955	20,929	4,840	20,929
Total cash and cash equivalents as in SoFP	5,316	21,177	5,201	21,156
Total cash and cash equivalents as in SoCF	5,316	21,177	5,201	21,156

29.2 Third party assets held by the NHS Foundation Trust

Northern Lincolnshire and Goole NHS Foundation Trust held cash and cash equivalents which relate to monies held by the Foundation Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	Group and Trust	
	31 March 2016	31 March 2015
	£000	£000
Bank balances	-	-
Monies on deposit	-	-
Total third party assets	-	-

30.1 Trade and other payables

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
NHS trade payables	2,963	4,508	2,963	4,508
Amounts due to other related parties	2,973	2,894	2,973	2,894
Other trade payables	9,725	6,808	9,725	6,808
Capital payables	4,018	2,816	4,018	2,816
Other taxes payable	4,505	4,406	4,505	4,406
Other payables	3,398	3,444	3,398	3,444
Accruals	10,564	9,989	10,564	9,989
PDC dividend payable	-	95	-	95
Trade and other payables held by NHS charitable funds	56	83	-	-
Total current trade and other payables	38,202	35,043	38,146	34,960
Non-current				
Total non-current trade and other payables	-	-	-	-

30.2 Early retirements in NHS payables above

Group and Trust	31 March 2016	31 March 2016	31 March 2015	31 March 2015
	£000	Number	£000	Number
The payables note above includes amounts in relation to early retirements as set out below:				
- to buy out the liability for early retirements over five years	-	-	-	-
- number of cases involved		11		17
- outstanding pension contributions	684		1,226	

31 Other liabilities

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Deferred goods and services income	1,473	1,307	1,473	1,307
Total other current liabilities	1,473	1,307	1,473	1,307
Non-current				
Total other non-current liabilities	-	-	-	-

The £1.47million of deferred income in 2015/16 includes £1.0million relating to the sale of land at Diana, Princess of Wales Hospital.

32 Borrowings

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Loans from the Department of Health	1,859	1,684	1,859	1,684
Obligations under finance leases	27	123	27	123
Total current borrowings	1,886	1,807	1,886	1,807
Non-current				
Loans from the Department of Health	32,479	19,338	32,479	19,338
Obligations under finance leases	38	65	38	65
Total non-current borrowings	32,517	19,403	32,517	19,403

33 Other financial liabilities

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Current				
Total	_____	_____	_____	_____
Non-current				
Total	_____	_____	_____	_____

34 Finance leases

Lessor

The Foundation Trust has arrangements with other NHS and non NHS bodies whereby the Foundation Trust receives income for the premises rented to these bodies. These arrangements are covered by annual service level agreements and are normally for a term of one year, renewable at the end of each year by mutual agreement. This income is included within this year's operating income shown in these financial statements. These arrangements are not classed as leases.

Lessee

Obligations under finance leases where Northern Lincolnshire and Goole NHS Foundation Trust is the lessee.

	Group		Trust	
	31 March 2016	31 March 2015	31 March 2016	31 March 2015
	£000	£000	£000	£000
Gross lease liabilities	70	201	70	201
of which liabilities are due:				
- not later than one year;	30	131	30	131
- later than one year and not later than five years;	40	70	40	70
Finance charges allocated to future periods	(5)	(13)	(5)	(13)
Net lease liabilities	65	188	65	188
of which payable:				
- not later than one year;	27	123	27	123
- later than one year and not later than five years;	38	65	38	65

There are no sub lease or contingent rents.

35.1 Provisions for liabilities and charges analysis

Group	Pensions - other staff £000	Other legal claims £000	Redundancies and Restructurings £000	Other £000	Total £000
At 1 April 2015	2,693	163	2,846	3,658	9,360
Arising during the year	31	189	1,022	1,208	2,450
Utilised during the year	(284)	(42)	(309)	(477)	(1,112)
Reversed unused	(1)	(53)	(1,802)	(1,026)	(2,882)
Unwinding of discount	33	-	-	36	69
At 31 March 2016	2,472	257	1,757	3,399	7,885
Expected timing of cash flows:					
- not later than one year;	279	257	966	889	2,391
- later than one year and not later than five years;	1,074	-	791	500	2,365
- later than five years.	1,119	-	-	2,010	3,129
Total	2,472	257	1,757	3,399	7,885

Other provisions include demolition provision of £0.7m, £0.06m of Carbon Reduction Commitment provision and the balance relates to injury benefit relating to named individuals' payments.

Trust	Pensions - other staff £000	Other legal claims £000	Redundancies and Restructurings £000	Other £000	Total £000
At 1 April 2015	2,693	163	2,846	3,658	9,360
Arising during the year	31	189	1,022	1,208	2,450
Utilised during the year	(284)	(42)	(309)	(477)	(1,112)
Reversed unused	(1)	(53)	(1,802)	(1,026)	(2,882)
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At 31 March 2016	2,472	257	1,757	3,399	7,885
Expected timing of cash flows:					
- not later than one year;	279	257	966	889	2,391
- later than one year and not later than five years;	1,074	-	791	500	2,365
- later than five years.	1,119	-	-	2,010	3,129
Total	2,472	257	1,757	3,399	7,885

35.2 Clinical negligence liabilities

At March 31 2016, £99,609k was included in provisions of the NHSLA in respect of clinical negligence liabilities of Northern Lincolnshire and Goole NHS Foundation Trust (March 31 2015: £62,967k).

36 Contingent assets and liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Value of contingent liabilities				
NHS Litigation Authority legal claims	(126)	(97)	(126)	(97)
Gross value of contingent liabilities	(126)	(97)	(126)	(97)
Net value of contingent liabilities	(126)	(97)	(126)	(97)
Net value of contingent assets	-	-	-	-

37 Contractual capital commitments

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
Property, plant and equipment	3,860	6,563	3,860	6,563
Intangible assets	26	-	26	-
Total	3,886	6,563	3,886	6,563

38 Defined benefit pension schemes

The Trust has no defined benefit pension schemes.

39 On-SoFP PFI, LIFT or other service concession arrangements

The Foundation Trust does not have any PFI or LIFT schemes at March 31 2016.

40 Off-SoFP PFI, LIFT and other service concession arrangements

The Foundation Trust does not have any Off-SoFP PFI or LIFT schemes at March 31 2016.

41 Financial instruments

41.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the year in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the Foundation Trust has with Clinical Commissioning Groups and the way those Clinical Commissioning Groups are financed, the Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The Foundation Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Foundation Trust in undertaking its activities.

The Foundation Trust's treasury management operations are carried out by the Finance Directorate, within parameters defined formally within the Foundation Trust's Standing Financial Instructions and policies agreed by the Board of Directors. Foundation Trust treasury activity is subject to regular review by the Trust's Resources Committee and the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust currently has borrowings of £34.338million of which £1.822million carries no interest charge. The remaining loans have an interest rate of 2.06 per cent (£8.256million), 2.39 per cent (£9.26million) and 1.5 per cent (£15.0million).

Credit risk

Because the majority of the Trust's income comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at March 31 2016 are in receivables from customers, as disclosed in the Trade and other receivables note 24.1.

Liquidity risk

The Trust's operating costs are incurred under contracts with Clinical Commissioning Groups, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from internally generated funds and funds obtained from Department of Health or Independent Financing Facility loans. The Trust has in place £18.9million Revolving Working Capital Facility agreed with the Department of Health and the Independent Financing Facility for short term working capital support. This gives the Trust liquidity assurance to cover the period prior to regulator approval of future plans and to manage normal variations in cashflow.

41.2 Financial assets

Group	Loans and receivables £000	Assets at fair value through the I&E £000	Held to maturity £000	Available - for-sale £000	Total £000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets					
	12,179	-	-	-	12,179
Cash and cash equivalents at bank and in hand (Trust)	5,201	-	-	-	5,201
Cash and cash equivalents at bank and in hand (Charitable Funds)	115	-	-	-	115
Financial assets held in NHS charitable funds	45	-	-	-	45
Total at 31 March 2016	17,540	-	-	-	17,540
Assets as per SoFP as at 31 March 2015					
Trade and other receivables excluding non financial assets					
	11,379	-	-	-	11,379
Cash and cash equivalents at bank and in hand (Trust)	21,156	-	-	-	21,156
Cash and cash equivalents at bank and in hand (Charitable Funds)	21	-	-	-	21
Financial assets held in NHS charitable funds	15	-	-	-	15
Total at 31 March 2015	32,571	-	-	-	32,571

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2016					
Trade and other receivables excluding non financial assets	12,179	-	-	-	12,179
Cash and cash equivalents at bank and in hand	5,201	-	-	-	5,201
Total at 31 March 2016	17,380	-	-	-	17,380

Trust	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total
	£000	£000	£000	£000	£000
Assets as per SoFP as at 31 March 2015					
Trade and other receivables excluding non financial assets	11,379	-	-	-	11,379
Cash and cash equivalents at bank and in hand	21,156	-	-	-	21,156
Total at 31 March 2015	32,535	-	-	-	32,535

41.3 Financial liabilities

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	34,338	-	34,338
Obligations under finance leases	65	-	65
Trade and other payables excluding non financial liabilities	33,638	-	33,638
Other financial liabilities	1,473	-	1,473
Provisions under contract	5,413	-	5,413
Financial liabilities held in NHS charitable funds	56	-	56
Total at 31 March 2016	74,983	-	74,983

Group	Other financial liabilities	Liabilities at fair value through the I&E	Total £000
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Borrowings excluding finance lease and PFI liabilities	21,022	-	21,022
Obligations under finance leases	188	-	188
Trade and other payables excluding non financial liabilities	30,376	-	30,376
Other financial liabilities	1,307	-	1,307
Provisions under contract	6,667	-	6,667
Financial liabilities held in NHS charitable funds	83	-	83
Total at 31 March 2015	59,643	-	59,643

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total £000
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2016			
Borrowings excluding finance lease and PFI liabilities	34,338	-	34,338
Obligations under finance leases	65	-	65
Trade and other payables excluding non financial liabilities	33,694	-	33,694
Other financial liabilities	1,473	-	1,473
Provisions under contract	5,413	-	5,413
Total at 31 March 2016	74,983	-	74,983

Trust	Other financial liabilities	Liabilities at fair value through the I&E	Total £000
	£000	£000	£000
Liabilities as per SoFP as at 31 March 2015			
Borrowings excluding finance lease and PFI liabilities	21,022	-	21,022
Obligations under finance leases	188	-	188
Trade and other payables excluding non financial liabilities	30,459	-	30,459
Other financial liabilities	1,307	-	1,307
Provisions under contract	6,667	-	6,667
Total at 31 March 2015	59,643	-	59,643

41.4 Maturity of financial liabilities

	Group		Trust	
	31 March 2016 £000	31 March 2015 £000	31 March 2016 £000	31 March 2015 £000
	39,165	37,389	39,165	37,389
	2,815	2,303	2,815	2,303
In one year or less				
In more than one year but not more than two years				
In more than two years but not more than five years				
In more than five years				
Total	74,983	59,643	74,983	59,643

42 Losses and special payments

Group and Trust	2015/16		2014/15	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	-	-	3	1
Bad debts and claims abandoned	83	51	165	59
Stores losses and damage to property	2	85	4	29
Total losses	85	136	172	89
Special payments				
Ex-gratia payments	51	50	70	137
Total special payments	51	50	70	137
Total losses and special payments	136	186	242	226
Compensation payments received	-	-	-	-

There were no cases exceeding £0.25million in this year and prior years.

43 Events after the reporting date

There are no post balance sheet events in the reporting year.

44 Related parties

During the year none of the Department of Health Ministers, Foundation Trust Board Members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Lincolnshire and Goole NHS Foundation Trust.

The Department of Health is regarded as a related party. During the year, this Foundation Trust has had a significant number of material transactions with other entities for which the Department of Health is regarded as the parent department. These entities are: NHS England, Clinical Commissioning Groups, NHS Trusts, NHS Foundation Trusts and NHS Litigation Authority.

In addition, the Foundation Trust has had a number of material transactions with other government departments and other central and local government bodies.

The Foundation Trust has also received revenue and capital payments from a number of charitable funds, the trustees of the charitable funds are also members of the NHS Foundation Trust Board.

	2015/16 Income	2015/16 Expenditure	31 March 2016 Receivables	31 March 2016 Payables
	£000	£000	£000	£000
Department of Health	-	-	136	-
Doncaster and Bassetlaw Hospitals NHS Foundation Trust	84	80	42	34
Health Education England	9,285	-	-	-
Hull and East Yorkshire Hospitals NHS Trust	1,627	1,716	1,240	696
Humber NHS Foundation Trust	-	-	-	-
Leeds Teaching Hospital NHS Trust	2	498	1	288
Lincolnshire Community Health Services NHS Trust	1,203	5	510	-
Lincolnshire Council	132	-	-	-
Lincolnshire Partnership NHS Foundation Trust	155	-	-	-
NHS Bassetlaw CCG	215	-	-	-
NHS Blood & Transplant	-	1,620	-	35
NHS Doncaster CCG	897	-	-	-
NHS East Riding of Yorkshire CCG	19,267	-	543	-
NHS England	24,437	25	1,669	41
NHS Hull Teaching CCG	200	-	30	-
NHS Lincolnshire East CCG	28,029	-	273	-
NHS Lincolnshire West CCG	10,429	-	93	-
NHS Litigation Authority	-	10,430	-	-
NHS North East Lincolnshire CCG	98,599	41	734	41
NHS North Lincolnshire CCG	109,116	2,858	-	571
NHS Pension Scheme	-	20,791	-	2,973
NHS Property Services	-	646	-	400
NHS South Lincolnshire CCG	1,115	-	-	-
NHS South West Lincolnshire CCG	2,386	-	23	-
NHS Vale of York CCG	696	-	-	-
NHS Wakefield CCG	156	-	23	-
North East Lincolnshire Council	316	845	5	-
North Lincolnshire Council	1,920	854	241	-
Nottingham University Hospitals NHS FT	78	129	37	36
Peterborough & Stamford NHS FT	14	220	-	-
Public Health England	-	246	-	-
Rotherham Doncaster and South Humber Mental Health NHS Foundation Trust	111	213	51	18
Sheffield Children's NHS Foundation Trust	42	222	38	85
Sheffield Teaching Hospitals NHS FT	633	552	153	331
United Lincolnshire Hospitals NHS Trust	10,459	861	219	142
University Hospitals of Leicester	-	71	170	29
York Hospitals NHS Foundation Trust	-	-	1	10
Other (Total)	2,051	1,190	622	206
Total Related Parties	323,654	44,113	6,854	5,936
HM Revenue and Customs (Taxes and Duties)	-	13,468	583	4,505
Other Government Departments	-	13,468	583	4,505
Comparatives 2014/15				
Total Related Parties	315,649	37,188	7,068	8,541
Other Government Departments	-	13,402	616	4,406

45 Third party assets

The Foundation Trust held £0 (2014/15 £3,000) cash and cash equivalents which relates to monies held by the NHS Foundation Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

